Exploring psychological safety in adult inpatient mental healthcare. How does restrictive practice impact psychological safety?

Bethany Leigh Griffin

Submitted in accordance with the requirements for the degree of Doctor of Philosophy

The University of Leeds

School of Psychology

February 2026

Intellectual Property and Publication Statements

I confirm that the work submitted is my own, except where work which has formed part of jointly authored publications has been included. My contribution, and the other authors to this work, has been explicitly indicated below. I confirm that appropriate credit has been given within the thesis where reference has been made to the work of others.

This thesis is an alternative style doctoral thesis and comprises jointly authored manuscripts, two of which are published, one is under review and one is drafted ready for submission. The formatting of these papers is dependent on the journal they are published in or are currently under review with. I confirm that I am the first author on each of the manuscripts included in this thesis and that each manuscript is derived from original research undertaken whilst registered as a doctoral student. I confirm that the material submitted complies with the alternative thesis guidance supplied by the University of Leeds.

Chapter 2 Published Manuscript

Griffin, B., Baker, J., Vogt, K. S., Rich, J., & Johnson, J. (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, 34(5), 624–640. https://doi.org/10.1080/09638237.2025.2478372

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.

Chapter 3 Published Manuscript

Griffin, B., Johnson J., Vogt, K. S., Mizen, E., Keyworth, C., and Baker, J. (2025). Exploring How the Psychological Safety of Patients Is Impacted by Restrictive Practices in Inpatient

Mental Healthcare: A Qualitative Study. International Journal of Mental Health Nursing, 34(6), e70148. https://doi.org/10.1111/inm.70148.

The authors confirm their contribution to the paper as follows. Conceptualisation and Design: BG, JJ, JB and KV; Development of Research Materials: BG, EM, JB, JJ and KV.; Data Collection: BG. And KV; Analysis: BG; Draft Manuscript Preparation: BG. All authors reviewed the results and approved the final version of the manuscript.

Chapter 4 Accepted Manuscript

Griffin, B., Keyworth, C., Johnson, J., and Baker, J. [In press]. Identifying barriers and facilitators to providing psychologically safe care in inpatient mental healthcare. A Theoretical Domains Framework-informed qualitative study. *Journal of Clinical Nursing.*

The authors confirm their contribution to the paper as follows. Conceptualisation and Design: BG, JB and JJ; Development of Research Materials: BG, JB and JJ; Data Collection: BG; Analysis: BG, supported by CK; Draft Manuscript Preparation: BG. All authors reviewed the results and approved the final version of the manuscript.

Chapter 5 Draft Manuscript

Griffin, B., Baker, J., and Keyworth C. (2025). Providing psychologically safe care in inpatient mental healthcare: a qualitative study with former patients and staff. [Unpublished manuscript]. School of Psychology, University of Leeds.

The authors confirm their contribution to the paper as follows. Conceptualisation and Design: BG, JB and CK; Analysis: BG, supported by CK; Draft Manuscript Preparation: BG. All authors reviewed the results and the draft version of the manuscript.

Acknowledgements

I would like to start by saying thank you to my incredibly supportive supervisors Professor John Baker and Dr Chris Keyworth. Thank you both for your insightful advice and constructive comments. This PhD would not have been possible without your guidance, encouragement and kindness.

Thank you to my previous supervisor Dr Judith Johnson for always being on hand to provide constructive feedback and advice. Thank you to Dr Kathy Vogt for encouraging me to apply to the PhD programme and providing support in the early days. To Dr Sarah Kendal and Dr Angela Teece, thank you for supporting the transfer and review processes and challenging my thinking. Thank you to the University of Leeds and Yorkshire and Humber Patient Safety Research Collaboration for funding this PhD. Thank you to the PGRs in the School of Psychology, especially Jessica Rich, working alongside you has been a highlight of the last 3.5 years.

A special thank you to all the former patients and staff who have taken part in this research and the members of the HEER group, PSRC lay leaders and lived experience advisors who advised on the research. Your contributions were invaluable, and I am incredibly grateful that you trusted me with your experiences. I hope the findings in this thesis can contribute to the change that you wish to see.

A personal thank you to Willis for his endless encouragement and belief in me, always and forever.

I'd like to dedicate this thesis to my Mum and Nannan Betty who didn't get to see me finish my PhD. I hope I continue to make them proud.

Abstract

In inpatient mental health services, restrictive practices are used to contain risk and maintain physical safety on wards but have shown to negatively impact patient wellbeing and trust. Researchers and professionals suggest mental health care often focuses on the physical safety of patients at the expense of psychological safety. There are two important gaps in the current literature: 1) an understanding of what psychological safety means to patients in inpatient mental health services, and 2) what is the relationship between restrictive practices and psychological safety. The overall aim of this thesis was to understand how restrictive practices can be made more psychologically safe for patients in inpatient mental health services. This thesis used an exploratory qualitative design comprising four studies, where the findings of each study informed the development of the next. A systematic review (Study 1) of published qualitative research found that restrictive practices were mainly experienced negatively by services users, but the use of supportive communication had the potential to mitigate feelings of coercion and increase trust in staff. An interview study with former patients (Study 2) was carried out and the findings reported on the complex relationship between restrictive practices and psychological safety. A working definition of psychological safety was also developed from the findings and refined with the Help from Experts by Experience for Researchers (HEER) group. An interview study with staff working in inpatient mental health services (Study 3) explored the barriers and facilitators to providing psychologically safe care in practice. Finally, a synthesis of former patient's and staff's suggestions for providing psychologically safe care in practice was conducted (Study 4) using data from semi-structured interviews carried out in Study 2 and Study 3. This study outlined key areas of mental health care provision that are implicated in providing psychologically safe care. The findings from all four studies have been triangulated and critically discussed to develop seven recommendations for how restrictive practices can be made more psychologically safe for patients in inpatient mental health services. The recommendations and findings from this programme of work demonstrate: 1) the importance

of supportive communication to enhance a patient's trust in staff and psychological safety, 2) the need to empower patients to be active participants in their care and 3) organisations providing safe environments to avoid reliance on restrictive practices.

Table of Contents

List of Tables

Chapter 1

Chapter 2

Chapter 3

Chapter 4

Chapter 5

List of Figures

Chapter 1

Chapter 2

Chapter 6

List of Abbreviations

BG	Bethany Griffin
CINAHL	Cumulative Index to Nursing and Allied Health Literature
CK	Chris Keyworth
CQC	Care Quality Commission
EM	Emily Mizen
HEER	Help from Experts by Experience for Researchers group
HSSIB	Health Services Safety Investigations Body
JB	John Baker
JJ	Judith Johnson
JR	Jessica Rich
KV	Kathy Vogt
MDT	Multidisciplinary Team
MS	Microsoft
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
PhD	Doctor of Philosophy
PPI	Patient and Public Involvement
RTA	Reflexive Thematic Analysis
TDF	Theoretical Domains Framework

Chapter 1 Introduction

1.1 Chapter Overview

This chapter provides an overview of the thesis objectives, introduces key terms and presents relevant literature to demonstrate the relevance of the current work. An overview of mental health services in the United Kingdom (UK) is outlined, before discussing research which explored factors related to psychological safety and the developed interventions to reduce restrictive practices. An overview of the gaps in current knowledge, rationale and methodological approach is reported at the end of this chapter.

1.2 Thesis Aims and Overview

The overarching aim of the programme of research is to understand how restrictive practices can be made more psychologically safe for patients in inpatient mental health services. This will be achieved through addressing the following objectives:

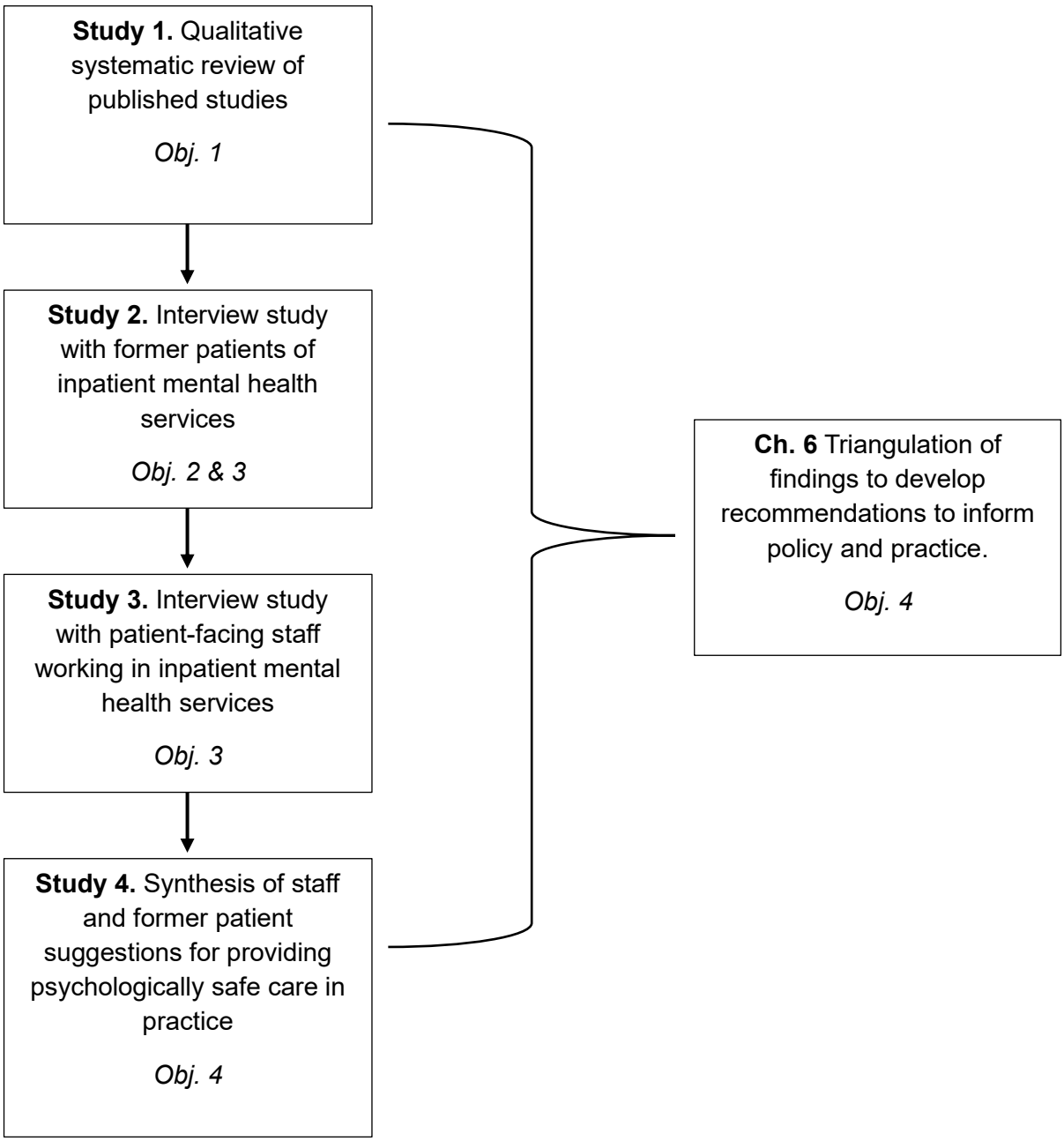
1) Understand and explore service users' experiences of restrictive practices.
2) Elucidate the relationships between restrictive practices and psychological safety from the perspective of former patients.
3) Explore what former patients and staff believe could be done in practice to make restrictive practices more psychologically safe.
4) Develop practical recommendations for how to provide psychologically safe care when restrictive practices are used.

This thesis used an exploratory qualitative design, following a sequential structure whereby each study informed the next, to address the overarching aim and objectives (detailed in Figure 1). This thesis is presented in an alternative format, describing a series of four studies. The four studies include: a qualitative systematic review of published literature (Chapter 2; Griffin et al., 2025a), an interview study with former patients (Chapter 3; Griffin et al., 2025b), an interview study with patient-facing staff working in inpatient mental health

services (Chapter 4) and a synthesis of former patient's and staff's suggestions for providing psychologically safe care in practice, using a theoretically informed framework (Chapter 5). Finally, the findings from the four studies will be triangulated and critically discussed to suggest recommendations for practice and future research (Chapter 6).

Figure 1.1

Sequential Structure of the Studies Included in the Thesis and the Addressed Objectives



1.2.1 Terminology

In practice and research, there are several terms used to refer to the key concepts of this thesis. After consideration of the literature and consultation with stakeholders, I have defined the following concepts to provide clarity for this thesis: patients, psychological safety and restrictive practices.

1.2.1.1 Patients. There are several terms used to refer to people who access mental health services including, patients and service users. After consultation with people with lived experience of mental health services, their carers and conversations with participants in Study 2, it was agreed that several terms could be used to reflect different circumstances. Patient is primarily used throughout this thesis and refers to a person currently accessing mental health services (inpatient and outpatient). Former patient is used to refer to a person who has previously accessed services at the time of participation (inpatient and outpatient) but is not currently receiving inpatient care. Service user was used as a collective term in the systematic review (Study 1) to refer to people who are currently accessing mental health services (inpatient and outpatient) and people who have previously accessed services (inpatient and outpatient). When conducting research or communicating with people who have accessed mental health services, their personal preference was used.

1.2.1.2 Psychological Safety. Psychological safety was a term originally coined in occupational psychology (Edmondson, 1999) and relates to whether workers feel it is safe to take interpersonal risks (e.g., reporting bad practice and suggesting improvements), without fear of negative consequences. Psychological safety is the term used in this thesis, but it can be acknowledged that the term emotional safety has also been used to describe feelings of safety, in relation to psychological harms experienced from inpatient care (Veale et al., 2023). While psychological safety is now used in reference to patients, what this means from

their perspective is under researched and undefined. The work presented in this thesis aims to clarify this.

1.2.1.3 Restrictive Practices. Several terms are used to describe actions and interventions that intentionally restrict or limit a person's movement and/or freedom in research, policy and practice. These vary across (and within) countries, mental health services and individuals. The term restrictive practices is used in this thesis to refer to deliberate acts to restrict a person's movement, liberty and/or freedom to take control of a potentially dangerous or harmful situation (Department of Health, 2015; National Institute for Health and Care Excellence [NICE], 2015, 2017). It is acknowledged that the terms restrictive interventions, coercive practice, coercive interventions, containment and coercion are also used in practice, policy and research. Specific interventions and actions included within the term restrictive practices are discussed in detail in Chapter 1.6.

1.3 An Overview of Mental Health Services in the UK

Mental health services are designed to provide care and treatment for people experiencing difficulties relating to their mental health caused by mental health conditions and distress. A range of services are provided in the UK, traditionally across primary, secondary and tertiary care settings. Primary care services refer to support provided by General Practitioners, some talking therapies provided through Improving Access to Psychological Therapies service and Primary Care Mental Health Services; a service that provides support to people experiencing a mental health problem that does not require secondary care input. Secondary care covers community and hospital care provided to patients experiencing mental ill-health and crisis. These services include crisis team intervention, community services, mental health wards, units and longer-stay rehabilitation units (Cuomo et al., 2020; NHS England, 2023). Tertiary care provides specialist care intended for patients with complex and concurrent mental health disorders through specialised services such as eating disorder units, secure and forensic mental health services (Cuomo et al., 2020; NHS England, 2023; Rethink Mental Illness, 2022). While

these levels of care are still recognised in practice, there is now a move to a more integrated model of care to reduce the impact that disjointed services can have on patients (Rethink Mental Illness, 2022).

Most people experiencing a mental health difficulty will be treated in the community through primary care services, but some people need admission to hospital. This can be voluntary or on a compulsory basis. In England and Wales this is decided by assessment under the Mental Health Act 1983 (updated most recently in 2025). The act provides a legal framework for the assessment and treatment of people under compulsory detention (also referred to as involuntary admission) who may pose a risk to themselves and others, ensuring that these patients receive necessary care while respecting their fundamental rights (NHS, 2022). The act was originally amended in 2007, and again in 2025, due to concerns raised about rising detention rates and the treatment of patients detained under the act (Akther et al., 2019; Department of Health and Social Care, 2024a; NHS Confederation, 2026). The new law has recently received royal ascent and is gradually being implemented across services.

Services should strive to deliver timely access to care, that is high quality, close to home and is in the least restrictive, therapeutic environment (NHS England, 2023). Least restrictive is arguably a subjective term; what is least restrictive to staff, might not be for patients. However, this generally refers to services that minimise the use of restrictive practices and use alternative methods to de-escalate high risk situations. Inpatient mental health services operate under a multidisciplinary approach to provide care to patients. Ideally, the workforce should be multi-disciplinary, and include nursing, medical, allied health professionals, psychological professions and additional wider team resources (for example, pharmacists, security and students; Health Services Safety Investigations Body [HSSIB], 2025). A healthcare organisations' workforce should comprise of sufficient numbers of experienced, skilled and qualified staff to provide quality care to patients (Health and Social Care Act 2008, 2008). However, there are clear issues with the current staffing of mental

health wards. Most notably staff shortages resulting in a stretched workforce and an over-reliance on temporary staff, which creates concerns for patient safety and staff wellbeing (Griffiths et al., 2020; NHS England, 2023; O'Dowd, 2024).

This thesis will focus on adult acute inpatient care provision which provides care to adults, typically 18-65 years of age, experiencing the acute, or most severe, phase of a mental health problem. This can include acute wards, wards that provide specialist focus (for example, eating disorder units) and psychiatric intensive care units (PICU) that provide care to patients that require more intensive intervention (Health Services Safety Investigations Body [HSSIB], 2025b). This excludes forensic services, older people's services and child and adolescent mental health services (CAMHS). In recent years, there has been a stark increase in the demand for acute mental health services, coupled with a reduction in beds and increased occupancy of wards (British Medical Association, 2024). This had led to increased spending on private providers and increased waiting times, whilst still trying to maintain the momentum of providing care which leads to overexertion and burnout in staff (Gibbons, 2025; Gibbons & O'Reilly, 2021). Given the demand for inpatient services, it is increasingly important that care be delivered in a way that is effective, efficient and safe for patients.

1.4 Patient Safety

Patient safety refers to the absence of avoidable harm and reduction of unnecessary risk to patients and is a worldwide priority for healthcare settings (World Health Organization, 2023b). Patient safety incidents are measured by organisations and encompass events that can create harm or risk to patients, such as falls, medication errors and drug-related adverse events (Cuomo et al., 2020). While the evidence base is growing, there is arguably less research on patient safety in inpatient mental health services, when compared to research in general healthcare settings such as General Practices and hospitals (Brickell & McLean, 2011; Thibaut et al., 2019). This often leads to the assumption that safety incidents in mental health services are transferable from general healthcare settings (Quinlivan et al., 2020).

This assumption is still made despite evidence from patients, carers and staff demonstrating additional factors impacting patient safety not previously described in general healthcare settings (Berzins et al., 2018). However, the reduced research interest could also be due to the complexity of defining safety incidents in inpatient mental health services and the stigma associated with the services.

Patients are admitted to acute mental health wards because they are perceived to be at risk to themselves and others; often labelled as presenting with complex behaviours. These behaviours are a result of patients being unwell and often experiencing high levels of distress and individual acuity that can lead to adverse events. Adverse events in inpatient mental health services are influenced by various clinical, social and patient factors and encompass a variety of unintended medical events. These have been categorised previously into non-drug related adverse events: falls, assault, sexual contact and self-harm and suicide, and drug related adverse events: response of a drug that results in unintended consequences (Marcus et al., 2021). In mental health services, there is an increased prevalence of unsafe behaviours associated with serious mental health problems, including self-harm and suicide and as such an increase in the use of risk management strategies (for example, risk assessment and environment modification) and restrictive practices (Dewa et al., 2018).

Several mental health wards in the UK are reported to be unsafe. The Care Quality Commission (CQC) reported that for 2023/24, 77% of NHS wards and 59% of private sector wards received a ‘requires improvement’ or ‘inadequate’ safety rating (wards referring to acute wards and psychiatric intensive care units; Care Quality Commission, 2024b). Unsafe wards can have higher reported safety incidents, adverse events and can have an overreliance on methods to contain patient risk in an overwhelmed and stretched environment (Care Quality Commission, 2024a). Patient safety in inpatient mental health is diverse and means that providing safe care relies on organisations, staff and patients (Kanerva et al., 2013; Shields et al., 2018). With that said, several factors that impact patient

safety are often internal to the patients and interconnected (for example, patient distress and staff response). These factors are hard to separate and address, creating complexity for those trying to facilitate and provide safe care.

1.4.1 Moving Away from a Physical Risk Approach to Patient Safety

Traditionally, patient safety priorities are defined in relation to risk and focuses on the reduction of medical errors and safety incidents that have the potential to cause physical harm (Delaney & Johnson, 2008; Thibaut et al., 2019). Risk refers to a perceived likelihood of a hazard combined with the severity it poses to a person or a group (Slovic, 2016). In inpatient mental health services, patient safety has become synonymous with a reduction in the risk that patients pose to themselves and others. Organisational priorities often focus on identifying and managing risk around violence, aggression, self-harm and/or suicide by patients (Baker et al., 2024). This has led to the use of risk management strategies as standard in services, which arguably has also led staff to become more risk averse in their practice (Deering et al., 2022). While the management of risk is necessary in high-stress situations, such as risk to life, there is potential for psychological and emotional harm when incidents and perceived risk are generalised to patient behaviour (Bendall et al., 2022). For example, making assumptions about patient risk and responding based on past experiences rather than evidence-based practice.

There have been reported concerns over how risk is perceived and assessed in inpatient mental health services for decades (The Royal College of Psychiatrists, 2016). On wards, staff aim to protect themselves, other staff and patients from violence and aggression by identifying and predicting it in advance (Briner & Manser, 2013). The issue with this approach in services comes from the subjective nature of risk (Deering et al., 2022; Nathan et al., 2021). There are concerns that perception, or perhaps fear, of patient risk could cloud staff's judgement when it comes to best practice for treatment and could lead to stigmatising patients (Deering et al., 2022; Szmukler & Rose, 2013). When a formal risk assessment is carried out, patients report that a staff members perspective is considered more seriously

than the patient's point of view, meaning the patient voice is lost in the process (Deering et al., 2022). Similarly, the use of scripted questions during assessment is perceived as inauthentic and comes across as a 'tick-box exercise' to patients (Hawton et al., 2022; Richards et al., 2019). There have been suggestions however that risk assessment when done using a collaborative approach, could strengthen the therapeutic relationship between staff and patients and increases desire to disclose true feelings and intentions (Deering et al., 2019; MacDonald et al., 2020). The National Institute for Health and Care Excellence (NICE) supports psychosocial risk assessment as a best practice preventative strategy and discourage the use of traditional, 'tick-box' risk assessment for self-harm behaviours (National Institute for Health and Care Excellence [NICE], 2022).

An organisational focus on reducing risk that centres around a more traditional, narrow view of what safety is, could mean that psychological harms experienced by patients on inpatient wards are minimised or missed by staff and organisations. It has been recognised in consultation exercises that further research is needed on harms outside of physical harm (for example, emotional and sexual harms for patients) and the importance of understanding and improving safety culture and environments (Dewa et al., 2018; Shields et al., 2018). Similarly, involving patients and their perspective of their own safety is thought to have the potential to aid in safety planning (a structured process to pro-actively plan activities and support to prevent and/or manage a developing crisis; Baker et al., 2024; Dewa et al., 2018). As a result, the consideration of psychological safety alongside the physical safety of patients has been suggested by researchers, clinicians and patients (Berzins et al., 2020; Veale et al., 2023).

1.5 The Application of Psychological Safety to Patient Safety in Mental Health Services

In the UK there are calls to encompass other elements of safety outside of physical harms within traditional patient safety definitions (Berzins et al., 2020; Veale et al., 2023). To regulating and governing bodies, patient safety now encompasses protection of patients

from physical, psychological and sexual harm, and seeks to ensure that patients feel safe and are protected from harassment and bullying during an admission (Care Quality Commission, 2024a; Health Services Safety Investigations Body [HSSIB], 2025a). Throughout the 21st century, there has been a move towards a recovery-oriented approach to inpatient mental health services. Recovery-oriented care refers to services supporting a patient to work towards their personal version of recovery, placing an emphasis on a patient's self-determination and individualised care (Le Boutillier et al., 2011; Melillo et al., 2025). To address this shift in approach, initiatives that approach care holistically (for example, multi-disciplinary approaches to care) have been developed. In response to several high-profile examples of unsafe care, NHS England have recently published the NHS Culture of Care Standards (NHS England, 2024a). The standards were developed in 2022 to support culture change across NHS-funded mental health, learning disability and autism services and were co-produced with a range of stakeholders, including people with lived experience of inpatient mental health and their families. The standards create a vision for inpatient services to be, and feel, safe for the people accessing them. The standards are encompassed within 12 core commitments and includes a relational, psychologically informed approach to safety and care (core commitment 2). A summary of the full 12 standards of the Culture of Care Standards is presented in Table 1. The standards are ambitious, especially in the current NHS climate that is facing workforce and resource issues (British Medical Association, 2024; NHS England, 2024a), something that is acknowledged by NHS England.

Table 1.1

Summary of NHS England's Core Commitments and Standards for the Culture of Inpatient Care (NHS England, 2024a)

Core commitments	Summary of standards
1. Lived experience	All patients are supported to have a voice in their care, and their experiences are used to improve care Integration of paid peer workforce at all levels of the organisation, that are provided with sufficient support
2. Safety	All people (patients, staff and visitors) feel safe on the ward and people's civil and human rights are respected and protected People's mental health and physical health needs are understood and the approach to safety is relational
3. Relationships	Staff are competent in building relationships with different people and responding compassionately to extreme states of distress and individuals' needs The organisation supports staff to protect and prioritise the therapeutic relationship and promotes healthy team dynamics
4. Staff support	Staff and ward leaders have the practical and emotional support they need to remain compassionate, understanding and emotionally available There is enough skilled staff on the ward that know spending time with patients is a measurable priority
5. Equality	Patient experience and outcome measures are captured and analysed by protected characteristics (including for levels of restrictive practice) The organisation's workforce and leadership is diverse and inclusive, and reflects the community and are provided with training/support covering inequality, equity and impact of own identity
6. Avoiding harm	Harm and traumatisation that can occur when people are in hospital is acknowledged There is a clear pathway of support for patients who have experienced abuse/harm, including access to advocacy
7. Needs led	Providing a needs-led services that respects people's individual understanding of their distress and ward processes reflect this
8. Choice	Patients always have choice over care decisions and are supported to do this. When this is not possible, reasonings are explained in a clear and transparent way
9. Environment	The environments are inclusive, accessible, autism-informed, trauma-informed and sensory friendly and co-designed with people with lived experience Internal locked doors are removed, and people have open access to outdoor and green space
10. Things to do on the ward	People are supported to spend their time doing activities they enjoy and that support physical wellbeing
11. Therapeutic support	People have access to preferred, culturally sensitive support and treatment that is helpful to them
12. Transparency	The organisation has a transparent, compassionate, safe and responsive complaints and decision-making process Organisations are transparent about the names, roles and responsibilities of everyone working on the ward and are aware of how closed cultures develop

Published best practice guidance recommends psychologically informed approaches to safety but research exploring patients' perceptions of what psychological safety is and how this is achieved in practice is lacking. Personal view pieces by clinicians discuss the importance of considering the psychological safety of patients in inpatient mental health services (Lauge Andersen, 2023; Veale et al., 2023). In a qualitative study of 13 service users and seven carers in the UK, it was reported that safety to service users relates to the interconnection between physical safety and psychological safety (Berzins et al., 2020). Lack of psychological safety in this study referred to experiences with services that led to fear, distress and/or psychological harm. Other qualitative studies which have directly explored factors associated with psychological safety have shown that being physically safe, having positive relationships with staff, patient's having choice, feeling respected by staff and having access to meaningful occupation improved the psychological safety of patients (Cutler et al., 2020; Cutler et al., 2021a; Cutler et al., 2021b; Vogt et al., 2024). On the other hand, methods used to contain physical safety, negative relationships with staff and not being involved in decisions around care can negatively impact feelings of psychological safety (Cutler et al., 2020; Cutler et al., 2021a; Cutler et al., 2021b; Vogt et al., 2024). Qualitative research in forensic settings in Finland reported that safety to patients encompasses physical and psychological safety, with psychological safety referring to care culture and challenges related to patients' mental illness (Asikainen et al., 2023).

Despite these findings, research explicitly exploring the psychological safety of patients is currently lacking. How psychological safety is defined in these studies is not always clear and the identified factors that implicate psychological safety are broad leaving space for further exploration. For example, containment methods to protect the physical safety of people on the ward negatively impact psychological safety but being protected from physical harm contributes to psychological safety. Understanding the relationship between

containment and psychological safety is important for understanding how to prevent harm resulting from inpatient admissions (iatrogenic harm).

While psychological safety is now used in guidance documents for UK healthcare settings and has been presented as an important factor in patients understanding of safety through research (Berzins et al., 2020; Health Services Safety Investigations Body [HSSIB], 2025a), what this means in the context of patient safety is unclear. It is positive that governing bodies and independent regulators recognise the importance of considering the psychological safety of patients as this shows progression from the model of containment and traditional focus on physical risk. However, the introduction of these ideas and concepts is constrained by the lack of evidence of what psychological safety means to patients. It also raises questions with respect to how a system moving towards considering safety from varying perspectives, could still use restrictive practices and if the two ways of working can co-exist on inpatient mental health wards.

1.6 Restrictive Practices

Restrictive practices is an umbrella term for a variety of interventions ranging from formal measures such as restraint, seclusion, and rapid tranquilisation, but also informal measures such as blanket restrictions, locked doors, limitations of movement around the ward and coercive language (National Institute for Health and Care Excellence [NICE], 2015). A full list of measures and their descriptions have been developed through the collation of sources (Cox et al., 2010; National Institute of Health and Care Excellence [NICE], 2015; NHS England, 2024b; Restraint Reduction Network, 2022; Szmukler, 2015) and are presented in Table 2. The Department of Health (2015) and NICE (2015) included involuntary admissions within their definitions of restrictive practices (NHS, 2022). For this thesis, the interest is placed on restrictive practices that are experienced by patients

regardless of their status under the Mental Health Act. As such, involuntary admission was not explicitly explored.

An area of particular concern in improving and maintaining safety on inpatient wards internationally, is the use of restrictive practices; particularly reducing its use and addressing the inconsistencies in reporting within and between trusts (Care Quality Commission, 2018; Mental Health Units (Use of Force) Act 2018, 2022). In the UK, 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). These practices are also used outside of hospital and in the community, but the focus of this thesis will be on the use of restrictive practices in adult inpatient mental health services. Research has typically focused on the more intrusive restrictions, for example the impacts of restraint and/or seclusion (Askew et al., 2019; Chieze et al., 2019; Ezeobele et al., 2014). While these restrictions could be seen as easier to measure and are often perceived to be more physically harmful (Dixon & Long, 2022; Duxbury et al., 2011; Paterson et al., 2003), the impacts of informal measures should still be considered.

Table 1.2

List of Restrictive Practices and Their Definitions

Restrictive practice	Definition
Physical restraint	Any direct physical contact where the intervener's intention is to prevent, restrict or subdue movement of the body, or part of the body.
Physical restraint: prone	Chest down position.
Physical restraint: standing	Been handled whilst standing.
Mechanical restraint	Use of mechanical aids (i.e., belt or cuffs) to control a patient's movement for the purpose of behavioural control.
Rapid tranquilisation/chemical restraint	Use of prescribed medication for the purpose of controlling or subduing behaviour, where it is not prescribed for the treatment of a formally identified illness. Can be administered orally or by injection.
Seclusion	Supervised confinement and isolation of a patient away from others, in an area where the patient cannot freely leave.
Segregation	A situation where a patient is prevented from mixing freely with other patients on the ward on a long-term basis. Typically used under the rationale to reduce sustained risk of harm to others.
Locked doors	Locked internal or external doors that are controlled by staff. Can refer to the ward or hospital doors been locked but also locking of bedrooms or communal space doors.
Observations	Refers to checks typically done by nursing staff at regular intervals. At the least this would be every hour but can be as frequent as every 15 minutes.
Enhanced observations	The provision of intensive care and involves the allocation of one nurse (or sometimes two) to an individual receiving care.
Blanket restriction/rules	Ward rules that everyone must follow. Some rules are in place for legal reasons. However, others are in place based on staff prerogative, irrespective of risk.
Coercive language/psychological restraint	When staff use communication strategies to put psychological pressure on a person to do something or to stop them from doing something they want to do.
Coercion and compulsion related to treatment	An umbrella term referring to forcing someone to something that they do not wish to do either through physical, psychological and/or social pressure.
Involuntary admission	In the UK, this refers to a patient being detained under the Mental Health Act (1983) and treated without their agreement. Patients detained under the Mental Health Act can be treated against their will under certain circumstances which are deemed in the persons best interest by their care team.

1.6.1 The Controversy Associated with the use of Restrictive Practices

Psychological harm caused by restrictive practices is widely reported in research, for example, service users have described feelings of anxiety, fear and powerlessness when restrictive practices are used (Chieze et al., 2019; Fugger et al., 2016). Iatrogenic harm typically refers to harm from a medical intervention that impacts a person's health, wellbeing or recovery. This traditionally focuses on medical procedures but more recently, psychological harm resulting from an inpatient admission has been suggested as a source for iatrogenic harm (Downs, 2024; Tamarelli et al., 2024; Ward-Ciesielski & Rizvi, 2020). As a result of the reported harm associated with restrictive practices, particularly seclusion, physical restraint and rapid tranquilisation, the use of these measures is debated. Restrictive practices are legitimised by psychiatric diagnosis, risk behaviours and the reasoning of their use being in the "patients' best interest" (Richter, 2025). However, a human right's-based perspective would argue that the use of restrictive practices might be in breach of several articles of the United Nations Convention on The Rights of Persons with Disabilities as has been brought to light by the World Health Organisation (World Health Organization, 2021b). Two articles to consider include article 12: "…all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person affected" (United Nations, 2006; pg.10) and article 15: "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment…no one shall be subjected without his or her free consent…" (United Nations, 2006; pg.12).

It is important for care providers to take these considerations into account when making decisions to use restrictive practices. However, using restrictive practices that are preventing serious, fatal harm to a patient or another person can be legitimised ethically, professionally and legally (Article 2, Equality and Human Rights Commission, 2018; Richter, 2025). Article 2, states that authorities can take appropriate measures to safeguard and

protect people when there is a risk to life, as everyone has a right to life. There is little legitimisation from a human right's perspective for restrictions that are applied with no individual basis or consideration of the context (for example, blanket restrictions and locked external doors for all patients, irrespective of risk).

Staff have reported the need for restrictive practices for them to feel that they can protect themselves and other patients on the ward (Bigwood & Crowe, 2008; Butterworth et al., 2022; Moghadam et al., 2014). However, staff that have taken part in research acknowledge the upset and harm that restrictive practices can cause but highlight the reliance on them to keep patients alive in a system where resources and skills are stretched (Power et al., 2020; Yurtbasi et al., 2023). Patients themselves recognise the need for restrictive practices when there is a risk to life and de-escalation techniques have failed (Allikmets et al., 2020). Ultimately, restrictive practices are experienced negatively by those who are receiving the treatment and the staff and patients that are witnessing it (Askew et al., 2020; Ezeobele et al., 2014). As a result, staff and patients have both called for alternatives to restrictive practices that protect the mental wellbeing of not only patients, but the people witnessing incidents as well (Allikmets et al., 2020; Kontio et al., 2012; Muir-Cochrane et al., 2012). There have been interventions developed to reduce the use of restrictive practices, despite concerns from staff on the complete abolition of these practices (Gerace & Muir-Cochrane, 2019; Snipe & Searby, 2023).

1.6.2 Interventions Developed for the Reduction of Restrictive Practices

Over 130 initiatives and reduction efforts have been designed for use in inpatient mental health settings internationally. These aim to reduce violent incidents, aggression and absconding, to improve ward safety and ultimately reduce the need for restrictive practices (Baker et al., 2021; Doedens et al., 2024; Gooding et al., 2020). Here, a select sample of the most widely cited and used initiatives across the UK are presented. These include specific initiatives such as, Safewards (Bowers, 2014), Six Core Strategies (Huckshorn, 2004), No Force First (Haines-Delmont et al., 2022) and general initiatives focused on adaptations to

the ward environment, including open door policies, staffing ratios, de-escalation strategies and surveillance.

1.6.2.1 Safewards. Safewards is a collection of interventions based on Bowers' (2014) model of conflict and containment, developed to keep wards safe and secure. Conflict refers to aggressive behaviour (self-harm and absconding) and containment includes methods to restrict a patient's movements and actions (seclusion, restraint and additional restrictive practices). The model proposes that there are a variety of factors at different levels (ranging from patient characteristics to regulatory frameworks) that can create 'flashpoints' that ultimately lead to conflict or containment (Bowers, 2014). Ten interventions were developed from the model with the aim to mitigate the frequency of flashpoints and improve the ward environment: 1) Clear Mutual Expectations, 2) Soft Words, 3) Talk Down, 4) Positive Words, 5) Bad News Mitigation, 6) Know Each Other 7) Mutual Help Meeting 8) Calm Down Methods, 9) Reassurance and 10) Discharge Messages (Bowers et al., 2015). Two studies evaluating the effectiveness of the Safewards interventions reported decreases in conflict and containment (Bowers et al., 2015) and reduction in the use of seclusion (Fletcher et al., 2017). However, the latter study reported that the intervention may be better suited to less acute settings.

1.6.2.2 Six Core Strategies. The Six Core Strategies intervention was initially developed based on a national effort in the United States of America to reduce and prevent conflict, violence and the use of restraint and seclusion (Azeem et al., 2011; Huckshorn, 2004). The initiative has now been adopted by several countries, including the UK (Duxbury et al., 2019). The framework consists of six evidence-based strategies utilising a prevention-oriented, trauma-informed approach (Doedens et al., 2024). The Six Core Strategies include: 1) leadership towards organisational change, 2) use of data to inform practice, 3) workforce development, 4) use of seclusion and restraint prevention tools, 5) service user roles in inpatient settings and 6) debriefing techniques. This approach is for staff at all levels, focusing on skill development, implementation of restrictive practice reduction interventions

and the use of data to take proactive steps to minimise adverse events. Several empirical studies have shown a decrease in the use of seclusion and restraint following implementation of the strategies (Gooding et al., 2020; Putkonen et al., 2013).

1.6.2.3 No Force First. The No Force First initiative was developed in the United States of America in 2006 and implemented in settings across the UK under the premise that any act of coercion is detrimental to the recovery of patients (Haines-Delmont et al., 2022). Organisations that adopt a No Force First philosophy implement a change in practice and culture, leaning towards proactive, recovery focused care to minimise the use of physical restraint, seclusion and rapid tranquilisation (Repper & Perkins, 2013). Research has demonstrated that programmes utilising a 'No Force First' approach can be effective in reducing restraint, but this is limited to small-scale studies (Ashcraft & Anthony, 2008; Repper & Perkins, 2013). A study focused on a large mental health organisation in England, demonstrated a reduction in the use of restraint (Haines-Delmont et al., 2022). The authors of this study did note concerns over how and when the intervention was implemented by staff and did not include a control group, which could impact the validity of the findings.

1.6.2.4 General Adaptations to the Ward Environment and Surveillance for the Purpose of Reducing the need for Restrictive Practices. There are several strategies that are used in practice to try and alleviate the restrictive nature of inpatient wards. One example is the reduction of locked doors, referred to as open-door policies. Locked doors are used to prevent absconding, suicide attempts and death by suicide (Huber et al., 2016). Patients have reported negative views about door locking and it has been reported to lead to anger, irritation and depression (Bowers et al., 2010). In comparison, staff seem to view locked doors as a positive implementation to prevent risk to patients (Bowers et al., 2010). Two studies, not conducted in the UK, have demonstrated that implementation of open-door policies does not increase adverse events (for example, absconding and suicide attempts) or the use of alternative restrictive practices (Indregard et al., 2024; Schneeberger et al., 2017). However, more research is needed to confirm this, especially in UK services. Other ward

adaptations include increasing the ratio of staff to patients, de-escalation techniques and making improvements to the ward environment (Gooding et al., 2020). These are often described in descriptive, observational studies and as such have not been traditionally evaluated in acute mental health services.

Surveillance based technology includes the use of cameras, digital devices and software to monitor and track the activities of patients and has been increasingly used in inpatient services under the premise of improving safety outcomes whilst being cost-effective (de Looff et al., 2019; Simpson, 2023). A review into the use of surveillance in inpatient mental healthcare identified the following categories being used in practice: Vision-Based Patient Monitoring and Management, closed circuit television/video surveillance, body worn cameras, wearable sensors and Global Positioning System monitoring (Griffiths et al., 2024). The review concluded that there is insufficient evidence to suggest that the use of surveillance technologies improve safety outcomes or reduce costs. In the UK, Vision-Based Patient Monitoring and Management systems are typically supplied by the company LIO (previously known as Oxehealth) under the product Oxevision and is a relatively new technology that uses video surveillance alongside infra-red cameras in patient's bedrooms for physical health monitoring (Buckley et al., 2024; Ndebele et al., 2024). Surveillance-based technology seems to generate a lack of trust and privacy in patients, with concerns raised about the ethics of the technology replacing standard care (Griffiths et al., 2024).

1.6.3 Limitations of Current Interventions

Concerningly there has been a reported increase in involuntary measures across England and Wales (Care Quality Commission, 2026; Richter, 2025), despite the developed initiatives and interventions aiming to reduce the need for restrictive practices. This could be due to potential improvements in reporting of restrictions, but it still leads to questions around the efficacy of the developed interventions and how they are used in practice. Some interventions have been evaluated using trial methodology, but others have not. It is also important to recognise that there is an issue of implementation in mental health settings

whereby developed, evidence-based initiatives are not consistently implemented in practice as intended (Gotham et al., 2022; Proctor et al., 2009). As such, it could be related to factors impacting the implementation of the interventions, not necessarily the efficacy of the reduction interventions.

Also, most interventions focus on the reduction of violence and aggression that leads to restraint and seclusion incidents and were not developed to reduce less explicit restrictions such as coercive language, blanket restrictions and ward rules (Baker et al., 2021). There is limited evidence examining patients' perceptions of these restrictions, how they relate to incidents, and what the impact of reducing them on inpatient wards could be (Lindekilde et al., 2024). It is important to recognise that some patients recognise times when certain restrictive practices are needed (Allikmets et al., 2020). As such, considering whether the focus of the reduction interventions match the priorities and needs of patients is needed to understand the least harmful way of providing care.

1.7 A Summary of the Presented Literature

The background literature presented provides context for the research presented in Chapters 2-5. Four main concepts were presented. First, an overview of mental health services was discussed, alongside the challenges services are facing, to provide context of where this research sits. Second, a discussion of patient safety research in inpatient mental health services was presented highlighting that what safety means to patients might be different from traditional patient safety priorities. Third, the integration of psychological safety into standard care was discussed demonstrating that psychological safety is not a new concept, but it has not received the same attention as physical safety in inpatient mental health settings. Fourth, an understanding of what restrictive practices are and a summary of the controversy surrounding the use of them was reported, demonstrating the need to

minimise the harm inherent in these practices but still keep patients physically safe.

Summarising the key concepts demonstrates three clear gaps in the research area that need to be addressed. First, in inpatient mental health services, restrictive practices (ranging from intrusive restrictions to blanket restrictions applied across a ward) continue to be used due to lack of resource, funding and the limited capacity for change given the circumstances. Understanding how the wide range of measures taken to contain risk and protect physical safety are experienced by patients could help to understand and explain the psychological harm caused by restrictive practices. Second, the relationship between psychological safety and restrictive practices has not been explicitly explored. Research on the experience of restrictive practices has demonstrated that service users perceive a power imbalance between staff and patients during incidents and believe that restrictive practices are a way for staff to exert control over patients with limited opportunity for patients to question decisions (Bendall et al., 2022; Ezeobele et al., 2014; Scholes et al., 2022). Service users in the UK have reported that restrictive practices are coercive by nature and that de-escalation and negotiating techniques further exacerbated feelings of coercion and threat (Bendall et al., 2022). This could be due to patients lacking trust and safety with staff members, knowing that restrictive practices can be used. Working with service users to explore this relationship and understand how restrictive practices can be more psychologically safe is imperative to improving recovery-oriented care. Third, exploring how staff provide safe care to patients in the context of restrictive practices is important for the development and implementation of future recommendations and interventions aimed at promoting the psychological safety of patients. If restrictive practices continue to be used, then it must be based on a holistic view of risk, to protect the safety of people on the ward and in the least harmful way. What this looks like and an understanding of what is feasible in

practice is yet to be explored. To address these gaps and the objectives detailed in Chapter 1.2, four studies have been developed and conducted.

1.8 Methodological Approach

1.8.1 The Rationale for the use of a Sequential Methodology for this Thesis

The psychological safety of patients is under researched despite the phrase being used in practice and included in the NHS Culture of Care Standards (NHS England, 2024a). Therefore, a qualitative exploratory approach to the PhD was initially taken whereby each study informed the next. The first study was a systematic review of the literature on the service user experience of restrictive practices (Chapter 2). The review aimed to understand the experience of a range of restrictive practices and revealed the psychological harm inherent in restrictive practices that were used without clear reasoning. The findings also demonstrated that patients reported the need for restrictive practices when themselves or their fellow patients could no longer keep themselves physically safe. There was a lack of literature on restrictive practices outside of seclusion, restraint and rapid tranquilisation, such as ward rules and coercive language. Given the complex experience of restrictive practices, whereby some patients saw them as inherently harmful but others felt they were necessary during crisis, an understanding of how safety was impacted by restrictive practices was needed. At this stage, a clear, working definition of psychological safety from the perspective of patients had not yet been developed. As such, Study 2 (Chapter 3) required an exploratory approach to understand what psychological safety meant to former patients, while exploring the impacts that restrictive practices had. The findings demonstrated instances where former patients felt their psychological safety had been considered when restrictive practices had been used, resulting in less harm and a strengthened relationship with staff. As such, exploring how staff provide psychologically safe care, whilst identifying

barriers to this in practice became the focus of Study 3 (Chapter 4).

Interviews in Study 2 and Study 3, carried out with both former patients and staff, captured data about recommendations for how the psychological safety of patients could be supported when restrictive practices are used. These data were analysed and synthesised in Study 4 (Chapter 5). The PhD programme of research, started broad and exploratory and has narrowed down to the use of a theoretical framework to develop recommendations, considering the patient need and staff reality throughout. This process has been outlined here, and specific methods are briefly reported below, before being discussed in detail from Chapters 2-5.

1.8.2 Study 1: A Systematic Review of Published Literature

Chapter 2 presents the first study, a systematic review of qualitative literature using meta-ethnographic synthesis (Sattar et al., 2021) which aims to explore service users' experiences of restrictive practices while in adult inpatient mental health services (Griffin et al., 2025a). The review synthesised the available literature on the service user experience across all interventions, both formal and informal, and all non-forensic adult inpatient mental health services to understand the full experience of restrictive practices. It is likely that some patients will experience a range of restrictive practices during their inpatient stay, therefore looking at the experience as a whole is essential for setting directions for policy and practice. A systematic review is a literature review that aims to locate, appraise and synthesise evidence relating to a specific research question (Boland et al., 2014). This type of review follows a rigorous process of defining the research question, identification and appraisal of the evidence and synthesis, leading to the development of relevant conclusions. The use of systematic methodology is thought to minimise bias and thus produce more reliable findings

(Munn et al., 2018). This was deemed appropriate to develop recommendations based on reliable findings.

1.8.3 Study 2: Semi-Structured Interviews with Former Patients

Chapter 3 presents the second study, a semi-structured interview study with former patients of inpatient mental health settings (Griffin et al., 2025b). This study aimed to explore the impacts of receiving, and witnessing, restrictive practices on psychological safety, to understand what could be done to make restrictive practices more psychologically safe. The data and analysis from study two led to the conceptual definition of psychological safety that was used and further developed in Study 3. The developed working definition of psychological safety is discussed in Chapter 6.

Due to the novelty of the area, an exploratory approach is used. As such, semi-structured interviews were deemed suitable for this, allowing the researcher to have a topic guide to follow, but having the opportunity to ask follow-up questions to allow participants to elaborate on their experience (Braun & Clarke, 2013). Alongside this, the data were analysed using Reflexive Thematic Analysis (RTA; Braun & Clarke, 2021). RTA allows for a flexible approach to analysis guided by the data and the added element of reflexivity allows for consideration of participants meaning and interviewers interpretations of this in context. Conducting applied health research requires a consideration of the wider context that the realities are experienced in. A flexible and reflexive approach like RTA is well-suited to this. More theoretically grounded research such as Grounded Theory or rigid approaches like Interpretative Phenomenological Analysis, might limit flexibility and exploratory approaches to analysis and interpretation (Braun & Clarke, 2013).

1.8.4 Study 3: Semi-Structured Interviews with Staff Working in Inpatient Mental Health Services

Chapter 4 presents the third study, which aims to explore the barriers and facilitators of providing psychologically safe care in inpatient mental health settings. In Study 2, former

patients discussed times when staff considered their psychological safety whilst using restrictive practices. As such, Study 3 focuses on how staff provide psychologically safe care to patients, while considering barriers to this in practice. The study was underpinned by the Theoretical Domains Framework (Atkins et al., 2017), in that the topic guide and analysis was informed by the 14 domains of the framework. The TDF was developed after identifying influences on the behaviour of healthcare professionals focusing on underlying cognitive, affective, social and environmental influences (Atkins et al., 2017; Cane et al., 2012). The study uses semi-structured interviews and was analysed using the principles of a Framework Analysis approach: transcription, familiarisation, coding, identification of the framework, charting and interpretation (Gale et al., 2013). The use of a predetermined framework that has been identified through inductive coding allows for a consideration of an experience in context, whilst enabling the identification of new and emerging thematic ideas. The full analysis, including the use of inductive coding and the decision to use the TDF is detailed in Chapter 4.

1.8.5 Study 4: A Synthesis of Staff and Former Patient Suggestions for Providing Psychologically Safe Care in Practice

Chapter 5 presents the fourth study which analyses and synthesises both perspectives (former patients and staff) on areas of improvement in mental health services for the integration of psychologically safe care. There are two aims for the study: to use the TDF to identify gaps in healthcare provision that are implicated in providing psychologically safe care to patients and to outline recommendations for how to support the psychological safety of patients when restrictive practices are used. In Studies 2 and 3, participants were asked “What suggestions and alternatives would you give for making inpatient mental healthcare more psychologically safe when restrictive practices are used?” with the intention that the collected data would be analysed separately in Study 4. Data were deductively coded to the TDF domains. Within each identified domain, themes were generated through inductive content analysis of the codes and quotes (Vears et al., 2022) to identify priority

areas for improvement in practice. This approach combined several methods to organise the recommendations. This allowed the participants' own recommendations to be organised in a way that is actionable for organisations and could inform the development of future interventions aimed at providing psychologically safe care. It is important that any suggestions and alternatives that are developed from research are based in stakeholder need. Combining patient and staff recommendations has allowed for commonalities between groups to be identified and to explore what is different in their suggestions.

1.8.6 Positionality

Before presenting the four studies, and to support the understanding of my perspective of the research topic, it is important to note that I have never been a patient or staff member of inpatient mental health services. My understanding of inpatient mental health services prior to the work presented in this thesis was admittedly limited and I acknowledge that there is still more to learn about the complexity of healthcare organisations. However, by being an outsider to the research area, it allowed me to engage with both participant groups without prior conceptions and may have resulted in more insightful questioning. This was originally to aid my understanding of the topic which inadvertently aided my reflexivity and interpretation of participant quotes in Study 2 and 3. A reflexivity journal was kept throughout the project and led to the reflections discussed in Chapter 6.

1.8.7 Epistemological and Ontological Positioning

Researching a complex area like applied health services, requires a critical approach and a recognition of the individual experience in context. As such, a critical realist philosophical paradigm was used to address the aim of the research project using qualitative methodology. Critical realism is both an epistemology and an ontology, providing a philosophical framework for understanding reality and knowledge. This approach emerged due to criticism of positivism, the idea that reality is objective and fully measurable (Bhaskar & Danermark, 2006; Morgan, 2015). Instead, critical realism acknowledges a shared reality

but considers that the experience of an individual does not exist in isolation but because of influence from relationships and interactions with external structures (Fletcher, 2017). Epistemologically, critical realism acknowledges reality exists independently of our knowledge of it but is impacted by perspective and experience. It acknowledges that our knowledge of the world is fallible and shaped by context (Ryan, 2019). Ontologically, critical realism suggests three domains of reality: the real (underlying, potentially unobservable structures and mechanisms that produce events), the actual (events that occur because of underlying mechanisms in the real) and the empirical (what we observe as a result of connection between the real and actual; Alderson, 2021; Bhaskar & Danermark, 2006).

This approach is well suited to complex research areas such as healthcare research, which requires consideration of different perspectives and experiences, and considering the context alongside (Alderson, 2021). Critical realism adds value to the research process through framing, identifying and understanding complex concepts in specific conditions (Sturgiss & Clark, 2020; Williams et al., 2017). Critical realism can also be used with various research designs and methodologies. For the current work, the research aims and objectives were guided by a consideration and evaluation of the literature. Acquisition of knowledge through a critical realist lens, encourages enquiry into different perspectives and supports the use of multiple methods to obtain knowledge these perspectives to build a complete picture (Pilgrim, 2020). This allows the building of an evidence-base to inform policy and practice, based on what works, for what people and in what circumstances focusing on practical application (Bhaskar & Danermark, 2006). Critical realism is suitable for methods that explain how and why events occur (Sturgiss & Clark, 2020), making it useful for exploratory qualitative methodology.

1.9 Patient and Public Involvement (PPI)

Involvement of patients and the public was sought throughout the project and in several ways. The development of research materials and topic guide for Study 2, was influenced by a member of the research team with lived experience of mental health

services. Changes were made based on the feedback given, for example, participants having the option for a phone call instead of a video call if needed and making the materials available beforehand. Similarly, feedback on tone and language made the participants information sheet and consent more accessible and suitable for the target population.

The Help from Experts by Experience for Researchers (HEER) group have been involved throughout the project from the interview study detailed in Chapter 3 to the end of the PhD project. The group consists of people that have experience with mental health services and their carers that work with Leeds & York Partnership NHS Foundation Trust, a local specialist mental health and learning trust. The group initially helped to define psychological safety based on the findings from Study 2 (Chapter 3) and have also advised on decisions made during the design and data collection of Study 3 (Chapter 4). The group receive regular updates on the project and have been involved in any developments to the definition.

For Study 3, advice was sought from two people who had previously worked in mental health services but now work as lay leaders (independent representatives of patients and members of the public) influencing PPI within the Yorkshire & Humber Patient Safety Research Collaboration. Due to their previous roles, they commented on tone and accessibility of the materials for to ensure suitability for the target population of mental health staff. Follow up meetings with one of the lay leaders have run throughout the project and have aided reflections around positioning of the researcher and the research team.

1.10 Chapter Summary

This chapter has provided an overview of the relevant background literature relating to patient safety research in inpatient mental health services, the application of psychological safety to services and a summary of restrictive practices and developed reduction

interventions. A summary of the methodological approach was also detailed, to provide an overview of the four studies presented in this thesis.

Chapter 2 Service Users' Experiences of Restrictive Practices in Adult Inpatient Mental Health Services. A Systematic Review and Meta-Ethnography of Qualitative Studies

2.1 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.

2.2 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; National Institute for Health and Care Excellence [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 (National Institute for Health and Care Excellence [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, 2023a).

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, 2021a). 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-Gagné 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?".

2.3 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 Material Table S1) and the Meta-Ethnography Reporting Guidelines (eMERGE; see Supplemental Material Table S2). The protocol was registered on PROSPERO (registration number:

CRD42023399272; URL: https://www.crd.york.ac.uk/prospero/display_record.php?ID=CRD42023399272).

2.3.1 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.

2.3.2 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 (National Institute for Health and Care Excellence [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.

2.3.3 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.

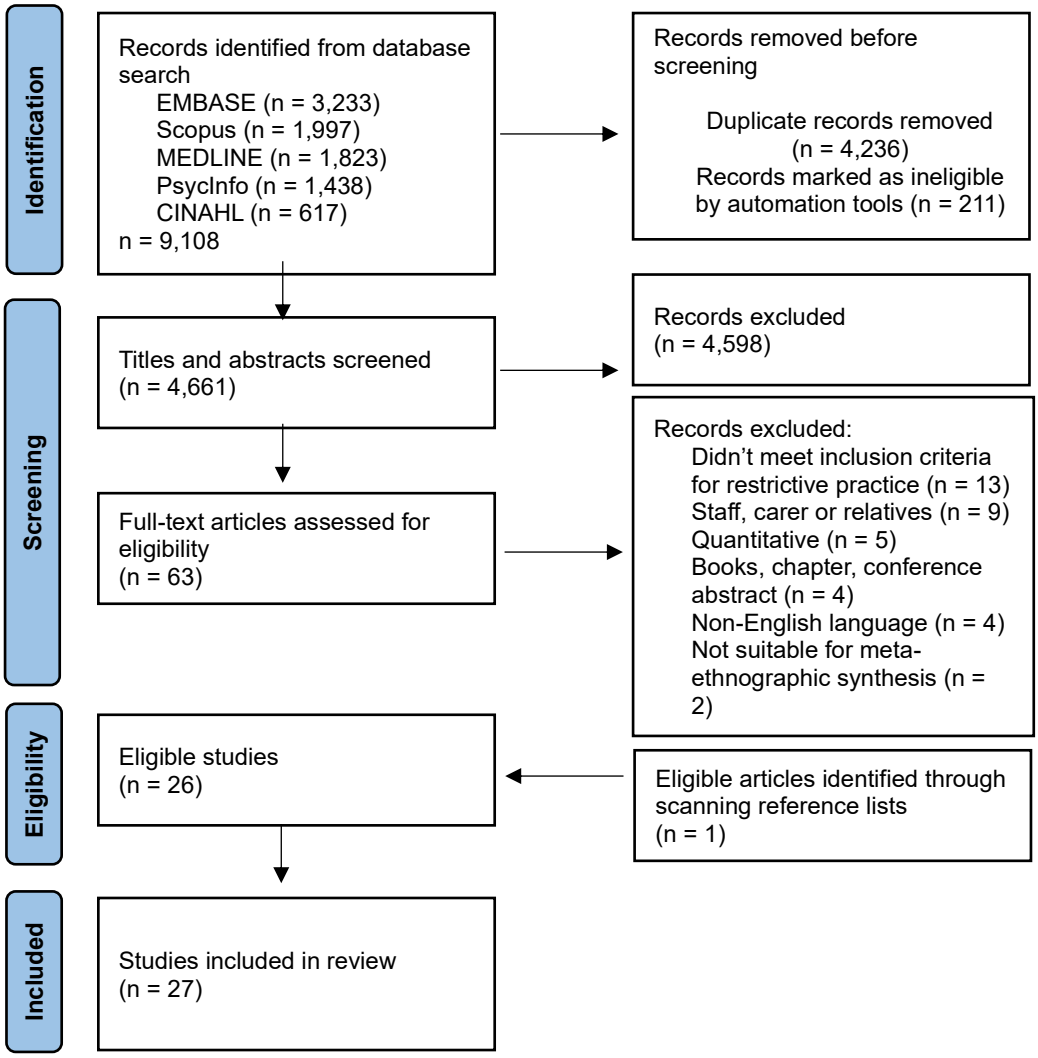
2.3.4 Study Selection

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 2.1

PRISMA Flow Diagram



2.3.5 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-order constructs) were extracted into a second Microsoft Word document.

2.3.6 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.

2.3.7 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.

2.4 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 2.1.

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	Nine service users (eight current inpatients, one discharged)	56%	Asian British Pakistani 11% Black British 11%	Inpatient participants were recruited by staff	Research took place on two adult acute wards, one male and one female,	A range of restrictive practice (coercion, restriction of	Qualitative semi-structured interviews	Thematic analysis

		restrictive practice 2) Explore how patients and staff members respond to restrictive practices?			Black British African 22% Mixed White and Black African 11% White British 22% White Irish 22%	members known to them	within a large city mental health hospital	movement, forced 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 85% of patients are involuntarily admitted	Seclusion	Semi-structured interviews utilising a phenomenological approach	Colazzi's (1978) data analysis steps

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 relations with care provider	Seven previous inpatient service users whose seclusion room experiences had taken place some time ago and were currently undergoing treatment at the VLMT Transmural Team of Mediant.	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

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	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			patients 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	Not reported	Not reported	Not clear	15 full-day dialogue seminars on	Coercion (restraint, seclusion, forced	Verbatim notes taken from the seminars	Thematic analysis

			and ex-patients				coercion and voluntariness	medication, CTO's, 'minor 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

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%	White British 77% 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

2.4.1 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.

2.4.1.1 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 experience restrictive 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.

2.4.1.2 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).

2.4.1.3 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.

Table 2.2.

Studies Represented Within Each Theme

Authors	Third Order Constructs				
	Anti-therapeutic and dehumanising	A vicious cycle	An abuse of power	The critical role of support and communication	
				The impact of communication	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)		✓		✓	✓

2.4.1.4 The Critical Role of Support and Communication.

2.4.1.4.1 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).

2.4.1.4.2 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).

2.5 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 the 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.

2.5.1 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.

2.5.2 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).

2.5.3 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.

Chapter 3 Exploring How the Psychological Safety of Patients is Impacted by Restrictive Practices in Inpatient Mental Healthcare: A Qualitative Study with Former Patients in the UK

3.1 Abstract

Restrictive practices are used to contain risk and maintain physical safety on inpatient mental health wards but have shown to negatively impact patient wellbeing and trust. Researchers and professionals have suggested that inpatient mental healthcare focuses on physical safety at the expense of psychological safety. The relationship between restrictive practices and psychological safety has not yet been explored. This study aimed to explore the impacts of receiving, and witnessing, restrictive practices on psychological safety, to understand what could be done to make restrictive practices psychologically safe. Eighteen semi-structured interviews were carried out with former patients (aged 20-60 years) who have been discharged for longer than 6 months from adult inpatient mental healthcare in the UK. Data were analysed using reflexive thematic analysis. Four themes were generated: 1) Reactive over proactive care: seeing the behaviour and not exploring the reason, 2) A chaotic environment cannot provide safety for patients and staff, 3) Psychological impact of the (perceived) power imbalance between staff and patients and 4) Emotionally all in it together, for better or worse. The results support that physical risk is heightened in inpatient settings but containing this should not come at the expense of psychological safety. Supportive communication and giving small acts of control to patients should be prioritised to enhance the psychological safety of patients.

3.2 Introduction

Patient safety, the absence of avoidable harm and reduction of unnecessary risk to patients, is a priority for healthcare organisations worldwide (World Health Organization, 2023b). Safety incidents encompass falls, medication errors and adverse drug events (Cuomo et al., 2020). On mental health wards, additional considerations to protect the physical safety of people on the ward are needed because of complexities related to patient

presentations, including potential physical and mental health multi-morbidities and risk of aggression (D'Lima et al., 2017). Restrictive practices and adaptations to environment are therefore used for the physical safety of patients and staff. After consultation with a lived experience advisory group, the term patient will be used throughout this article to refer to people receiving inpatient care.

Many inpatient mental health wards in the United Kingdom (UK) are rated as 'required improvement' or 'inadequate' for safety, including 77% of NHS Trusts and 59% of independent sector organisations caring for adults on acute wards and PICUs (Department of Health and Social Care, 2024b). Unsafe wards have an overreliance on restrictive practices to contain risk, demonstrating an overwhelmed and stretched environment (Care Quality Commission, 2024a). Restrictive practices are deliberate acts that restrict movement, liberty and/or freedom to take control of a potentially dangerous or harmful situation (Department of Health, 2014; National Institute for Health and Care Excellence [NICE], 2015); also referred to as coercion and restrictive interventions. Practices include intrusive methods such as restraint, seclusion, observations and rapid tranquilisation, and practices applied throughout a ward, like locked doors and blanket restrictions (i.e., limitations on belongings and ward rules).

The use of restrictive practices is controversial, particularly the use of physical measures. Both patients and staff have reported physical and psychological harm from restrictive practices (Butterworth et al., 2022). Patients report feeling controlled, traumatised and fearful when restrictive practices are used (Bendall et al., 2022; Scholes et al., 2022). As a result, there have been interventions developed with the aim of reducing the use of, and need for restrictive practices (i.e., Safewards and Six Core Strategies; Bowers et al., 2015; Huckshorn, 2004). Staff acknowledge the distress that restrictive practices can cause but have expressed concerns for complete abolition and the reliance of practices in high-risk situations (Gerace & Muir-Cochrane, 2019; Snipe & Searby, 2023). There appears to be a

disconnect between keeping patients physically safe whilst protecting them from psychological harm in inpatient care.

3.3 Background

Safety in mental health care is often defined physically, focusing on quantifying and reducing risk and incidents (Delaney & Johnson, 2008; Thibaut et al., 2019). Managing risk is necessary in high-stress situations (i.e., posing a risk to life) but can lead to psychological harm when incidents are generalised to patient behaviour (Bendall et al., 2022; Tully et al., 2022). Safety to both patients and former patients, means a combination of physical and psychological safety (Berzins et al., 2020). Lack of psychological safety in Berzins et al. (2020) referred to experiences that led to fear, distress and/or psychological harm. Qualitative research has identified factors that impact the psychological safety of patients in inpatient mental health settings (Cutler et al., 2021b; Vogt et al., 2024). Enhancing factors included: being physically safe, positive relationships with staff, patient choice, and having access to meaningful occupation. Detrimental factors included: use of methods to contain physical safety, negative relationships with staff, and not being involved in decisions around care. Patient focused research in this area is currently in its infancy. Therefore, identified factors of psychological safety are broad and require further exploration.

Discrepancies between organisational priorities, patient needs, and staff capabilities need to be addressed. Patient safety priorities do not consider that patient safety means psychological safety to patients (Berzins et al., 2020). How this looks in practice should be explored further. The reduction of restrictive practices is seen as improving patient safety and Bowers et al. (2015) demonstrated a link between employing alternative psychologically informed approaches and reducing restrictive practices. However, in practice staff do not consistently have psychologically safe alternatives available to do this, especially in crisis situations. How restrictive practices are used in crisis situations needs to be explored to mitigate long-lasting psychological impacts. Research exploring the patient experience of restrictive practices is growing, however there is limited research on the impact of witnessing

restrictive practices from the perspective of patients (Wilson et al., 2018). Understanding the experience of restrictive practices first-hand and witnessing incidents with peers is important for overall safety on inpatient mental health wards.

No research to date has explored the relationship between restrictive practices and psychological safety explicitly. It is imperative that the lived experience voice be considered when setting priorities for patient safety research. Therefore, this study utilised an exploratory qualitative approach interviewing former mental health inpatients (discharged for longer than 6 months) in the UK. This study aimed to explore the impacts of receiving, and witnessing, restrictive practices on psychological safety, to understand what could be done to make restrictive practices psychologically safe.

3.4 Method

3.4.1 Design

An exploratory qualitative study, which used semi-structured interviews, was conducted.

3.4.2 Sampling and Recruitment

Adults with experience of restrictive practices in UK inpatient mental health services (discharged for longer than 6 months) were eligible for participation. Former patients of forensic units and whose only experience was in child and adolescent services were not eligible to participate. Participants had to be able to provide informed consent. This study utilised volunteer sampling where potential participants volunteer to participate (Gill, 2020).

The study was advertised on the social media platform X, using a study poster. The study poster contained information about the study and listed restrictive practices as: segregation, locked doors, seclusion, restraint, rapid tranquilisation, coercion and compulsion related to treatment and observations. The recruitment method allowed participants that are no longer in touch with mental health services to take part. During

recruitment, participation from people that were male and/or from ethnic minority backgrounds was purposefully requested.

3.4.3 Ethical Approval

Ethical approval was granted by the University of Leeds, School of Psychology Ethics Committee (20/07/2023; reference PSCETHS-674). Consent for this study was obtained using Qualtrics to reduce burden on participants printing and returning the consent form. After the interview, participants were sent a debrief email containing a £30 voucher code for their participation.

3.4.4 Procedure

Interested participants emailed the lead researcher and eligible participants were provided with an information leaflet. Semi-structured interviews were carried out online through MS Teams and were recorded for transcription purposes. A topic guide was established through reviewing the literature and research team expertise (mental health nursing, clinical psychology, and lived experience). People with lived experience were involved in the development of research materials, topic guide development and conceptualisation of psychological safety. This was achieved through the inclusion of lived experience researchers on the research team and a review of the findings by an independent lived experience advisory group. The full topic guide is presented in the supplementary material (Appendix S1).

Participants were encouraged to discuss any ward experience that they deemed restrictive. KV conducted the first three interviews, due to previous experience with psychological safety research, while BG observed. BG then carried out the remaining 15 alone. The decision to end recruitment was made based on a pragmatic decision that a breadth of restrictive practices and experiences had been discussed. Interviews were

transcribed verbatim using MS Teams and then checked/edited by the lead researcher to ensure accuracy.

3.4.5 Analysis

Braun and Clarke's Reflexive Thematic Analysis (RTA; 2021b) guided the analysis, providing a contextual and situational reflection of former patients' experiences (Braun & Clarke, 2021a). The six-phases to analysis using Braun and Clarke's RTA (2021b) were followed. A critical realist approach to analysis was taken, using a combination of latent and semantic coding.

The first author (BG) a female, PhD student with no prior experience working in, or being a patient of mental health services, led the analysis. This work was supervised by a mental health nurse (JB) and a clinical psychologist (JJ), both of whom have extensive research experience. They both contributed to the generation of themes and theme development. The full process is detailed in the supplementary material (Appendix S2).

The rest of the research team comprised two trainee clinical psychologists (KV and EM) and a chartered psychologist (CK), all of whom have experience conducting qualitative research. Members of the research team had lived experience but to protect researcher confidentiality, no identifying initials are provided.

3.5 Results

Thirty-four former patients expressed interest through email, with 20 meeting eligibility criteria and providing consent. Two people did not attend their interview meaning there were 18 participants, with a mean age of 38.1 years (range: 20-60 years). The participants were predominately female (n = 13). Fifteen participants were White-British, one participant was White-Irish, one participant was from a Roma background and one participant was from a mixed ethnic background. Participants had experienced inpatient care in a range of areas across the UK. Eleven participants were employed full-time, nine of which worked in mental health services, healthcare or social work. None of the participants had received a post-

incident debrief following restrictive practices, that they deemed adequate. Only one participant had received a debrief after witnessing restrictive practices on the ward. See Table 1. for additional information about the participants' experiences of restrictive practices. Interviews ranged from 23 to 70 minutes and averaged 51 minutes. The total data collected amounted to 15 hours, 21 minutes.

3.5.1 Reflexive Thematic Analysis

Four themes were generated:

1) Reactive over proactive care: seeing the behaviour and not exploring the reason for it
2) A chaotic environment cannot provide safety for patients and staff
3) Psychological impact of the (perceived) power imbalance between staff and patients
4) Emotionally all in it together, for better or worse

Quotations are included to provide evidence for the findings in participant's own words.

3.5.1.1 Theme 1. Reactive Over Proactive Care: Seeing the Behaviour and Not Exploring the Reason for it. Restraint and observations were deemed necessary to keep patients alive in high-risk situations (self-harm incidents and suicide attempts), but participants felt that staff often used them without insight into the cause of the behaviour. The detachment of 'observed' behaviour from underlying feelings and thoughts, contributed to participants feeling less psychologically safe. Pacing or expressing frustration often resulted in sanctions (e.g., discussions at ward round, cancellation of leave and restrictions of activity involvement) without discussion with staff to understand the cause. This resulted in participants feeling responded to with violence and made the ward an unsafe space for honest expression of thoughts and feelings.

"I had made attempts to harm myself and that's about coping with feelings of distress and

assuming that's now recognised…but that just escalated things even further." Participant 2

In addition, locked wards made participants feel trapped in an unsafe space. For many, this impacted their progress as they would often "shut down" to avoid interactions with staff. Combined, distress that led to the initial use of restrictive practices was perpetuated.

"I guess, what staff are trying to do is to keep everyone safe. But then, if you're in that situation, the patient, the fact the doors are locked makes you feel unsafe because you're locked in this situation." Participant 14

Participants interpreted physical intervention (seclusion, restraint and/or rapid tranquilisation) as a negative reaction to their emotions. The restrictions were viewed as disproportionate and immediate with little consideration for prior de-escalation. The experience could be described as reactive care, interventions used quickly for convenience, rather than proactive, considering the context and de-escalation.

"I do think there is a kind of default to restrictive practice actually. And yeah, there's all this sort of rhetoric around is the step of last resort and I don't think that's true in practice." Participant 9

For many participants, psychosis was experienced as fear, danger and related to the belief that others were trying to harm them. When psychosis was not considered as cause for a patient's 'risky' behaviour or discussed openly, staff became 'real-world' manifestations of psychotic experiences. Here, restrictive practice use was interpreted as intention to cause harm and injury, making it difficult for participants to feel physically and psychologically safe.

"Having and feeling like someone was gonna be grabbing me, to then having actual people that I that I believe were supposed to be there to help me, then almost turning against me and like treating me like I was the problem. Yeah, I felt really unsafe." Participant 12

Reactive restrictive practices left participants alone with negative emotions and impacted psychological safety. Vulnerable and frightening experiences with staff had

repercussions for the therapeutic alliance and participants' emotional wellbeing. When restrictive practices were about to be used, communication was prioritised in some instances, which supported psychological safety and relationships between patients and staff.

"She [staff] was able to kind of make that assessment and seeing it was just a bit over the top and that it didn't need to be done. I feel so much better for the fact that she'd actually like listened and could see that me having my shower was actually gonna help me." Participant 4

3.5.1.2 Theme 2. A Chaotic Environment Cannot Provide Safety for Patients and Staff. Participants described an unrelenting chaos on the ward, with little opportunity for refuge to decompress amongst the waves of incidents. Exclusion from decisions, particularly after restrictive practices had been used, caused upset and further incidents. Restrictive practices were frequently made more psychologically harmful by compounded layers of unwritten rules and inconsistencies in decisions and skills of practitioners. An environment and culture based on uncertainty and chaos, limited participants' capacity to feel psychologically safe.

"… it's that thing of feeling on edge all the time and not being able to … just be able to get on with things." Participant 1

Disagreements between staff (i.e., nurse and doctors, and between nurses), created a culture of uncertainty and led to questions about staff competence and decision-making ability. Lack of faith in care providers, meant the safety of participants and peers was questioned. The working environment was described as unpredictable and stretched. Examples given included: not having enough staff on shift and no time to communicate effectively with patients.

"It's really chaotic. It didn't make me feel unsafe for me. It made me feel unsafe for other people, like for months I was saying someone is gonna get seriously hurt or killed… it's very understaffed, it's stretched to capacity … as an incident is going on, you can't just leave like

you're locked in there with it and there's alarms going off and you worry for that person... It didn't make me feel unsafe, but I just recognized that my home was unsafe, you know?" Participant 18

Participants felt compassion for staff and mentioned that working in a psychologically safe way cannot be prioritised in that environment. The chaos translated into an unpredictable and custodial dynamic between staff and patients. Without a strong therapeutic relationship and safe environment, treatment decisions came across as ill-informed, not considered and resulted in a default to restrictions.

"If you generate a culture that is impersonal, a "doing to" culture, it's not particularly empathic culture. You are gonna end up doing stuff to people without questioning it…I think in that environment, that's not gonna be conducive to recovery, right?" Participant 11

3.5.1.3 Theme 3. Psychological Impact of the (Perceived) Power Imbalance Between Staff and Patients. Restrictive practices were seen as reflections of staffs' frustrations towards participants and were often viewed as a medium for staff to demonstrate their power. Staff had the power to remove belongings and strip rooms, which was interpreted as "*callous and cruel*" (Participant 6). Participants then felt punished, "bad" and guilty for behaviour that was caused by their symptoms and distress. Participants often felt that staff underestimated the weight of their actions.

"I was there because I was unwell, not because I was bad… I think in hospital you're just made to feel that you're bad." Participant 2

Meaningful occupation and belongings were seen as game pieces in the power play between staff and patients, particularly when the decisions for permitting or withholding them were not explained. To regain power, participants would rebel and act in atypical ways.

"And because staff were, like, making what felt like really arbitrary decisions without actually telling me any explanation or why they thought it was important, I suddenly wanted to do all

the things I couldn't do." Participant 16

Belongings brought from home were of the few things that participants had a degree of control over, but in some hospitals, they were removed. When these were removed, so was their safety.

"I think if you're not giving people choice and things, sort of try to give them small elements of control." Participant 1

Blanket restrictions around personal items, i.e., razors, items of clothing that had drawstrings or electrical cables on the wards, were used irrespective of individual risk. This was interpreted as another way for staff to control patients. Safe items being labelled as unsafe items often increased perception of personal risk when participants received their items back at discharge. To participants this felt counter intuitive and changed the view of safety for the items once discharged.

"…to then be discharged to the community a couple of months later, having had no access to any of my belongings, the entire time. And then a few months later, I've been discharged with everything in my suitcase." Participant 8

Containment methods to keep patients physically safe in mental health settings would not be acceptable in any other context. Participants often viewed their circumstances in contrast with someone that had not been an inpatient.

"If somebody in the community was like locked in a room and been made to take medication, that would be really traumatic for them. So it isn't any different if you're in hospital and have a mental illness. It's still and if anything, probably it's more traumatic because you're already sort of scared…hearing voices on top of it would be scary for anybody." Participant 14

Dignity of care and control was compared to receiving treatment in a physical healthcare setting. Being on observations and using the bathroom or not having access to a toilet in a seclusion room, was a traumatising and upsetting experience for many

participants. Participants felt that staff were not aware of the impact that lack of dignity and control over personal decisions had on psychological safety.

“So it was just mimicking the fear that I already had and comparing that. Like the fact that I couldn't use a toilet and that I had all my clothes taken off me, I wasn't even asked if I would undress. They just ripped them off me and it was it just. Yeah, it just I felt so unsafe.” Participant 12

3.5.1.4 Theme 4. Emotionally all in it Together, for Better or Worse. Relationships on the ward added a complexity to the inpatient experience; they were intensified but also had the potential to make participants feel psychologically safe. Constant proximity to staff and other patients, complicated the development of positive relationships. The weight and importance of relationships on the ward felt increased and led to participants being more invested in the lives of others. Having friends, or peers to relate to, allowed for shared experiences and peer-support. Increased importance of relationships meant that upsetting peer-staff interactions impacted participant’s own psychological safety and caused fear for the physical safety of their peers. Upset and distress when their peers were restrained or separated from the ward was common.

“You might be close to and support each other, and then yeah, to have to see that [restrictive practices] is…that can be difficult at times and that was certainly something that- I wouldn't sleep. I'd be in tears for days.” Participant 8

Peer-relationships were frowned upon by staff, with participants being told they were too involved in their peer’s care. An “us vs them” mindset was common where participants supported and defended peers against staff, often resulting in further conflict.

“No, no, because if I even tried to raise it, it was we can't talk about the patients and so you couldn’t, and it was it was me versus them.” Participant 3

Close relationships with staff members were beneficial for most participants. However, when staff behaviour did not meet participant’s expectations, it resulted in upset

and setbacks to the therapeutic relationship. Staff who worked to promote the psychological safety of patients through empathetic and individualised care, did not “fit in” with the ward’s culture and often left. As a result, participants felt hopeless and psychologically unsafe when they thought about the future of their care, especially when they had been subject to multiple restrictions.

“You've got good staff members who are nice, it's really hard for them in a culture where everybody else is in on it [ward culture] to try and make a difference or to stand up.” Participant 16.

Communication with staff was often limited, meaning psychological safety and trust was low before restrictive practices were used. This also meant that communicating decisions in the “wrong way”, i.e., through posters or in ward rounds, came across as threatening. Communication, when done in a positive and individualised way, could strengthen the therapeutic relationship and psychological safety before and after restrictions.

“…possibly if I'd been given some time to talk with somebody, I wouldn't have become sort of so agitated and distressed. I don't know, it wouldn't have changed the situation, but maybe I would have felt that I was being listened to.” Participant 14

The wards were described as closed environments that only people who have been on, could understand. Communication with family and peers was hard after discharge as they had not experienced inpatient treatment. Not having a post-incident debrief made leaving the ward harder. Several participants were discharged when they were still on observations or had stripped rooms.

“It made it much harder when I left the ward environment to suddenly have freedom. I think it made it a bigger deal. Not being able to build up my own level of trust in my own ability to keep myself safe. So when I then went out, I was I was far riskier.” Participant 5

Table 3.1.

Participant Overview and Quote Identification

Participant ID	Gender	Age Range	Occupation	Most recent inpatient stay	Restrictive Practices Discussed	
		(Years)		(Year)	Experienced	Witnessed
Participant 1	Female	26-35	Doctor	2015	1:1 Observations Seclusion Rapid tranquilisation Sectioned mid-stay	Restraint
Participant 2	Female	36-45	Student adviser	2021	1:1 Observations Restraint	Restraint
Participant 3	Female	46-55	Unemployed	2006	Restraint Rapid tranquilisation	Coercive language Locked doors
Participant 4	Female	26-35	Postgraduate student	2018	1:1 Observations Locked doors	Restraint Restraint for nasogastric (NG) feeds
Participant 5	Female	46-55	Senior caseworker	2021	Blanket restrictions Coercive language Locked doors Segregation	1:1 Observations
Participant 6	Non-binary	36-45	Unemployed	2018	Restraint Seclusion Sectioned mid-stay	Restraint
Participant 7	Female	36-45	Administrator and expert by experience	2020	Rapid tranquilisation Coercive language	Restraint

Participant 8	Female	18-25	Unemployed	2021	Restraint Rapid tranquilisation 1:1 Observations Blanket restrictions	Restraint
Participant 9	Male	46-55	Researcher	2019	Locked doors Coercive language	Restraint Rapid tranquilisation
Participant 10	Female	18-25	Doctor	2022	Restraint Rapid tranquilisation Removal of belongings Locked doors	Restraint
Participant 11	Male	55-65	Team manager	2013	Rapid tranquilisation Observations	N/D
Participant 12	Female	36-45	Emergency care assistant	2021	Restraint Rapid tranquilisation Seclusion	Physical handling
Participant 13	Female	18-25	Healthcare	2023	2:1 Observations “Treated under restrictive practice” Restraint CCTV observations	Restraint
Participant 14	Female	46-55	Social worker	2022	Seclusion Coercive language	Segregation Locked doors
Participant 15	Female	46-55	Full-time carer	2002	Seclusion Rapid tranquilisation	Seclusion
Participant 16	Non-binary	26-35	Student and project co-ordinator	2017	Observations Locked doors Blanket restrictions	N/D
Participant 17	Non-binary	36-45	Unemployed	2021	Rapid tranquilisation Blanket restrictions	Restraint

Participant 18	Female	18-25	Student	2022	1:1 Observations Restraint	Restraint

3.5.2 Psychological Safety

Based on this thematic work, psychological safety was conceptualised as, “Feeling validated in your experience of the world and the belief you will be treated fairly based on your individual needs. Being psychologically safe provides protection from lasting psychological harm from your environment. It’s not just about being physically safe but being protected from events that may have lasting effects in the future.” The development process and lived experience collaborator feedback is outlined in the supplementary material (Appendix S3).

3.6 Discussion

This is the first qualitative study to explicitly explore the relationship between restrictive practices and psychological safety in UK inpatient mental health settings. There are four key findings. First, perceived risk is heightened on mental health wards due to concerns over patient aggression, self-harm and suicide attempts. Containing risk should not come at the expense of the psychological safety of patients. Psychological safety and physical safety are interlinked; patients cannot have one without the other. Second, restraint and observations were seen as necessary in crisis situations but can easily lead to fear, distress and compounded trauma when psychological safety is not considered. Third, the physical safety of patients was seen to be emphasised throughout the inpatient process, ignoring psychological safety, individual recovery progress and the participant’s perception of their risk. Fourth, communication and empathetic care have the potential to foster psychological safety when restrictive practices are used.

The current work extends the literature on the experience of restrictive practices. Psychological safety is not just impacted by physical measures but also by blanket restrictions (locked doors and ward rules). Research in this area predominantly focuses on the impacts of formal measures (Askew et al., 2019; Butterworth et al., 2022; Larue et al., 2013), meaning measures such as blanket restrictions and ward rules are considered less

harmful in practice. The present study extends previous knowledge by demonstrating that psychological harm to patients is not limited to restraint, seclusion and rapid tranquilisation.

Perceived power imbalances have negative impacts on the psychological safety of patients and can create a vicious cycle of incidents. Inpatient mental health settings are naturally coercive environments because of the Mental Health Act (Department of Health, 2015). Locked doors, restraint and ward rules lead to patients feeling disempowered and not trusted (Cusack et al., 2018; Missouridou et al., 2022; Pelto-Piri et al., 2019). The current study demonstrates that an environment fuelled by containment and misuse of power leads to miscommunications and a break down in trust. It is important to consider how lack of trust and resulting behaviours impact the recovery of patients and relationships with care providers.

Uncertainty around when restrictive practices were going to be used impacted mood and caused ‘risky’ behaviours (described by participants as pacing the wards and appearing anxious). Bowers (2014) suggested the idea of containment (restrictive practices) and conflict (patient and staff negative interactions) as having a dynamic reciprocal relationship, whereby containment can give to rise conflict instead of defusing it. In the current study the uncertainty about when restrictive practices would be used resulted in further conflict. There is scope to expand and develop existing interventions by explicitly considering the use of restrictive practices (i.e., ward rules) as a ‘flashpoint’ for further restrictions.

Positive therapeutic relationships are interpreted as psychologically safe care. A positive relationship with care providers, built on good communication, is known to have strong impact on the outcomes of patients in mental healthcare, such as wellbeing, recovery and engagement with services (Hartley et al., 2020; McAndrew et al., 2014; Moran et al., 2014). Communication techniques (i.e., de-escalation and debriefing) have been developed (Celofiga et al., 2022; Grundy et al., 2024; Price et al., 2024) and are recommended in relevant UK policy guidance when restrictive practices are used (NICE Guideline 10; National Institute of Health and Care Excellence [NICE], 2015, and NICE Quality Standard

154; National Institute for Health and Care Excellence [NICE], 2017). However, the current work and previous research suggest that de-escalation methods are not always utilised in practice, suggesting there is a need to consider how relevant policies can be translated into usable guidance (Inglis & Clifton, 2013; Sustere & Tarpey, 2019).

3.6.1 Implications for Practice

Organisations should support training and use of evidence-based resource to move away from reliance on restrictions and containment to psychologically safe care. Priority should be on training around patient risk and appropriate responses to behaviour. Similarly, systemic issues that allow unsafe practices to happen should be addressed. Organisations should work to promote the psychological safety of staff to ensure they feel comfortable to speak up about unsafe practices (Hunt et al., 2021; O'Donovan et al., 2021).

Staff should be aware of the lasting impacts care practices can have on patients. All participants of the current study described the lasting impacts restrictive practices had on their lives post-discharge. None of the participants in the current study received an appropriate post-incident debrief, which has likely caused lasting harm. Iatrogenic harm means harm resulting from medical care and typically refers to physical harm caused by treatment (for example, adverse drug reactions; Sampath, 2022). Iatrogenic harm can mean psychological harm resulting from interactions and restrictions placed on patients for their physical safety (Downs, 2024).

Restrictive practices can be viewed as an abuse of staff power. It is acknowledged that there are legal implications in the use of restrictive practices through the Mental Health Act (Department of Health, 2015). Giving small acts of control to patients could improve perspectives on staff and restrictive practices. In practice, this could be achieved through allowing choice over small decisions, discussing preference of de-escalation techniques,

patient feedback being considered and actioned, and allowing open and honest communication around ward rules through community meetings.

3.6.2 Implications for Future Research

As participants recognised the need for restrictive practices in some cases to maintain their physical safety, reducing restrictive practices without providing psychologically safe care (care where the patient feels supported and validated in their experience) could mean that patients feel at risk to themselves. Further exploration of what providing psychologically safe care looks like when restrictive practices must be used for the physical safety of patients, could mean that harm from these practices is minimised.

Further research into relationships on the wards is needed. In inpatient mental health it is important that the confidentiality of patients be respected but the closed nature of the ward causes overlap in patient experience. The current work has demonstrated the complexity of relationships and the impact they have on the psychological safety of patients. Further exploration of how patients and staff could be supported to build healthy and respectful relationships with one another is needed. This could potentially reduce the number of incidents and the need for restrictive practices.

3.6.3 Limitations

There are four main considerations to note. Firstly, participants were recruited using volunteer sampling. It is possible that the sampling method resulted in sampling bias, meaning participants volunteered who were more likely to have had negative experiences. Secondly, the study recruited previous patients that had to have been discharged for longer than 6 months. As there were no limitations on how long they had been discharged, it is possible that there could have been issues with participant recall. Third, while the current study did address the first-hand experience of restrictive practices, there was limited discussion of the witnessed restrictions in comparison. While the researchers expected the discussion to be limited to explicit restrictions, participants mainly discussed their experience

of witnessing the restraint of other patients. Fourth, half of the participants had experience working in health and social care roles. This could have impacted their patient experience and reflections after discharge, thus should be considered when interpreting the results.

3.6.4 Conclusions

This thematic account of former patients provides an insight into how restrictive practices can leave patients feeling like ‘risks’ rather than people and that psychological wellbeing is often ignored in inpatient settings. A move towards the rehabilitation of patients seeking care for their mental health is needed. Supporting people with their symptoms and experiences, whilst helping them to feel safe, should be priority over containment and restrictions.

3.6.5 Relevance for Clinical Practice

Ensuring that patients are physically and psychologically safe whilst receiving mental health care is important. This study demonstrates the impact that restrictive practices have on psychological safety, from the perspective of former patients and starts to identify key areas for improvement. Improving the ways restrictive practices are conducted is crucial to enhance psychological safety in patients. Improvements could include giving small acts of control to patients, increasing consistency and certainty around the use of practices, creating calm ward environments, enhancing communication between patients and staff and promoting positive relationships on the ward.

Chapter 4 Identifying barriers and facilitators to providing psychologically safe care in inpatient mental healthcare. A Theoretical Domains Framework-informed qualitative study

4.1 Abstract

Aim(s). To explore the facilitators and barriers to staff providing psychologically safe care in inpatient mental healthcare when restrictive practices are used.

Design. Qualitative interview study.

Keywords. Mental healthcare, psychological safety, restrictive practices, nursing, inpatient

Methods. Twenty semi-structured interviews were conducted with staff with experience working in inpatient mental healthcare in England. Analysis included principles of framework analysis, informed by the Theoretical Domains Framework.

Results. Access to resources and a safe environment for both patients and staff were recognised as important (environmental context and resources) but access was impacted by competing organisational priorities and expectations (beliefs about capabilities). Participants recognised knowledge gaps in themselves and their colleagues (knowledge). Being able to confidently make decisions about risk was seen as central to the staff role (social/professional role and identity). Collaboration between staff is needed to make positive change and progression towards psychologically safe care (social influences). Empathy and compassion were driving factors in participants trying to use psychologically informed alternatives, but burnout hindered this (emotions).

Conclusion. Ensuring that staff feel supported in their role to implement psychosocial informed alternatives to restrictive practices, as well as providing safe environments for both patients and staff could support the integration of psychologically safe care on inpatient mental health wards.

Implications for the profession and/or patient care. Key facilitators and barriers to staff

providing psychologically safe care are identified to support practice and improvements to patient care.

Reporting method. Consolidated criteria for reporting qualitative studies (COREQ).

Patient or public contribution. Former patients and members of the public were involved in the conceptualisation of key concepts and design of this study.

4.2 Highlights

4.2.1 Impact

- Unsafe wards have an over reliance on restrictive practices, prioritising physical safety over the psychological safety of patients. This study is the first to explicitly explore how staff provide psychologically safe care in the context of restrictive practices, whilst also considering areas for organisational improvement.
- Staff recognise the importance of providing psychologically safe care but report the lack of support to do so. Key factors of healthcare practice both support and hinder this.
- Findings from this paper have implications for clinicians and organisations providing inpatient mental healthcare.

4.2.2 What Does this Paper Contribute to the Wider Global Clinical Community?

- Ensuring that staff feel supported in their role to implement psychologically informed alternatives to restrictive practices, as well as providing safe environments for both patients and staff could support the integration of psychologically safe care on inpatient mental health wards.
- This paper has identified key factors within mental health settings that limit opportunities for staff to provide psychologically safe care. It has also demonstrated how staff provide psychologically safe care within a restricted environment. Key learnings around organisational support could be transferred to other healthcare

settings.

4.3 Introduction

Inpatient mental health wards provide care to people facing acute distress. In England, care can be provided on a voluntary or compulsory basis subject to assessment and detention under the Mental Health Act 1983 (amended as of 2007). All wards should follow a multi-disciplinary approach to care comprising medical, nursing, allied health professionals and psychological services (Health Services Safety Investigations Body [HSSIB], 2025a). This approach allows for comprehensive and holistic treatment, under the assumption that multidisciplinary teams (MDTs) can improve the quality of care provided to patients (Haines et al., 2018).

There are concerns over the safety of people on inpatient mental health wards in England (Department of Health and Social Care, 2024b). Safety in this context refers to the protection from both physical and psychological harm, whilst considering risk, and sensory and support needs (Care Quality Commission, 2024a). Unsafe wards have an overreliance on restrictive practices to contain perceived risk, prioritising physical safety over, and often at the expense of, psychological safety (Berzins et al., 2020; Care Quality Commission, 2024b). Restrictive practices are deliberate acts that restrict movement, liberty and/or freedom to take control of a potentially dangerous or harmful situation (Department of Health, 2014; National Institute for Health and Care Excellence [NICE], 2015); also referred to as coercion, coercive and restrictive interventions. Practices include physically intrusive methods such as restraint, seclusion, observations and rapid tranquilisation, and practices applied throughout a ward, like locked doors, surveillance and blanket restrictions (i.e., limitations on belongings and ward rules such as set mealtimes and bedtimes; NHS England, 2025).

Restrictive practices have been shown to have detrimental impacts on patients, ranging from psychological harm (fear, distress and loss of trust) to physical harm (injuries

and in some cases death; (Chieze et al., 2019; Cusack et al., 2018; Duxbury et al., 2011). Despite this, restrictive practices are often described as necessary in times of crisis by patients and staff (Butterworth et al., 2022). It is possible that the psychological harm caused by restrictive practices could be minimised by supportive communication, patient involvement in decisions around their use and promoting positive therapeutic relationships through relational care (Griffin et al., 2025a).

4.4 Background

Recently, consideration of patients' psychological safety has been recognised as important for the wellbeing of patients in mental health settings and is included in the recent NHS Culture of Care Standards (NHS England, 2024a). Previous qualitative research has demonstrated times where patients felt psychologically safe and acknowledges that when communication is prioritised, psychological harm from restrictions can be minimised (Cutler et al., 2020; Griffin et al., 2025b; Vogt et al., 2024). Research exploring what psychologically safe care looks like in practice is in its infancy and is limited to the patient perspective, meaning how staff might provide psychologically safe has not yet been explored.

There are many challenges that mental health services in England are facing, including reports of insufficient funding, lack of training, support for staff and staffing factors impacting patient care (British Medical Association, 2024). As such identifying these barriers in the context of staff providing high quality, psychologically safe care to patients is needed. Similarly, identifying times when good quality care is achieved whilst under constraints of limited resources, from the perspective of the people working in those settings, is important for moving forward to a more holistic view of safety on inpatient mental health wards.

The use of behavioural theories allows for underlying structural and psychological processes to be explored in relation to the implementation of new ways of working (Atkins et al., 2017). The Theoretical Domains Framework (TDF) was developed with the aim to identify influences on the behaviour of healthcare professionals (Cane et al., 2012). The

fourteen-domain TDF allows for the cognitive, affective, social and environmental influences on healthcare professionals behaviour to be explored to develop actionable recommendations (Atkins et al., 2017). The TDF has been extensively used to understand healthcare professional behaviours (Atkins et al., 2017), for example investigating the implementation of interventions in both general and mental healthcare settings (Chung et al., 2023; Johnston et al., 2022). While the framework has been used in mental healthcare settings, it has not been used to understand the barriers and facilitators to providing psychologically safe care in inpatient mental healthcare.

4.5 The Study

Exploring how staff provide psychologically safe care to patients, in the context of restrictive practices, is important for the development and implementation of future recommendations, as well as understanding how interventions could be developed and incorporated into existing organisational structures. The current study aimed to explore the facilitators and barriers to staff providing psychologically safe care in inpatient mental healthcare when restrictive practices are used to answer the research question, “How do staff in inpatient mental health care provide psychologically safe care to patients?”.

4.6 Methods

4.6.1 Design

This study used a qualitative descriptive design using semi-structured interviews and was informed by principles of the framework approach (Gale et al., 2013). The topic guide and analysis were underpinned by the 14 domains of the Theoretical Domains Framework (TDF) (Table 1).

4.6.2 Study Setting and Recruitment

Participation was sought from a range of staff who had more than one year’s experience of working on an inpatient mental health ward in England, with the aim of speaking to a range of staff working day-to-day as part of the Multi-Disciplinary Team (MDT).

Staff with experience only in forensic settings or who had only worked with children and adolescents were not eligible for participation. Participants had to be able to provide informed consent. The study recruited through social media (using volunteer sampling) instead of recruiting through NHS trusts, to allow participants to speak freely about their experiences at work with the understanding that their participation would not be known by their employer. Trusts are NHS organisations responsible for directly managing and providing healthcare services in England and Wales. Trusts are typically responsible for several hospitals and services within or across counties. Initially, participants were mainly mental health nurses (including ward managers and reducing restrictive practice leads) therefore a decision was made to purposively sample healthcare assistants and psychologists to allow representation from several roles within the MDT. Snowball sampling was also used whereby agreeable recruited participants shared the advert within their networks.

4.6.3 Positioning the Research Team

The lead researcher is a female PhD student that has no prior experience working as, or being a patient in, inpatient mental healthcare. This work was undertaken as part of her PhD project. The supervision team has extensive experience working in, (JB is a mental health nurse and JJ is a clinical psychologist) and researching, inpatient mental healthcare and restrictive practices and two members of the research team has expertise in the Theoretical Domains Framework (CK and JJ). Before the current study was designed and carried out, the researcher had conducted interviews for a separate study with patients and had started the analysis of their experience. The researcher acknowledged the potential impact this could have on interview questions. Members of the research team (JB and JJ) and two independent lay leaders reviewed the interview materials. Lay leaders are members of the public that advise on research projects. Both lay leaders had previous experience working in mental health care but now work with the Yorkshire and Humber Patient Safety Research Collaboration as lay leaders. It is also recognised that the researcher’s positioning

as an outsider (has not been a patient in, or worked in, a mental health setting) could have meant that there were fewer personal points of connection for the participants and the researcher when interpreting data. Similarly, this could mean that the researcher was less sensitive to the issues raised by the participants. However, the researcher was supervised by senior researchers with experience working in inpatient mental health services and this perspective could have led to deeper and more insightful questioning during the interviews to aid the researcher's understanding.

Researching a complex area like applied health services, requires a critical approach and a recognition of the individual experience in context. For this study, it was important to consider the wider mental healthcare context, organisational priorities and the participant's experience within this. As such, this study was informed by a critical realist paradigm, acknowledging that staff experiences are shaped by organisational conditions but interpreted through individual perceptions (Alderson, 2021). Critical realism acknowledges the realities of the participant but considers that the experience of an individual does not exist in isolation and is because of relationships and interactions with external structures (i.e., ward environment, staff skills and policy) that have influenced those experiences and realities (Fletcher et al., 2017).

4.6.4 Data Collection

The study poster was shared on X, LinkedIn and Facebook groups consisting of mental health staff and listed restrictive practices as: locked doors, seclusion, restraint, rapid tranquilisation, observations and limitations on movement (including segregation). Participants were given the option to participate through MS Teams or via a phone call. Initially, participants were mainly mental health nurses (including ward managers and reducing restrictive practice leads) and occupational therapists. During recruitment a decision was made to purposively sample healthcare assistants and psychologists to allow representation from several roles within the MDT. Interested participants emailed the lead researcher and were provided with an information leaflet and opportunity to ask any

questions about the study before agreeing to take part. Consent was recorded via Qualtrics.

The topic guide was informed by the 14 domain TDF (presented in Table 1; Atkins et al., 2017) and was developed in collaboration with the research team and two additional people who had previously worked in mental health. The full topic guide can be found in Supplementary Material S1. Interviews were carried out between September 2024 and February 2025. Participants were encouraged to discuss how they provided psychologically safe care at work in the context of any ward experience that they deemed restrictive. After the interview, participants were sent a debrief email containing a £30 voucher. Recruitment ended when a range of staff roles were included, and a range of restrictive practices had been discussed. Interviews were audio recorded and transcribed verbatim using MS Teams and checked for accuracy.

Table 4.1.

The Theoretical Domains Framework (v2) with Definitions and Constructs (Atkins et al., 2017)

Domain	Definitions	Constructs
1. Knowledge	An awareness of the existence of something	Knowledge (including knowledge of condition/scientific rationale) Procedural knowledge Knowledge of task environment
2. Skills	An ability or proficiency acquired through practice	Skills Skills development Competence Ability Interpersonal skills Practice Skill assessment
3. Social/professional role and identity	A coherent set of behaviours and displayed personal qualities of an individual in a social or work setting	Professional identity Professional role Social identity Identity Professional boundaries Professional confidence Group identity Leadership Organisational commitment
4. Beliefs about capabilities	Acceptance of the truth, reality or validity about an ability, talent or facility that a person can put to constructive use	Self-confidence Perceived competence Self-efficacy Perceived behavioural control Beliefs Self-esteem Empowerment Professional confidence
5. Optimism	The confidence that things will happen for the best or that desired goals will be attained	Optimism Pessimism Unrealistic optimism Identity
6. Beliefs about Consequences	Acceptance of the truth, reality, or validity about outcomes of a behaviour in a given situation	Beliefs Outcome expectancies Characteristics of outcome expectancies Anticipated regret Consequents
7. Reinforcement	Increasing the probability of a response by arranging a dependent relationship, or contingency, between the response and a given stimulus	Rewards (proximal/distal, valued/not valued, probable/improbable) Incentives Punishment Consequents Reinforcement

		Contingencies Sanctions
8. Intentions	A conscious decision to perform a behaviour or a resolve to act in a certain way	Stability of intentions Stages of change model Transtheoretical model and stages of change
9. Goals	Mental representations of outcomes or end states that an individual wants to achieve	Goals (distal/proximal) Goal priority Goal/target setting Goals (autonomous/controlled) Action planning Implementation intention
10. Memory, attention and decision processes	The ability to retain information, focus selectively on aspects of the environment and choose between two or more alternatives	Memory Attention Attention control Decision making Cognitive overload/tiredness
11. Environmental context and resources	Any circumstance of a person's situation or environment that discourages or encourages the development of skills and abilities, independence, social competence and adaptive behaviour	Environmental stressors Resources/material resources Organisational culture/climate Salient events/critical incidents Person × environment interaction Barriers and facilitators
12. Social influences	Those interpersonal processes that can cause individuals to change their thoughts, feelings, or behaviours	Social pressure Social norms Group conformity Social comparisons Group norms Social support Power Intergroup conflict Alienation Group identity Modelling
13. Emotion	A complex reaction pattern, involving experiential, behavioural, and physiological elements, by which the individual attempts to deal with a personally significant matter or event	Fear Anxiety Affect Stress Depression Positive/negative affect Burn-out
14. Behavioural regulation	Anything aimed at managing or changing objectively observed or measured actions	Self-monitoring Breaking habit Action planning

4.6.5 Consideration of the Relationship Between Researcher and Participants

To build rapport with participants in the current study, there was initial contact over email. Here, participants had the opportunity to ask questions, state preferences, and request the topic guide in advance. Before the interview began, the researcher re-introduced themselves stating that they were a PhD student with no prior experience as an inpatient or as staff in mental health services. Participants were reassured that the interviewer wanted to hear their story and were happy for the participant to discuss any experience of providing psychologically safe care, in the context of restrictive practices, that they felt comfortable with. While transcripts were not returned to participants after the interviews, participants did have the opportunity to view and comment on the results of the study prior to submission for peer review.

4.6.6 Data Analysis

Data was analysed using principles of the framework approach: transcription, familiarisation, coding, identification of the framework, charting and interpretation (Gale et al., 2013; Keyworth et al., 2019).

4.6.6.1 Phase One: Familiarisation with the Data. The interviews and analysis were led by the lead researcher, meaning that familiarisation began during the interviews when contextual notes were made. The transcripts and audio recordings were reviewed, and the researcher's own thoughts, emotions and reflections were noted. On the second read through, additional notes of contextual information (participant role, work setting, views on restrictive practices and understanding of psychological safety) were made.

4.6.6.2 Phase Two: Coding. Inductive coding was used; generated from the data following an unrestricted approach (Gale et al., 2013). This process was supported by the software NVivo. The coding was initially done independently and took a semantic approach starting with the first interview and going in chronological order. An iterative approach whereby initial codes were revisited and developed through reflecting on the initial

interpretation leading to deeper, latent coding. The aim of coding was to follow an open coding process whereby anything related to staff providing psychologically safe care to patients, or incidences where that could not be prioritised, was identified.

4.6.6.3 Phase Three: Identification of the Framework. Coding was discussed in an analysis meeting. Underlying themes of ‘culture’, ‘attitudes’, ‘understanding’ and ‘requirements of the role’ were identified to have positive and negative influences on whether staff could provide psychological safe care for patients. . Following the initial inductive coding process, emerging codes and themes were deductively mapped onto the 14 domains of the TDF to organise and present the nuance and complexity of staff experiences of providing psychologically safe care in the context of restrictive practices.

4.6.6.4 Phase Four: Charting. A matrix was developed by the lead researcher with the domain and explanations (following guidance; Atkins et al., 2017) and the charted codes. A researcher with experience with the TDF (CK), independently coded and charted 35% (approximately 60 quotes) of the quotes onto the TDF. Agreement was reached based on an iterative process between the researchers and any disagreements were presented to the research team. Two criteria were used to establish the importance of a TDF domain: assessing the number of times a domain was mentioned across participants and qualitatively assessing where a domain was explicitly labelled as a barrier or facilitator. This approach is consistent with previous studies (Keyworth et al., 2019).

4.6.6.5 Phase Five: Interpretation. The TDF allowed for the identification of relevant behavioural domains but further interpretation of how the domains impacted whether psychologically safe care was delivered was needed. As such, the codes within each domain were then further analysed into explanatory themes to aid interpretation of the facilitators and barriers associated with each domain of the TDF. This followed an iterative process, revisiting the quotes and developing the codes to eventually develop explanatory themes. This process was led by the lead researcher and codes and themes were checked during ongoing research meetings with the team until the explanatory themes were developed. The

detailed analytical process, progressing from inductive coding to deductive mapping and thematic interpretation demonstrates how the facilitators and barrier were developed from the initial interview transcripts.

Throughout the analysis process rigour was ensured through several mechanisms. First, regular meetings with the research team were held to debrief on interpretation. Second, independent coding and charting of 35% of the quotes onto the TDF framework by a second coder whereby discrepancies were reviewed and resolved through discussion. Third, reflexive notes were kept by the lead researcher throughout data collection and analysis to support transparency of interpretation of the presented discussion points. The regular research team meetings allowed for any areas of contention to be discussed and led to codes and themes being refined accordingly. This process alongside ongoing critical reflection during the drafting of the manuscript, contributed to the trustworthiness of the analysis.

4.6.7 Ethical Considerations

A favourable ethical review was received by the University of Leeds, School of Psychology Ethics Committee (07/09/2024; reference number: PSCETHS-1127).

4.7 Findings

There were 20 participants with a mean age of 37.4 years (range: 23-60 years). Participants had a range of job roles: nurse (n = 7; including ward managers and reducing restrictive practice leads), clinical psychologist (n = 5), assistant psychologist (n = 2), pharmacist (n = 2), healthcare assistant (n = 2), peer-support worker (n = 1) and occupational therapist (n = 1). They were predominantly White British (n = 17); one participant was from a mixed ethnic background (Black Caribbean and White British), one participant was White Irish, and one participant did not disclose their ethnicity. See Table 2. for demographic information, including the restrictive practices discussed. MS Teams was used for 19 of the interviews, with one person participating via phone call. Interviews ranged

from 31 to 65 minutes (mean 53 minutes). Total data amounted to 17 hours and 21 minutes.

Six of the 14 TDF domains were identified as particularly salient within the analysis, each with associated explanatory themes. The most salient TDF domains were: environmental context and resources (138 occurrences, reported by 20 participants), beliefs about capabilities (62 occurrences, reported by 17 participants), knowledge (48 occurrences, reported by 12 participants), social/professional role and identity (42 occurrences, reported by 15 participants), social influences (40 occurrences, reported by 13 participants) and emotions (39 occurrences, reported by 12 participants). Quotes are included to provide context in the participants' own words. Additional quotes are provided in supplementary material S2.

Table 4.2.

Participant Demographics and Quote Identification

Participant ID	Gender	Age Range (Years)	Occupation Discussed	Inpatient Setting	Tenure in mental healthcare (Years)	Region of UK Worked In	Restrictive Practices Discussed
Participant 1	Male	46-55	Mental health nurse	Eating disorder wards	16	West Midlands	Locked doors, observations, physical restraint
Participant 2	Female	26-35	Occupational therapist	Adult acute wards	16	North West	Seclusion, segregation, blanket restrictions
Participant 3	Female	36-45	Deputy ward manager (mental health nurse)	Female adult acute ward	3	North West	Blanket restrictions
Participant 4	Male	46-55	Pharmacist	PICU and adult acute wards	25+	North West	Rapid tranquillisation
Participant 5	Female	26-35	Reducing restrictive practices nurse	Trust wide	12	North West	Seclusion, restraint, observations and blanket restrictions
Participant 6	Female	36-45	Bank healthcare assistant	PICU and adult acute wards	2	North East	Restraint, observations

Participant 7	Female	26-35	Ward manager	Adult acute ward	15	South West	Seclusion, nasogastric feeding under restraint, intramuscular injection under restraint
Participant 8	Male	46-55	Ward manager	Adult acute ward	30+	South West	Seclusion, segregation
Participant 9	Female	26-35	Clinical lead	Acute assessment unit	9	North East	Seclusion, restraint
Participant 10	Female	46-55	Pharmacist	PICU	20	South West	Rapid tranquillisation
Participant 11	Female	26-35	Ward manager	PICU	10	North West	Restraint, seclusion, blanket restrictions
Participant 12	Female	26-35	Healthcare assistant	Eating disorder unit and personality disorder unit	2	North West	Observations, seclusion, restraint, nasogastric feeding under restraint and locked doors
Participant 13	Female	18-25	Peer Support Worker/Expert by experience	Disordered eating ward and personality disorder ward	1	North West	Blanket restrictions, nasogastric feeding under restraint, locked doors
Participant 14	Female	18-25	Assistant psychologist	Mixed gender adult acute ward	1	North West	Seclusion, coercive

							language, observations
Participant 15	Female	26-35	Clinical psychologist	Two adult acute wards (one male, one female)	2	North West	Locked doors, blanket restrictions (meal times, standard menu and limit on phone chargers)
Participant 16	Male	26-35	Principal clinical psychologist	Adult inpatient wards	3	North West	Blanket restrictions
Participant 17	Female	26-35	Assistant psychologist	Previously adult acute ward, current older adult acute ward	5	North West	Blanket restrictions, restraint, seclusion, rapid tranquillisation
Participant 18	Female	26-35	Principal clinical psychologist	Two adult acute wards (one male, one female)	3	North West	Restraint, seclusion, rapid tranquillisation
Participant 19	Female	26-35	Clinical psychologist	Two adult acute wards (one male, one female)	2	North West	Locked wards, restraint, blanket rules
Participant 20	Male	56-65	Principal clinical psychologist	Trust wide (acute wards and PICU)	25	North West	Restraint, seclusion, psychological restraint

4.7.1 Domain 1: Environmental Context and Resources

Access to resources and a safe environment for both patients and staff were recognised as imperative for the psychological safety of patients. The ward environment and negative cultures hinder proactive and psychologically informed ways of working. Two facilitators and three barriers were identified.

4.7.1.1 Facilitators.

4.7.1.1.1 Resource. Participants described the importance of resources including psychologically informed alternatives to risk assessment, patient preferences and history, adequate staffing levels without reliance on agency staff, and wellbeing support for staff. Some participants mentioned that having access to these resources on the ward often led to a less risk-focused and restrictive form of care. Staffing challenges were mentioned by most participants, with the belief that if their ward had access to adequate staffing, restrictive practices would be reduced.

"I mean it always comes back to sort of resources and staffing. I think because things are so stretched, people aren't able to think psychologically or think holistically. They are just focused on risk." Clinical Psychologist (Participant 15)

4.7.1.1.2 Creating Safe Spaces for Patients. Participants discussed the importance of patients having access to a safe space, for example a private bedroom that they felt comfortable in. Where a safe environment for patients was absent, this was created by staff through holding meetings away from bedrooms, using 'knock and wait' and consistently trying to meet patient preference, even when staff did not think the preference would be helpful for patients. Accepting this conflict was seen as part of the role.

"We work psychologically within the limitations of that restriction… we have 11 different groups or activities that we facilitate each week to try and continue to promote that psychological safety on the ward, even with the restrictions. Assistant Psychologist (Participant 17)

4.7.1.2 Barriers.

4.7.1.2.1 Ward Environment. All participants mentioned their work environment, described as both the physical structures (i.e., ward layout and the condition of communal spaces) and patient-mix (i.e., patient acuity and interactions of patients on the ward), when discussing psychologically safe care. Participants described the impact that the environment can have on a patient's thoughts and emotions and in turn the behaviour that follows, such as the impact of a busy area of the ward. Some staff discussed how their response to a patient's behaviour is dependent on how 'acute' the ward is, for example higher acuity can result in more restrictions and less use of psychologically informed alternatives. Providing psychologically safe care in their current workplace felt impossible for some and for others an aspiration to work towards. To some, the ward environment needs the addition of restrictive practices and ward rules to keep patients safe.

"You would think that by having no restrictive practices that would enhance the psychological safety on the ward. But I guess when working in healthcare there are various different things, which mean that the two have to go hand in hand and sit next to each other and complement each other." Occupational Therapist (Participant 2)

4.7.1.2.2 Lack of Time. Nurses described not having the time to implement psychologically informed ways of working on top of their responsibilities. Resolving incidents and physical safety were viewed as priority. Working in a fast-paced environment meant that some participants felt themselves and their colleagues did not have time to reflect on their decisions or the incidents they had witnessed on shift.

"I think that that's what that boils down to is time on your shift. You work a 12 1/2-hour shift and you get 9 hours into it and you think, oh my God, the list of things I've got to do is like this long still." Nurse (Participant 7)

"Well, it's just constantly chasing your tail because as soon as you resolved one thing, the other thing pops up and it's just the actual definition of madness." Clinical Psychologist

(Participant 18)

4.7.1.2.3 Staff Culture. Many participants perceived a negative work culture and identified the role management play in creating this. Participants felt that poor staff culture, translated into patients receiving poor quality care. A lack of support for non-nursing staff was mentioned.

"It's down to management, down to what staff are in that day. You knew what the day would be like. I think you even knew how many kickoffs [violent incidents] there would be by the staff you saw in the morning because are these people going to talk people down or are they quite kind of trigger happy not having any nonsense from anyone." Health Care Assistant (Participant 6)

4.7.2 Domain 2: Beliefs About Capabilities

When staff felt confident in their assessment of risk and ability to face complexity in patient presentation, they were more likely to implement psychologically safe alternatives. However, this was impacted by organisational priorities and expectations. Two facilitators and two barriers were identified.

4.7.2.1 Facilitators.

4.7.2.1.1 Importance of Understanding Actual Risk. Being able to accurately assess risk through proactive, meaningful conversations with patients around restrictive practices, was a driving factor in whether restrictive practices were used or not. Staff that understood a patient's presentation and associated risk, felt they could implement psychologically informed alternatives.

"I will honestly say to a patient you are worrying me like I feel really threatened right now and then they'll say back, well, I don't mean to be threatening, and sometimes it just, you know, opens that conversation of the threat and the risk that we see really…I suppose people could quite quickly move to IM [intra-muscular] injection but actually you just need to create

opportunities to see green behaviours from patients." Nurse (Participant 11)

4.7.2.1.2 Dealing with Complexity. Feeling capable (described by participants as having self- confidence and belief) to deal with the challenge of verbally communicating with unwell patients on busy wards with a mixture of patient needs was seen as imperative to the role for some participants. Facing complexity and finding alternative ways of working meant that participants could prioritise psychologically safe ways of working over restrictive practices.

"I think maybe when those risks are higher, we go to sort of the medical model and medication and the kind of restriction rather than thinking about what's going on for people because it's too much to actually, sit with that and find that out would be so much more complex and there's something about, I think people struggle to sit with the complexity." Clinical Psychologist (Participant 15)

4.7.2.2 Barriers.

4.7.2.2.1 Expectations vs Reality. Some participants described the conflict between expectations and reality in the current NHS climate with regards to providing psychologically safe care. Participants reflected that some decisions they make to meet organisational priorities and demands might not be patient centred and could compromise quality of care.

"I think that it's not through a lack of staff really wanting and that is such a difficult thing in this job…there's things in the system and societally, and also in the immediate system of the trusts and XY and Z that just we can't get there and that is suffocating to staff because all they want to do is to provide good quality care, which good quality care is psychological safety." Clinical Psychologist (Participant 18)

4.7.2.2.2 Conflicting Priorities Limiting the Possibility of Psychologically Safe Care. Some participants recognised how the process driven nature of the NHS does not allow for therapeutic, person-centred opportunities. An organisational focus on patient flow,

bed numbers and external pressure and fear of litigation was mentioned. Some participants described how they felt that these priorities differed from patient's needs.

"My gut reaction is, no management and leadership do not prioritize psychological safety. It's that physical safety that's the priority". Pharmacist (Participant 4)

4.7.3 Domain 3: Knowledge

One facilitator and one barrier were identified in relation to the knowledge domain. Knowing the patients that staff are caring for, improved the care they provided. Knowledge gaps and the impact they can have on patient care were discussed.

4.7.3.1 Facilitator.

4.7.3.1.1 Healthcare Professional – Patient Relationship. Knowing the patients meant that participants felt they could have conversations around the use of restrictive practices, patient preference and risk assessment. Some participants felt this improved the therapeutic relationship and allowed for an understanding of patient behaviour that mitigated the need for restrictive practices. Having awareness of psychologically informed alternatives supported this. Limiting the use of restrictive practices at work was seen as providing psychologically safe care by most participants.

"If you'd been able to build up a relationship with somebody so that you could negotiate with them, but in a way that was really collaborative, I imagine that would help people to feel you're moving away from restriction and towards cooperation." Clinical Psychologist (Participant 19)

4.7.3.2 Barrier.

4.7.3.2.1 Knowledge Gaps. Most participants recognised a lack of understanding of patient behaviour and disorders across the MDT. Concerns over lack of training and

understanding for non-nursing staff, that had regular patient contact were expressed by some participants.

“Like healthcare assistants, don't have enough training to be dealing with people in such high stress environments.” Peer Support Worker (Participant 13)

4.7.4 Domain 4: Social/Professional Role and Identity

Two facilitators and one barrier were identified for this domain. Being able to confidently make and communicate decisions to patients was seen as central to the role. Inconsistency and staff concern over connections with patients were identified as barriers.

4.7.4.1 Facilitators.

4.7.4.1.1 Professional Confidence to Make and Explain Decisions. Being able to assess risk confidently, work in alternative ways (i.e., symbol-based communication) and make decisions effectively was seen as a key asset to the nursing role. Some participants also recognised the importance of having the confidence to question potentially detrimental practices by colleagues to ensure a positive culture, such as restraint being used without de-escalation or questioning why someone is being moved to seclusion.

“If I see something that I don't like, I will discuss it and it might just be that that's me, that doesn't like it and actually, that’s the way it has to happen. And I'm quite happy to have that open conversation with people.” Nurse (Participant 7)

4.7.4.1.2 Building Therapeutic Relationships Through Engagement and Purposeful Communication. Ensuring that patients felt heard, recognising the importance of explaining decisions and having positive interactions and communication with patients daily were some of the ways that participants felt staff could add value to interactions on the ward. Some participants described how certain staff, such as named nurses, key workers and psychologists, were purposefully not involved in restrictive practices (i.e., restraint and rapid tranquilisation) to protect their relationship with the patients. Some participants

described intentionally finding pockets of opportunity to engage with patients, for example during enhanced observations and informal communication in communal spaces.

"Communication before, during and after…I have seen where people have been in restraint for minimal periods of time due to the way that staff have communicated with them… it just calms things, right down, and then everyone's fine." Healthcare Assistant (Participant 6)

4.7.4.2 Barrier.

4.7.4.2.1 Inconsistency in Ways of Working. Participants perceived inconsistent work practices in mental health settings, particularly in the approaches of different staff on shift. Lack of definitions (for example, trauma-informed care and psychological safety) and standardised ways of working can mean that staff work in different ways, leading to conflicting decisions and messages to patients. Skill differences between different groups of staff, i.e., day and night staff and permanent and agency staff was briefly mentioned.

"Some staff will encourage patients to sort of learn these therapy skills they've used, advocate for them when they can't and then sometimes you have others and they have absolutely no idea what's going on and they have no idea how to implement it and they say completely the wrong thing and make situations 10 times worse… it really just depends." Healthcare Assistant (Participant 12)

4.7.5 Domain 5: Social Influences

The social relationships between staff, including having shared values and collaboration within a team was seen as important to make positive change and progression towards safe care. Resistance to implement new ways of working and issues around engagement with patients were mentioned. One facilitator and two barriers were identified within this domain.

4.7.5.1 Facilitator.

4.7.5.1.1 Collaboration and Shared Priorities. Staff buy-in and collaboration was recognised as important for new ways of working to be adopted into day-to-day practice.

Participants believed that knowledge sharing, and a shared team focus is how good quality care, where alternatives to restrictive practices are considered, is achieved.

"Everyone's embracing a new way of working, more therapeutic, a less restrictive way of working…it feels quite unified that everyone wants to progress and make it less restrictive." Nurse (Participant 8)

4.7.5.2 Barriers.

4.7.5.2.1 Staff vs Patients: Preventing Engagement with Care. Personal opinions, for example patients' views of staff and vice versa was mentioned as preventing psychologically informed alternatives been used. Some participants described how themselves and their colleagues held certain beliefs about patient behaviour that meant they were less likely to engage with patients. Examples of these beliefs included: patients want attention and that unwell patients should take responsibility for behaviours that challenge.

"I think there are some circumstances where patients simply won't allow you to do it in a psychologically safe way. There are some people that are so pissed off, so pumped up that actually no matter what you say you're not going to be able to do anything without restraint and without seclusion." Pharmacist (Participant 4)

4.7.5.2.2 Resistance to Change. Concerns over multi-disciplinary ways of working were reported by several participants, specifically the impact that more senior members of staff have on the direction of the teams' decisions. Clinical psychologists mentioned the notion of 'battling against the MDT' when consultants and nurses focused on delivering care according to the medical model in cases of trauma. Some participants felt that the implementation of psychologically informed ways of working was prevented by resistance from their colleagues.

"Obviously we've got matrons and senior leaders and people that will ask and see incident reports on the PICU and say, well, he needs this [restrictive practice]... I suppose they don't

know the patient. They just see an incident, don't they?" Nurse (Participant 11)

4.7.6 Domain 6: Emotions

Empathy and compassion were driving factors in participants trying to use psychologically informed alternatives with patients. Staffs' personal opinions of patients and burnout was seen to impact care. One facilitator and two barriers were recognised within this domain.

4.7.6.1 Facilitator.

4.7.6.1.1 Empathy and Compassion. Having empathy and compassion for patients positively impacted the way staff provided care and communicated with patients. Some described how the context that decisions are made in, for example on a mental health ward compared to a public setting, impacts the acceptability of them. Participants discussed how they continued to communicate with people in crisis as they would with people not in crisis (for example, not infantilising or patronising adult patients).

"You can still make choices even if you are in a mental health crisis. Why do these people not get treated like adults. What is the problem here? I genuinely don't understand what the problem is, bizarre isn't it." Nurse (Participant 1)

4.7.6.2 Barriers.

4.7.6.2.1 Burnout and Compassion fatigue. Staff burnout and compassion fatigue was seen to impact patient care, stating that the psychological safety of patients was "the first thing to go in order to get through the shift" Clinical Psychologist (Participant 18). Some participants recognised aspects of the jobs that contributed to stress and eventually burnout, for example repeated incidents on a shift and staffing issues.

"I think there's a massive link with burnout and stress and frustration and how it like impacts care…I suppose if you are feeling stressed and burnt out your tolerance isn't the same as

that- your resilience isn't the same." Nurse (Participant 11)

4.7.6.2.2 Fear and Personal Opinions Driving Decisions About Patient Care.

Participants that feared for their own safety or being concerned for the repercussions if they were to not use restrictions meant that reactive care was more likely to be used. Concerns over damaged reputations because of incidents (for example, patient suicide) was also described by some participants. Some participants said their colleagues used restrictive practices on patients they did not like or in some cases stereotyped certain diagnoses.

"I think fear is always a big one. People are afraid of being hurt, and rightly so. You know, you're looking at a group of people who, on a day-to-day basis for very long days, very long hours, are exposed to significantly unpredictable unstable environments in which they receive an awful lot of abuse physically and mentally. And that has a price." Clinical Psychologist (Participant 20)

4.8 Discussion

This study is the first to identify facilitators and barriers to providing psychologically safe care in inpatient mental healthcare, from the perspective of healthcare staff. Two important contributions to the literature are made through this study. First, six salient TDF domains were identified that participants felt were important in aiding, or hindering, their ability to support the psychological safety of patients. Secondly, staff recognise the importance of providing psychologically safe care but report the lack of support to do so in practice. Three key findings are discussed in relation to key components of mental health staffs' practice.

All participants recognised the ward environment as having the potential to both support and prevent staff from providing psychologically safe care to patients. Having access to resource and being able to modify the environment to support patients was seen as important. When there were factors that staff felt were out of their control (i.e., patient mix and organisational priorities), more restrictive measures were used. Staff have previously

reported patient acuity and distress as barriers to the implementation of psychological therapies and how staff feel they lack control over ways of working set by organisations (Evlat et al., 2021; Polacek et al., 2015). The current study demonstrates that staff try to work within the restrictions to provide safe spaces for patients. Having access to resources is important in supporting this. The resources identified in the current study included, psychologically informed policies and guidelines, wellbeing support for staff and staffing resource. Healthcare providers, are facing resource and staffing issues, creating lack of time for meaningful engagement which is well-documented in the UK literature (Evlat et al., 2021). While increasing resource and investment in psychologically safe alternatives should be priority for organisations, in the interim reporting and sharing the way in which staff are providing care to patients within constraints is important for shared learning across organisations.

Approaches to risk assessment and the management of self-harm was discussed at length. Specifically, moving away from traditional and structured ways of assessing risk, such as structured questions and assumptions based on hospital records from previous admissions. Instead, staff in the current study described the importance of being proactive in having meaningful conversations with patients about their behaviours, instead of relying on structured questions often described as ‘tick-box’ questions. Staff recognise the role that training plays in this to be able to confidently have these conversations instead of defaulting to risk-averse, restrictive practices. The National Institute for Health and Care Excellence do not recommend traditional, ‘tick-box’ risk assessment for self-harm behaviours and instead support psychosocial assessment as a best practice preventative strategy (Guideline 225; National Institute for Health and Care Excellence [NICE], 2022). Psychosocial assessment encompasses a co-produced formulation of a patient’s needs, safety considerations and vulnerabilities to develop a shared understanding of a patient’s behaviour that goes beyond quantifying risk (National Institute for Health and Care Excellence [NICE], 2022). Patients have expressed concerns over how traditional risk assessment is typically carried out,

minimising the patient voice and replacing meaningful engagement with ‘tick-box’ exercises (Deering et al., 2022). In the current study there was positive discussion about using risk assessment at work, but what this meant to the participants varied from traditional risk assessment to more formulaic assessments of risk. Given that their still seems to be reliance on ‘tick-box’ methods of risk assessment, moving to more formulaic psychosocial assessments could be challenging. Interventions that focus on strengthening staff capability and capacity to carry out psychosocial risk assessment and providing skills-based training could support this shift. Supporting staff to have meaningful conversations, where co-produced formulations are developed is important for the future of management of aggression and self-harm. The findings of this study support this shift in perspective in that participants accepted that this is an area of improvement needed on mental health wards.

Investment in staff knowledge and feelings about the use of restrictive practices at work was recognised as important by most participants. The current mental health workforce in England is facing challenges which could lead to dissatisfaction at work, burnout and compassion fatigue (Marshman et al., 2022). Burnout refers to emotional exhaustion, depersonalisation and disengagement and low personal accomplishment at work and is thought to be more prevalent in mental healthcare workers than staff in other settings (Johnson et al., 2018). Compassion fatigue refers to a loss of compassion in clinical practice due to the high demand of providing care in emotionally charged environments and can lead to lower quality care for patients due to reduced engagement (Marshman et al., 2022). Feeling valued, supported and psychologically safe in their role could potentially increase staff buy-in to psychologically informed ways of working and positively impact the care patients receive. The link between psychological safety, burnout and patient outcomes is under-researched (Montgomery et al., 2025) but has been identified in the current study as a concerning possibility if staff do not feel invested in and supported. The findings of this study demonstrate key areas of healthcare practice that could be targeted by tailored-training packages to empower staff to provide care in line with their values. Examples include

psychologically-informed alternatives to restrictive practices, how to conduct co-produced safety planning and building confidence in initiating complex, emotionally charged conversations about risk.

4.8.1 Implications for Practice and Research

The use of the TDF allowed for the identification of salient domains relevant to mental healthcare practice that can be targeted by organisations to implement psychologically safe care. Three specific recommendations for practice are outlined here. First, staff recognise the importance of psychological safety alongside physical safety but often feel it is not recognised by organisations, limiting their beliefs in their capabilities. Organisational buy-in of psychologically informed training (for example, human rights act training, de-escalation and trauma related topics) and resource could drive cultural change, improving nurses' and healthcare assistants knowledge and morale to provide and engage meaningfully with patients. Second, collaboration between and within services is imperative for future improvements in patient safety at a national level. At present, staff recognise the fragmented and inconsistent ways of working between and within organisations, from undefined concepts and ideas and the use of different technologies and communication systems. An inconsistent environment for nurses and the wider MDT potentially translates to an inconsistent environment for patients. Third, meaningful engagement with patients should be a priority for nursing staff. Finding pockets of opportunities for engagement with patients, whether through observations, ward rounds or informal communication on the wards was recognised as important and feasible in the current study, despite working in restrictive environments. Providing and encouraging nursing staff to participate in ongoing reflective practice (where patient-facing staff are provided time and supervision to reflect on their role and the decisions that they make at work) could facilitate these conversations with patients and avoid compassion fatigue.

There are two recommendations for future research based on the findings from this study. First, future research should focus on identifying ways in which psychologically safe

care can be provided in the current mental health services climate, including combining suggestions from nursing staff, the wider MDT and patients to ensure any recommendations are grounded in the voice of the people experiencing these environments. It is imperative that any future interventions, whether that be for reducing restrictive practices, implementing trauma-informed care or workforce initiatives are acceptable and feasible for the staff and organisations implementing them. Acceptability (how people think and feel about interventions; Sekhon et al., 2017) has been identified as a key driver to intervention effectiveness and implementation (Skivington et al., 2021) and participants in the current study recognised the importance of belief in their capabilities to drive change. Further exploration of how these barriers can be addressed prior to intervention development is needed. Second, this study was conducted in England and captures experiences shaped by England-centric policy and law, for example the Mental Health Act. It is possible that the identified domains and several findings might align with international priorities and barriers to change as reducing restrictive practices and integrating psychologically informed alternatives is a global priority (World Health Organization, 2023). As such, countries facing similar healthcare pressures or that use similar MDT structures may resonate with the findings of the current study but future research could build on the current findings to explore how psychologically safe care could be provided within different service delivery contexts across the UK and internationally.

4.8.2 Strengths and Limitations of the Work

The current study is the first to use the theoretically grounded TDF to identify facilitators and barriers for staff to provide psychologically safe care, demonstrating how staff recognise the importance of supporting the psychological safety of patients alongside protecting and maintaining their physical safety. There are four key limitations to note. The first limitation to note is around the sampling and resulting participants. This study only recruited participants that worked in England and as the participants shared the study within their teams, several participants were from the same NHS trusts and could have potentially

shared similar experiences that could impact the results. Second, participants were primarily white and female staff. While recruitment was focused on discussing a range of restrictive practices and the inclusion of a range of healthcare professionals, the demographics of participants is not entirely representative of the NHS mental healthcare workforce and should be interpreted with this in mind (GOV.UK, 2023). Third, while the study incorporated a wide range of job roles representing the MDT, there were key roles missing such as psychiatrists and social workers. Fourth, while the term restrictive practice is used in this study, methods such as technological surveillance and cultural restraint that are included in the recent NHS England guidance (NHS England, 2025) were not included in this study. It is important that researchers, clinicians and policy makers are consistent in language and terminology used in this area.

4.8.3 Conclusions

The current study identifies key facilitators and barriers to staff in inpatient mental health settings providing psychologically safe care. The use of the TDF allowed for the identification of salient TDF domains that organisations could target to support the integration of psychologically safe care into practice. Ensuring that staff feel supported in their role to implement psychologically informed alternatives to restrictive practices, as well as providing safe environments for both patients and staff could support the integration of psychologically safe care on inpatient mental health wards. Supporting the psychological safety of patients whilst protecting them from physical harm is recognised as integral to caring for patients in acute distress.

4.8.4 Supplementary Material

The supplementary material (topic guide and additional quotes) associated with this article is available in the supplementary section.

Chapter 5 Providing Psychologically Safe Care in Inpatient Mental Healthcare: A Qualitative Study with Former Patients and Staff

5.1 Abstract

Background: The psychological safety of patients should be considered in patient safety priorities, but what this looks like in practice is under researched.

Aims: To use the Theoretical Domains Framework (TDF) to identify the gaps in healthcare provision that are implicated in providing psychologically safe care to patients and to outline recommendations for how to support the psychological safety of patients when restrictive practices are used

Methods: A qualitative design using semi-structured interviews with 18 former patients and 20 staff that have worked in adult inpatient mental health services in England. Relevant TDF domains were identified using deductive coding. Inductive content analysis was used to generate themes to identify key priority areas for improvement.

Results: Recommendations centred around changes to the ward environment, improvement to the culture on wards (environmental context and resources) and the inclusion of peer support and advocacy roles (social/professional role and identity). Intentional communication with patients (intentions), the training provided for staff (skills) and the improvement to knowledge sharing within and between organisations (knowledge) was important to former patients and staff. Participants want organisations to empower staff to advocate for patients and encourage patients to be involved in care decisions (beliefs about capabilities).

Implications: The current study presents areas of care provision that require improvements to support patients' psychological safety during admission. Consistency of approach is

important for the psychological safety of patients. Organisations need to invest in their workforce to support staff retention and implementation of evidence-based practice.

5.2 Introduction

Inpatient mental health services in the United Kingdom (UK) provide care to people who are acutely unwell and require a place of safety when they can longer keep themselves safe. Safety in this context often refers to a service-oriented physical risk management perspective, despite patient's definitions focusing on feeling safe and being protected from psychological harm (Berzins et al., 2020; Canvin et al., 2024). Physical safety, defined here as protection from physical harm, is necessary and is required when there is a risk to life or the potential for serious harm to people on an inpatient mental health ward. However, the risk management strategies that are used to do this, such as restrictive practices, can cause physical and psychological harm to patients (Askew et al., 2020; Chieze et al., 2019). Restrictive practices refer to interventions used to deliberately restrict a person's movement, liberty and/or freedom to take control of a potentially dangerous or harmful situation (Department of Health, 2014; National Institute for Health and Care Excellence [NICE], 2015). A criticism of inpatient mental healthcare is its continued focus on physical, at the expense of psychological, safety (Berzins et al., 2020; Veale et al., 2023).

Research has started to identify factors which impact patients' psychological safety, including relationships with staff, access to activities and therapy on wards and the use of restrictive practices (Berzins et al., 2020; Cutler et al., 2021a; Griffin et al., 2025b; Vogt et al., 2024). The factors identified in these studies require further exploration into how the psychological safety of patients can be supported. Research has demonstrated that the relationship between restrictive practices and psychological safety is complex (Griffin et al., 2025b); some patients believe the practices are inherently harmful, while some patients view their use as necessary. Identifying key areas for improving psychological safety in this context and developing feasible recommendations for how this looks in practice would progress the research area and improve practice in line with governing and regulatory

organisations' request to view safety holistically (Care Quality Commission, 2024a; Health Services Safety Investigations Body [HSSIB], 2025a; NHS England, 2024a).

Any recommendations for mental healthcare policy and practice should be grounded in patient voice and be feasible and acceptable for the patients and healthcare staff responsible for implementing them. For both staff and patients, there are barriers and enablers to reducing the use of restrictive interventions and implementing relational approaches instead; most notably the level of engagement that stakeholders have with the implementation of these approaches (Martello et al., 2018; Muir-Cochrane et al., 2018). Involving patients in their care and creating safer services is a priority for the NHS (Department of Health and Social Care, 2023). Therefore, involving both patients and staff in the identification of priority areas and development of recommendations is needed and could improve implementation into practice. This study synthesises both perspectives (former patients and staff), using a theoretical framework to outline recommendations for how to provide psychologically safe care to patients when restrictive practices are used in inpatient mental health settings in a way that is both feasible and acceptable.

Due to psychological safety being a relatively new concept that does not have a widely used working definition, the current study presents the exploratory work of developing recommendations for policy and practice. A working definition developed through a wider work package that this study sits within is used (Griffin et al., 2025b). This study has two aims. First, to use the Theoretical Domains Framework (TDF) to identify the gaps in healthcare provision that are implicated in providing psychologically safe care to patients.

The secondary aim is to outline recommendations for how to support the psychological safety of patients when restrictive practices are used, considering current practice.

5.3 Methods

5.3.1 Design

A qualitative design, using data from two qualitative studies which used semi-structured interviews. One study explored the impact of restrictive practices on the psychological safety of former patients and the other reported on the barriers and facilitators of staff providing psychologically safe care in inpatient mental health services.

5.3.2 Theoretical Framework

Changing existing practices in healthcare services requires an understanding of behaviours in the context they occur. The use of a behavioural theory allows for underlying structural and psychological processes to be explored in relation to the implementation of new ways of working (Atkins et al., 2017; Cane et al., 2012). The TDF was developed with the aim to identify influences on the behaviour of healthcare professionals (Cane et al., 2012). The TDF “provides a theoretical lens to view the cognitive, affective, social and environmental influences on behaviour” (Atkins et al., 2017, pg. 2) and was synthesised from 128 theoretical constructs from 33 theories relating to implementation questions. This theoretical framework, consisting of 14 domains (detailed in Table 1; Atkins et al., 2017), has been used in mental health settings to investigate the de-escalation of conflict in forensic mental health settings (Johnston et al., 2022) and to inform the implementation of a virtual reality-based intervention (Chung et al., 2023), but to date has not been used to understand the implementation of psychologically safe care into practice. The use of the TDF in qualitative studies can generate evidence-based behaviour change targets and inform future intervention development (Debono et al., 2017; Johnston et al., 2022). Here, the TDF was

used to identify gaps in healthcare provision and organise the recommendations reported by former patients and staff.

Table 5.1.

The Theoretical Domains Framework (v2) with definitions and constructs (Atkins et al., 2017).

Domain	Definitions	Constructs
1. Knowledge	An awareness of the existence of something	Knowledge (including knowledge of condition/scientific rationale) Procedural knowledge Knowledge of task environment
2. Skills	An ability or proficiency acquired through practice	Skills Skills development Competence Ability Interpersonal skills Practice Skill assessment
3. Social/professional role and identity	A coherent set of behaviours and displayed personal qualities of an individual in a social or work setting	Professional identity Professional role Social identity Identity Professional boundaries Professional confidence Group identity Leadership Organisational commitment
4. Beliefs about capabilities	Acceptance of the truth, reality or validity about an ability, talent or facility that a person can put to constructive use	Self-confidence Perceived competence Self-efficacy Perceived behavioural control Beliefs Self-esteem Empowerment Professional confidence
5. Optimism	The confidence that things will happen for the best or that desired goals will be attained	Optimism Pessimism Unrealistic optimism Identity

6. Beliefs about Consequences	Acceptance of the truth, reality, or validity about outcomes of a behaviour in a given situation	Beliefs Outcome expectancies Characteristics of outcome expectancies Anticipated regret Consequents
7. Reinforcement	Increasing the probability of a response by arranging a dependent relationship, or contingency, between the response and a given stimulus	Rewards (proximal/distal, valued/not valued, probable/improbable) Incentives Punishment Consequents Reinforcement Contingencies Sanctions
8. Intentions	A conscious decision to perform a behaviour or a resolve to act in a certain way	Stability of intentions Stages of change model Transtheoretical model and stages of change
9. Goals	Mental representations of outcomes or end states that an individual wants to achieve	Goals (distal/proximal) Goal priority Goal/target setting Goals (autonomous/controlled) Action planning Implementation intention
10. Memory, attention and decision processes	The ability to retain information, focus selectively on aspects of the environment and choose between two or more alternatives	Memory Attention Attention control Decision making Cognitive overload/tiredness
11. Environmental context and resources	Any circumstance of a person's situation or environment that discourages or encourages the development of skills and abilities, independence, social competence and adaptive behaviour	Environmental stressors Resources/material resources Organisational culture/climate Salient events/critical incidents Person × environment interaction Barriers and facilitators
12. Social influences	Those interpersonal processes that can cause individuals to change their	Social pressure Social norms Group conformity Social comparisons Group norms

	thoughts, feelings, or behaviours	Social support Power Intergroup conflict Alienation Group identity Modelling
13. Emotion	A complex reaction pattern, involving experiential, behavioural, and physiological elements, by which the individual attempts to deal with a personally significant matter or event	Fear Anxiety Affect Stress Depression Positive/negative affect Burn-out
14. Behavioural regulation	Anything aimed at managing or changing objectively observed or measured actions	Self-monitoring Breaking habit Action planning

5.3.3 Participants and Recruitment

The current study was part of a wider programme of research. Participation was sought from former patients (discharged for longer than 6 months) and staff (more than one year's working experience) currently working in inpatient mental health wards in the UK. People with experience only in forensic settings or child and adolescent services were not eligible for participation. Recruitment was carried out separately, with one study advertising for former patients and the other for healthcare professionals. Volunteer sampling was used in both studies and snowball sampling, whereby healthcare professionals shared the advertisement within their networks, was also used for the recruitment of staff.

5.3.4 Procedure

Ethical approval was granted by the University of Leeds, School of Psychology Ethics Committee (20/07/2023; reference PSCETHS-674 and 07/09/2024; PSCETHS-1127). Detailed data collection methods for both papers are outlined in separate publications (Griffin et al., 2025b; Griffin et al., under review). The study poster was shared on X, LinkedIn and Facebook groups relating to inpatient mental healthcare in the UK and listed restrictive

practices as: locked doors, seclusion, restraint, rapid tranquilisation, observations and limitations on movement (segregation).

Semi structured interviews were primarily carried out on MS Teams and one person opted for a telephone interview, all were recorded and transcribed verbatim. Participants were encouraged to discuss recommendations and suggestions based on their own experiences or interventions that they would like to see implemented on wards to make restrictive practices less psychologically harmful and more psychologically safe. Participants received a debrief email containing a £30 voucher for their participation in the original studies. In this study, new data (not analysed in the previously mentioned studies) pertaining to the question, “What suggestions and alternatives would you give for making inpatient mental healthcare more psychologically safe when restrictive practices are used?” was analysed.

5.3.5 Analysis

Data were coded by the lead author (BG) using deductive latent coding to identify priority domains of the TDF, using the definitions of each domain (presented in Table 1) as a guide (Atkins et al., 2017) in Microsoft Excel. Twenty five percent of the quotes were independently coded by a member of the research team who has expertise with the TDF (CK). Establishing the importance of a domain as an identified area of improvement was based on two criteria: 1) domain mentioned frequently across participant groups, 2) specific codes were explicit mentioned as important suggestions and alternatives for improving services. This approach has been used in previous studies (Francis et al., 2012; Keyworth et al., 2019). Codes and the associated quotes within each domain were themed using inductive content analysis (Vears et al., 2022) to identify priority areas for improvement based on the participant’s recommendations. Priority areas were key elements of inpatient

mental health services that participants identified as requiring improvements for patients to feel psychologically safe.

5.4 Results

Data from 18 former patients and 20 staff with experience working in inpatient mental health services were analysed. Participant demographics are presented in Table 2.

Six of the 14 TDF domains were identified from the analysis as priority areas of healthcare provision that required improvements. The domains were: environmental context and resources (115 occurrences, reported by 18 former patients and 18 staff), intentions (36 occurrences, reported by 13 former patients and five staff), skills (31 occurrences, reported by nine former patients and 11 staff), social/professional roles and identity (26 occurrences, reported by 10 former patients and seven staff), beliefs about capabilities (18 occurrences, reported by eight former patients and six staff) and knowledge (15 occurrences, reported by six former patients and five staff). Quotes are included to help provide context and the specific recommendations are included in Table 3.

5.4.1 Domain 1: Environmental Context and Resources

Improvements to the environment, including physical changes to the ward, the culture and the available resources, were identified by all former patients and 18 of the staff that participated.

5.4.1.1 Ward Environment. Former patients' recommendations included: reducing locked doors, increasing access to outdoor spaces and ensuring that wards were not mixed sex. Staff focused more on improving ward processes such as, the admissions process and more consistent orientation to the ward and its routines. Both groups identified the need for investment in the structural ward environment and emphasised the provision of spaces to work through emotions that felt therapeutic and supportive. These were described as

‘psychologically safe environments’ that encompassed a therapeutic, community environment.

“[Access to] basic things that are often for free. Just like outdoor spaces, the great outdoors and just having places to think rather than being in an environment where you're just like on guard constantly and you're not able to take time out of your life to get better.” Former Patient 2

5.4.1.2 Ward Culture. Suggestions to improve ward culture included individualising care, assessing risk based on collaborative formulations and honest and transparent communication about restrictive practices on the wards. Improvements to staff culture included adopting a ‘just and learning culture’ (where concerns and engagement with patients were seen as an opportunity to learn) and increased team collaboration for care delivery. Fewer participants suggested revisiting definitions of restrictive practices to include restrictions beyond the physical and to ensure that the development of ward procedures and policy should include staff at all levels and the patient voice.

“I think those spaces: one to ones, ward rounds, community meetings, like staff should be saying these are spaces where you can tell us how you really feel and we're gonna sit and we're gonna listen and we’ll try and respond if we can.” Former Patient 9

“We have what's called the just and learning culture which means that basically it's a safe environment that recognises that errors do happen…but it encourages more thinking about the processes that happen around that [and asking] what went wrong?” Deputy Ward Manager (Staff 3)

5.4.1.3 Need for Resources for Patients and Staff. Most participants perceived a need for more resources for staff and patients on the wards. For former patients, improving access to meaningful activities and therapeutic engagement opportunities were seen as a

priority. Having a range of activities that patients had a choice over, and the opportunity to do more things outdoors, was also recognised as important.

"I do think that having access to meaningful activities and therapy groups [is important] and I've been on units where there are billions spent on that and EDUs [eating disorder units] do tend to do that a little better." Former Patient 4

Both staff and former patients reported that organisational investment into staffing (increasing the number of permanent, personable staff over agency staff) and 'psychological safety initiatives' were needed on the wards. These initiatives were described by staff as organisational support to work in the least restrictive, trauma-informed way. Similarly, emotional, psychological and wellbeing support resources were requested by staff for themselves to support the delivery of psychologically safe care to patients.

5.4.1.4 Time and Prioritisation. Both former patients and staff discussed time constraints impacting the opportunity for therapeutic input from staff. Most participants agreed that psychologically informed approaches, such as risk formulations, safety planning (proactive discussions about how patients could manage and prevent future crises) and therapy sessions with patients, were not prioritised and opportunities were missed. Participants reported that organisational priorities need to be re-assessed for meaningful change to be achieved. Some former patients requested that staff consistently implement debriefs and relational care over administrative responsibilities when restrictive practices are used.

"[I'd recommend] creating psychological safety initiatives on the wards and reducing restrictive practice on the wards… a lot of it comes down to the resources and time." Clinical Psychologist (Staff 16)

Table 5.2.

Participant Demographics and Quote Identification

Participant ID	Gender	Age Range (Years)	Occupation	Restrictive Practices Discussed
Former Patient 1	Female	26-35	Doctor	1:1 Observations Seclusion Rapid tranquilisation Sectioned mid-stay Restraint
Former Patient 2	Female	36-45	Student adviser	1:1 Observations Restraint
Former Patient 3	Female	46-55	Unemployed	Restraint Rapid tranquilisation Coercive language Locked doors
Former Patient 4	Female	26-35	Postgraduate student	1:1 Observations Locked doors Restraint Restraint for nasogastric feeds
Former Patient 5	Female	46-55	Senior caseworker	Blanket restrictions Coercive language Locked doors Segregation 1:1 Observations
Former Patient 6	Non-binary	36-45	Unemployed	Restraint Seclusion Sectioned mid-stay
Former Patient 7	Female	36-45	Administrator and expert by experience	Rapid tranquilisation Coercive language Restraint
Former Patient 8	Female	18-25	Unemployed	Restraint Rapid tranquilisation 1:1 Observations

Former Patient 9	Male	46-55	Researcher	Blanket restrictions Locked doors Coercive language Restraint Rapid tranquilisation
Former Patient 10	Female	18-25	Doctor	Restraint Rapid tranquilisation Removal of belongings Locked doors
Former Patient 11	Male	55-65	Team manager	Rapid tranquilisation Observations
Former Patient 12	Female	36-45	Emergency care assistant	Restraint Rapid tranquilisation Seclusion Physical handling
Former Patient 13	Female	18-25	Healthcare	2:1 Observations “Treated under restrictive practice” Restraint CCTV observations
Former Patient 14	Female	46-55	Social worker	Seclusion Coercive language Segregation Locked doors
Former Patient 15	Female	46-55	Full-time carer	Seclusion Rapid tranquilisation
Former Patient 16	Non-binary	26-35	Student and project co-ordinator	Observations Locked doors Blanket restrictions
Former Patient 17	Non-binary	36-45	Unemployed	Rapid tranquilisation Blanket restrictions Restraint
Former Patient 18	Female	18-25	Student	1:1 Observations Restraint
Staff 1	Male	46-55	Mental health nurse	Locked doors Observations

Staff 2	Female	26-35	Occupational therapist	Physical restraint Seclusion Segregation Blanket restrictions
Staff 3	Female	36-45	Deputy ward manager (mental health nurse)	Blanket restrictions
Staff 4	Male	46-55	Pharmacist	Rapid tranquilisation
Staff 5	Female	26-35	Reducing restrictive practices nurse	Seclusion Restraint Observations Blanket restrictions
Staff 6	Female	36-45	Bank healthcare assistant	Restraint Observations
Staff 7	Female	26-35	Ward manager	Seclusion Nasogastric feeding under restraint Intramuscular injection under restraint
Staff 8	Male	46-55	Ward manager	Seclusion Segregation
Staff 9	Female	26-35	Clinical lead	Seclusion Restraint
Staff 10	Female	46-55	Pharmacist	Rapid tranquilisation
Staff 11	Female	26-35	Ward manager	Restraint Seclusion Blanket restrictions
Staff 12	Female	26-35	Healthcare assistant	Observations Seclusion Restraint Nasogastric feeding under restraint Locked doors
Staff 13	Female	18-25	Expert by experience	Blanket restrictions Nasogastric feeding under restraint Locked doors
Staff 14	Female	18-25	Assistant psychologist	Seclusion Coercive language

Staff 15	Female	26-35	Clinical psychologist	Observations Locked doors Blanket restrictions (mealtimes, standard menu and limit on phone chargers) Blanket restrictions
Staff 16	Male	26-35	Principal clinical psychologist	Blanket restrictions
Staff 17	Female	26-35	Assistant psychologist	Blanket restrictions Restraint Seclusion Rapid tranquilisation
Staff 18	Female	26-35	Principal clinical psychologist	Blanket restrictions
Staff 19	Female	26-35	Clinical psychologist	Blanket restrictions Restraint Seclusion Rapid tranquilisation
Staff 20	Male	56-65	Principal clinical psychologist	Restraint Seclusion Rapid tranquilisation

5.4.2 Domain 2: Intentions

Eighteen participants reported the importance of staff being intentional in how they interact with patients; 13 of these were former patients. Suggestions and alternatives centred around explaining the decision to use restrictive practices to patients and being intentional in how staff communicate.

5.4.2.1 Explaining Decisions About, and Reasons for, Restrictive Practices. Staff explaining and reviewing their decision to use restrictive practices at regular intervals, regardless of perceived capacity, was important for former patients. If participants had been told that the restrictions were being used to protect the physical safety of people on the ward, they would have been more likely to potentially accept the decision. Most felt that this explanation was missing. Prioritising patient dignity when making decisions was also mentioned as part of providing care that balances physical and psychological safety.

"I think just explaining things to people, talking to people and involving people in decisions about their care as well…So rather than saying, this is what we're doing and you don't have any say in it actually asking people what they think, asking them what they want and involving them as much as they can be involved." Former Patient 8

5.4.2.2 Communication and Engagement. Improvements to how and when staff engaged and communicated with patients were requested by both patients and staff. Suggestions included having a relational aspect to observations (both routine and enhanced), debriefing patients that have witnessed incidents and rebuilding the therapeutic relationship when restrictive practices have been used. Participants suggested

improvements to the language used when communicating with patients, for example avoiding invalidating language that minimises the patient experience.

“I think that all of this [communication] would really help with keeping that psychological safety… when you're having these conversations, these therapeutic relationships build up.” Nurse (Staff 3)

“Just, you know, treat people like humans, treat them like people, not patients. Treat them how you would want to be treated.” Former Patient 18

5.4.3 Domain 3: Skills

Nine former patients and 11 staff reported the need for improvements to training priorities to ensure staffs’ skills match patient presentations. Participants recognised knowledge gaps of staff that arise through lack of appropriate training. As such, improvements to the way training is delivered were suggested.

5.4.3.1 Importance of Training for Healthcare Staff. The topics that participants felt need to be prioritised in training packages included: debriefs and de-escalation, specific disorders and restrictions, and autism and neurodivergence. Training for staff about responding to self-harm, that go beyond enhanced observations, and immediate restraint was requested by former patients. Staff reported that current training heavily focused on risk and physical intervention training (i.e., breakaway and self-defence) instead of psychologically informed alternatives.

Staff wanted improvements to the way training was delivered: ensuring delivery matches the topic, making training available to staff at all levels (including, peer support workers, HCAs and operational staff) and making sure training standards were consistent across trusts (i.e., all wards are trained to the same standards to improve skills of bank staff

that might be travelling between different wards). The importance of the inclusion of lived experience in training delivery was recognised by both former patients and staff.

"Offer everyone the training. Help them understand being psychologically informed…really look at the skill set you are putting on each ward. Our last lot are the reason we're struggling as a team at the minute with the people not having morals that align." Assistant Psychologist (Staff 17)

5.4.4 Domain 4: Social/Professional Role and Identity

Ten former patients and seven staff provided suggestions that centred around the social/professional role and identity of staff on the ward. These included ways in which therapeutic care could be incorporated into staff's practice as well as additional roles that could add value to the wards.

5.4.4.1 Implementing Therapeutic Alternatives into the Role. Suggestions from former patients for how staff could incorporate relational ways of working into their role included: having responses to incidents based on context over procedure, supporting patients to build positive relationships on and off the ward and staff having a flexible approach to implementing ward rules (for example, based on patient circumstance rather than ward routines). Both former patients and staff reported that reflective practices (giving staff the space to reflect on the decisions they made at work with a psychologist), debrief and supervision should be embedded as standard practice. However, both participant groups recognised that time constraints and resource allocation limited the ability to do this.

"It's important to have the team conversation of we've just had to restrain so how did we all feel it went. Or maybe we could have deescalated that earlier. But there's nothing that helps more than having immediate feedback on how you did…it needs to be heard." Pharmacist (Staff 10)

5.4.4.2 Roles on the Ward. Several participants reflected that peer-support workers and independent advocates could support the delivery of psychologically safe care. A few

participants caveated the need for role clarity to protect peer support workers. Staff also reported that care co-ordinators, family and carers should be involved in explaining decisions to patients to support staff. One participant mentioned the importance of staff being easily identifiable to unwell patients (for example, the ‘Hello My Name Is’ campaign and consistent uniforms for staff).

“I know they have advocates now, which they didn't have for me. You can’t trust staff so much so maybe you’d want to talk to the advocates instead?” Former Patient 15

5.4.5 Domain 5: Beliefs about Capabilities

Eight former patients and six staff mentioned the perceived capabilities of both patients and staff on wards. Suggestions focused on empowering patients to be involved in care decisions and staff being able to speak up at work.

5.4.5.1 Patients as an Active Participant in their Care. Having choice and input was recognised as a protective safety factor for patients. Having proactive discussions about the use of restrictions on the wards was recognised as important for patients by both participant groups. Suggestions for how this could be facilitated included, providing information about what restrictions are used during high-risk situations, and how they are carried out, and allowing patients to communicate their preferences for this (for example, same-sex staff members being involved in restraint).

“I think that's maybe when you get that psychological safety, when there's been a time when you can discuss those practises, when someone's not in distress… what might need to happen, how can we keep you safe, how can you keep yourself safe? I think those conversations around restrictive practises are what helps people to feel psychologically safe.” Clinical Psychologist (Staff 19)

5.4.5.2 Being Able to Speak up About Harmful Practices. Being able to ‘speak up’ about practices that could harm patients was deemed as important by staff. Examples included ward rules based on custom and practice over best practice guidelines, using

outdated restraint methods, such as ‘swan-grip’ (described as twisting and holding a patient’s hand behind their back) and applying pressure to specific pressure points on a patient’s body, and not interacting in a positive way with patients. Alongside this, staff having the confidence to advocate for patients when decisions are made without patient input was reported by participants.

“Being aware of the psychological harm of restrictive practice…and fighting, I suppose them restrictions.” Nurse (Staff 11)

5.4.6 Domain 6: Knowledge

Eleven participants (six patients and five staff) mentioned the role of knowledge sharing to help facilitate care. Participants requested improvements to sharing information with patients about elements of their care and ward processes. Staff’s knowledge gaps were also discussed.

5.4.6.1 Knowledge Sharing with Patients and Staff. Knowledge sharing, both between staff and patients and within the workforce, were seen as important by both participant groups to avoid perceived gaps. Recommendations included, clearly defining mental health specific terms (defining restrictive practices, sectioning (detention) and treatment options), providing information of ward processes, rules and routines and providing information to patients about potential side effects of medications.

“I think when you’re admitted explain what restrictive practice means. For me they would always say take these medications or in the worst-case scenario, we could give it forcefully. But what does that actually mean?…Just explaining to you why it's used on the ward in case you see it being used on other people, so you can understand.” Former Patient 13

Key knowledge that some participants felt staff needed to acquire included: understanding the psychological consequences of restrictive practices, using advanced directives, being aware of a patient’s preferred coping techniques and escalation avoidance. Some staff requested access to opportunities for sharing knowledge with other staff in other

wards and trusts, to learn what works best in practice and to create consistency between services.

“Being able to go elsewhere and network with other teams to see kind of what ideas they're doing. We could have regular meetings doing kind of audits and stuff to see how the things that we've implemented have changed the way we look after our patients, for better hopefully.” Nurse (Staff 7)

Table 5.3.

Participants' Recommendations for Making Restrictive Practice More Psychologically Safe

TDF Domain	Priority Areas	Former Patient Recommendations	Staff Recommendations	Shared Recommendations
Environmental Context and Resources	Ward environment	Create safe/calm spaces for patients No mixed sex wards Provide access to outdoor spaces Provide therapeutic, community-focused environments Reduction of locked doors and wards De-escalation rooms/private rooms available to work through emotions	Improvements to processes on the wards (admission, discharge and risk assessment) Psychologically safe environments for staff	Improvements to the physical ward environment, including structural changes Remove blanket restrictions from wards
	Ward culture	Discussing risk collaboratively on an individual basis rather than a culture of reactive containment Honesty around cameras and restrictive practices on the ward Improvements in staff culture	Create a culture of engaging patients in their care decision Just and learning culture for staff - staff feeling safe to question practices Defining restrictive practices to go beyond physical restrictions	Review of policies with inclusion of MDT roles and lived experience Improve means for raising concerns and how staff respond to patient concerns/feedback

		Prioritising individualised approaches to care	More team collaboration to develop improvement initiatives	
	Need for resources for patients and staff	Provide access to meaningful activities/therapies	Organisational investment to implement psychologically safe care initiatives	Organisations to prioritise and invest in safe staffing and retention
		Having staff available for patients to have gender preference for 1:1s	Organisational investment in training and upskilling staff	Improvement to community services to avoid admission
		Developing collaborative early warning sign toolkits for incidents	Monitor use of restrictive practices on wards to identify areas for improvement	
			Access to therapeutic resources on the wards	
			Funding for reducing restrictive practice leads	
			Development of realistic interventions that are based on current ways of working	
			Emotional, psychological and wellbeing support being available for staff	
	Time and prioritisation	Staff prioritising regular review of observations	Prioritising relational care over admin duties	Staff protecting time to therapeutically engage with patients
		Consistently implement debriefs considering patient preference		
Intentions	Explaining decisions about,	Explaining decisions – before during and after incidents		

	and reasons for, restrictive practices	Emphasising physical safety for why restrictive practices are used		
		Regular review of decisions		
		Regular review of a detained person's rights		
		Set clear timings and expectations for patients		
		Provide written records of decisions and restrictions		
		Prioritise patient dignity in decisions		
	Communication and engagement	Providing regular reassurance to patients witnessing incidents	Engage patients in their care	
		Including a relational aspect to observations	Using communication to build the therapeutic relationship	
		Staff should prioritise (re-)building rapport	Work in a therapeutic way	
		Validate the patient experience	Avoid invalidating language	
Skills	Importance of training for healthcare staff	Staff should have de-escalation skills and should receive regular training for this	Training for specific restrictive practices being available at all levels	Inclusion of lived experience in training opportunities
		Staff should receive training on responding to self-harm	Training on psychologically informed alternatives	Specific training for individual disorders and

			Training being made available to staff at all levels	patient types (i.e., psychosis, neurodivergence)
			Training delivery being matched to the topic (i.e., in-person training for de-escalation and debrief training)	Improving staff debrief skills through training
			Upskilling young managers	
			Consistent training standards between trusts	
Social/Professional Role and Identity	Implementing therapeutic alternatives into the role	Flexible attitude to interactions from both patients and staff	Support patients to build positive relationships on the wards	Embedding reflective practice, debrief and supervision for staff at all levels
		Staff having proportionate responses to incidents		
		Prioritising communication on wards to get to know peers		
		Active engagement with patients being part of staff's role		
	Roles on the ward	Clearly defining the peer support worker role	Making sure staff are identifiable to unwell patients (name badges and uniforms)	Inclusion of peer support workers on the wards
		Utilising care co-ordinators/peer support workers and family and carers as a means of communicating decisions		
		Debriefs should be run by an independent person		

Beliefs about Capabilities	Patients as an active participant	Empower patients to have input in decisions about their care	Allow patients access to their belongings	Giving choice to patients and respecting preference Being able to have proactive and open discussions around restrictive practices and alternatives
	Being able speak up about harmful practices		Have the belief that staff can make positive change in difficult situations Have the confidence to advocate for patients Feeling able to speak up about questionable practices at work	
Knowledge	Knowledge sharing with patients and staff	Provide information of ward specific processes, rules and routines Staff having awareness of the psychological consequences of restrictive practices Provide information about medications and their side effects Staff having knowledge about patients individual coping techniques	Assessing suitability of restrictive practices for different disorders Share knowledge with staff from other trusts Explore why people are readmitted Have the knowledge of advanced directives Having knowledge about psychologically informed alternatives (i.e., communication and formulaic risk assessment)	Clearly define mental health specific terminology

5.5 Discussion

The current study presents priority areas and recommendations from former patients and staff to improve the psychological safety of patients in inpatient mental health services. The findings demonstrate two key contributions to the literature. First, areas of inpatient mental health services that are implicated in the provision of psychologically safe care have been identified using the theoretical domains framework. Six of the 14 TDF domains were recognised as aspects of inpatient mental health services that impacted the psychological safety of patients. Second, by synthesising data from both former patients and staff, shared priorities have been identified. There was agreement between participant groups on several priorities and recommendations, including: improvements to the ward environment, the importance of communication and engagement on wards, training priorities for staff and the need for staff and patients' collaboration to improve ward processes and understanding. Two key findings are discussed.

First, there is a shared commonality of both groups not feeling in control over their environment and organisational priorities. Former patients reported that they are often not involved in the decisions made about their care, while staff do not feel they are in control over organisational decisions that impact the patients on their wards. A lack of perceived control can pose problems for both patients and staff in mental health services. For patients, lack of control and perceived power imbalances in inpatient mental health care can negatively impact psychological safety, leading to withdrawing from interactions with staff. Withdrawing from interactions with staff could risk meaningful personal recovery for patients (Deering et al., 2025; Griffin et al., 2025b; Phillips et al., 2022). In the UK, policy and guidance emphasise the importance of moving towards a recovery-focused care orientation, incorporating informed choice and participation from patients (Le Boutillier et al., 2011; National Institute for Health and Care Excellence [NICE], 2014, 2016; Saunders et al., 2023). For staff, research suggests that autonomy and perceived control over job role is associated with job satisfaction in mental health nurses (Hudays et al., 2024), although UK-based

research on these topics is limited. It does not appear that either group recognises this perceived lack of control in the other. It is possible that without this recognition, there will be continued implications for perceived power dynamics, further preventing collaboration and working towards a common goal. The recommendations presented here, and recognition of commonalities, could facilitate future patients and staff working together to improve the quality of care provision, whilst empowering patients to become an active participant in their care.

Second, participants recognised the need for the integration of relational care into mental health practice, viewing it as vital to supporting psychological safety. So much so that recommendations for how relational care can be implemented cut across multiple of the identified domains and key priority areas. These include improvements to ward culture, how staff can support intentional communication with patients, identified staff training needs and the recommendation for how therapeutic alternatives can be incorporated into the nursing role. Relational care prioritises interpersonal relationships built on respect, trust, humility, compassion and shared humanity (Griffiths et al., 2025). Policy guidance recommends the inclusion of relational and compassionate approaches to assessing and planning a patient's risk (NICE Guideline 225; National Institute for Health and Care Excellence [NICE], 2022). However, interventions aimed at integrating relational and compassionate care in inpatient mental health, often are focused on increasing staff resource and potentially running the risk of increasing empathy-based stress, such as burnout and compassion fatigue (Lombardo & Eyre, 2011; Maddox et al., 2025). The resource crisis and difficulties the NHS are currently facing is well discussed (British Medical Association, 2024). However, recommendations presented in the current study focused on staff adapting ways of working and re-prioritising their time to incorporate relational care over administrative duties. While organisational investment in resource and training is needed, the current study reports on the relational

aspects of care that former patients and staff recognise as working in practice over developing complex interventions.

5.5.1 Implications for Practice and Research

First, new practices and ways of working need to be feasible for the staff that will be ultimately responsible for implementing them. Previous research reporting on the implementation of psychosocial interventions, has demonstrated the key role that systemic factors and leadership have in implementing interventions as intended, to maintain a change in practice (Berry et al., 2025; Lean et al., 2015; Taylor et al., 2024). Organisations should be empowering and investing in their workforce to support staff retention and implementation of evidence-based practice.

Second, staff should be consistent in how they provide care, both within wards but also between wards and trusts. Unpredictable and inconsistent care has been shown to impact the psychological safety of patients (Griffin et al., 2025b). One area that could be improved is the use of language and transparency around restrictive practices to ensure patients understand what can happen on wards to make care more predictable. NHS England (2025) have recently published guidelines for naming and defining restrictive practices, including the addition of cultural and psychological restraint. While it is acknowledged that some terminology used on wards has a subjective nature, for example what psychological safety means to individuals, it is important that there is a shared understanding between staff to support working towards a common goal. As such, the current study provides recommendations for how transparency around ward procedures and processes could be improved.

Third, collaboration within and between services needs to be improved. This study has demonstrated the need for culture change around shared learning. Staff need to share evidence-based learnings and discuss what works in practice, within teams and wider networks. Similarly, learning from constructive patient feedback, will contribute to a

collaborative culture. Collaboration and staff that feel psychologically safe at work (able to take interpersonal risks and speak up; Edmondson, 1999) will help contribute to a learning culture where people on the wards can speak up about their care, learn from one another and avoid blame culture.

There are two main considerations for future research, based on this work. First, the current suggestions and recommendations have not been subjected to wider consensus to understand which recommendations would be most feasible to implement in practice. Further exploration of the identified priority areas with both patients and staff, using consensus methodologies such as Delphi methodology, is needed. Second, there is a clear overlap between the psychological safety of patients, relational care and other compassionate care approaches, such as trauma-informed care. Research defining and understanding overlaps and differences in approaches is needed to avoid siloing or overcomplication of concepts in inpatient mental healthcare.

5.5.2 Strengths and Limitations

A notable strength of this work is the use of the TDF to synthesise the findings from both former patients and staff. This integration has allowed for shared understanding across the groups to be identified, providing priority areas for practitioners, organisations and researchers to target. This approach has also identified domains that were not identified as relevant for providing psychologically safe care. Interestingly, the domains relating to consequence, reinforcement and goals were not identified during analysis. This could be due to both staff and former patients feeling as though psychologically safe care was not an organisational priority and as such, their recommendations focused more on what front-line staff can realistically achieve without organisational input. Similarly, domains related to social influence and emotion were not identified as priority areas for recommendations, despite staff identifying barriers and facilitators within these domains when asked about their own practice (Griffin et al., under review). It is possible that this could be due to the phrasing of

the question which resulted in staff focusing more on how these elements could be integrated into staff roles, rather than focusing on themselves at work.

There are two limitations to consider when interpreting the findings of this study. First, most participants in this study were White-British and female and might not be representative of the wider population. It is important to recognise that this sample might have experienced inpatient mental health services differently to others which could have impacted the identified priority areas and recommendations. Second, the use of deductive coding and a pre-determined framework to identify the priority areas might have limited additional priorities being identified. It is important to note that the identified areas and recommendations are grounded in the data and to mitigate restrictions that deductive coding can pose, each code and recommendation was assessed for importance.

5.5.3 Conclusions

The current study presents the key areas of inpatient mental health practice that require improvements to promote the psychological safety of patients during their admission. The findings also demonstrate the lack of control inherent in the experience of both staff and patients, where both groups would like more involvement in the decisions and priorities set by organisations. Relational care cuts across several of the domains presented with both staff and patients suggesting improvements in communication, engagement and collaboration to improve the experience of patients. Focusing on small evidence-based changes that can be achieved in practice, should be priority for organisations. This could support care providers to integrate psychologically safe care into inpatient mental health services, whilst ensuring patients are safe from harm.

Chapter 6 General Discussion

6.1 Chapter Overview

This chapter provides a critical discussion of the work presented as part of this programme of research. The findings will first be discussed in relation to the overall aim and objectives before presenting key findings in relation to the wider literature. A reflection of the thesis strengths and limitations will be presented alongside considerations for future research. Finally, methodological and personal reflections of conducting patient safety research in inpatient mental health services will be discussed before presenting final conclusions.

6.2 A Summary of the Findings in Relation to the Thesis Objectives

This programme of research is the first to explicitly explore the psychological safety of patients in the context of restrictive practices. This thesis had an overarching aim to understand how restrictive practices can be made more psychologically safe for patients on UK inpatient mental health wards, which has been addressed through four objectives.

6.2.1 Objective 1: Exploring Service Users' Experience of Restrictive Practices

The first objective was to understand and explore service users' experience of restrictive practices. This was addressed through the qualitative systematic review findings in Chapter 2. Twenty-seven qualitative papers were included and synthesised using meta-ethnographic synthesis (Sattar et al., 2021). Findings from this study are presented in Chapter 2 and show that restrictive practices are mainly experienced negatively by service users. Service users' experiences detailed long-lasting impacts from isolation and trauma resulting from the use of restrictive practices.

Previous reviews, both scoping and systematic, have focused on specific interventions, such as seclusion and restraint and/or were limited to acute or forensic settings (Butterworth et al., 2022; Chieze et al., 2019; Lawrence et al., 2021). This review included papers that explored the experience of a range of restrictive practices (seclusion,

restraint, locked doors, restrictions on movement, rapid tranquilisation, blanket restrictions and forced treatment generally). Including a range of interventions demonstrated that negative experiences were not limited to seclusion and restraint. Interventions such as restrictions on movement through limitations on leave and the use of locked doors, exacerbated anger and frustration, resulting in further restrictions such as seclusion and forced medication. Service users experience harm from these measures but recognise times when they are needed. When explanations for decisions were missing, feelings of coercion increased but when staff were caring and empathetic, restrictive practices provided safety in times of crisis. Open communication and therapeutic support from staff were identified as an alternative way to manage aggression and to reduce the feeling of being coerced that often leads to further incidents.

6.2.2 Objective 2: Elucidate the Relationship Between Restrictive Practices and Psychological Safety

The second objective was to elucidate the relationship between restrictive practices and psychological safety. Healthcare regulators, clinicians and researchers have highlighted the importance of considering the psychological safety of patients within patient safety priorities (Berzins et al., 2020; Care Quality Commission, 2024b; Health Services Safety Investigations Body [HSSIB], 2025a; NHS England, 2024a; Veale et al., 2023). However, what psychological safety means to patients and how it is impacted by restrictive practices had not been explicitly explored. Objective 2 was addressed through the findings of the interview study with former patients, presented in Chapter 3. Data from 18 participants were analysed using reflexive thematic analysis (Braun & Clarke, 2021b) and demonstrated that the relationship between restrictive practices and psychological safety is complex.

The findings suggest that physical and psychological safety are interlinked; restraint and observations were often seen as necessary during times of crisis but can lead to fear, distress and compounded trauma when psychological safety is not considered. The participants reported that the physical safety of patients and perception of risk was

emphasised by staff throughout the inpatient process, ignoring psychological safety, individual recovery progress and the participant's own perception of their risk. This led participants to feel ‘reacted to’ by staff, causing participants to withdraw and not express their frustration at upsetting incidents. The use of restrictive practices in mental health settings contributed to a chaotic environment where participants felt they did not have a safe space to decompress. Participants did discuss times when restrictive practices were used, and their psychological safety was supported. During these experiences, participants reported that staff were empathetic, explained their decision to use restrictions and were individualised in their approach to care. The findings from this study highlighted areas of the patient experience that can be impacted by restrictive practices (the environment, relationships, staff time and priorities), which ultimately led to participants feeling psychologically unsafe when on the wards.

6.2.3 Objective 3: What Could Make Restrictive Practices More Psychologically Safe?

While restrictive practices are mainly experienced negatively, they can provide physical safety for acutely unwell patients. Therefore, understanding what is done in practice to minimise the psychological harm from restrictive practices was therefore needed. As such, the third objective was to explore what former patients and staff believe could be done in practice to make restrictive practices more psychologically safe. Objective 3 was addressed through the findings from Study 2 and Study 3. Study 2 (Chapter 3) demonstrated that when staff are empathetic, engage with patients during observations and allow open communication about frustrations and feelings, their psychological safety was supported when restrictive practices were used. Two specific recommendations from the findings of Study 2 were to address organisational factors that contribute to chaotic environments and to implement debriefs for patients to discuss and reflect on incidents prior to discharge.

The findings from Study 3 (Chapter 4) addressed the third objective in two ways. First, participants identified key barriers and facilitators to staff providing psychologically safe care to patients when restrictive practices are used. Staff reported that competing priorities

and lack of support from leadership and organisations can minimise opportunities for staff to provide psychologically safe care to patients. Staff reported that increased organisational buy-in to therapeutic alternatives and support for staff to engage with patients could improve the psychological safety of patients when restrictive practices are used. Staff reported that psychologically safe care is possible when they have access to resources such as consistent and permanent staffing numbers to be able to support patients. Additionally, a safe ward environment, where patients have space to decompress is needed for de-escalation and for staff to avoid reliance on restrictive practices.

Second, the findings demonstrated how staff provide psychologically safe care despite the restrictive environment and the restrictions on the patients they are caring for. Examples included: finding pockets of opportunities to engage with patients outside of formal observations, meetings and medication rounds, and creating safe environments for patients. Knowing the people they are caring for was also mentioned as a facilitator for providing individualised, psychologically safe care to patients, by considering their underlying triggers and preferences. While there are clear barriers to integrating psychologically informed alternatives into practice, taking a proactive approach that includes knowledge sharing with colleagues, allowed for care that can balance physical safety and psychological safety. The addition of organisational buy-in and reprioritisation of resource would support the integration of new initiatives.

6.2.4 Objective 4: Develop Practical Recommendations for how to Provide Psychologically Safe Care when Restrictive Practices Must be Used

To understand how restrictive practices can be made more psychologically safe for patients in inpatient mental healthcare, there needs to be a clear understanding of what psychological safety means to patients. The following definition and recommendations have been developed from the analysis of the data from Study 2 (Chapter 3) and refined with the Help from Experts by Experience for Researchers (HEER) group based in Leeds. The full

consultation process for the development of this definition and recommendations is included in Appendix D.

“Psychological safety is feeling validated in your experience of the world and the belief you will be treated fairly based on your individual needs. Being psychologically safe provides protection from lasting psychological harm from your environment. It’s not just about being physically safe but being protected from harm that may have lasting effects in the future.”

The fourth objective of this thesis was to develop practical recommendations for how to provide psychologically safe care when restrictive practices must be used. This was addressed through findings from all four studies (Chapter 2-5), particularly the suggestions made by participants in Study 4 (Chapter 5). The developed practical recommendations are presented here.

6.2.4.1 Recommendation 1: Be Recovery Focused and Trauma Informed in your Approach to Patient Care. It is important that staff in inpatient mental health care know the patients they are caring for and support them with their past and future in mind. Making care decisions with considerations about a patient’s life beyond the admission, including potential iatrogenic harm from their admission, is important.

6.2.4.2 Recommendation 2: Fully Explain Decisions and Allow Space for Patients to ask Questions. Decision making should be a collaborative approach between staff and patients where possible. If this is not possible, then decisions should be fully explained with the expectation that patients can ask questions and provide feedback. When decisions are not explained to patients, an additional level of coercion is added to the experience of restrictive practices. When decisions are explained, even when patients do not agree with the reasoning, feelings of coercion can be reduced.

6.2.4.3 Recommendation 3: Encourage the Independence and Choice of Patients Through Positive Communication and Relationships. Inpatient care is a

naturally coercive environment, and communication can be interpreted as coercion when patients are not given the opportunity to express choice. Allowing choice over small decisions (for example, personalising bedrooms, choice over snacks and having access to personal belongings during admission) creates a sense of safety and independence for patients. Encouraging positive communication through peer support and relationships between staff and patients, is important for the patient experience.

6.2.4.4 Recommendation 4: Provide a Safe Space for Patients to Express Feelings and Frustrations. Patients can sometimes feel that staff see a patient's behaviour and do not try to understand the underlying feelings that have caused it. When staff do not try to understand the cause of patient behaviour, patients can feel reacted to with restrictive practices which can lead to increased frustration and a cycle of incidents. When patients can express themselves in a safe environment, feelings of safety and trust in staff is increased. Patients feeling heard and understood could lead to a reduction in the cycle of incidents.

6.2.4.5 Recommendation 5: Provide a Physically Safe Environment. Psychological safety and physical safety are intertwined. Ward environments need to be safe for everyone on the wards. If staff do not feel physically safe, they are more likely to be restrictive and reactive to patient behaviour. If patients do not feel safe, they are more likely to be reactive and combative to decisions.

6.2.4.6 Recommendation 6: Provide Access to Meaningful Occupation on the Wards. Removal of belongings, activities and leave is interpreted as an abuse of power by patients. Ensuring patients can participate in activities and have choice over what they participate in, could limit disruptive behaviour (described by former patients as 'rebelling') and subsequent restrictive practices.

6.2.4.7 Recommendation 7: Provide Individualised Care to Meet Patient Need. It is important to patients that they have input into what will happen during their admission. Limiting the use of blanket restrictions and creating collaborative psychosocial risk

assessments and safety plans could support patients to be an active participant in their care. Also, openly discussing ward routines and what restrictive practices could be used (allowing space for patient preference if appropriate) could promote the psychological and physical safety of patients from the beginning of their admission.

6.3 Key Findings in Relation to the Literature and Current Mental Health Practice

6.3.1 Experiences of Restrictive Practices

There are three key findings from this thesis that contribute to the literature related to the experience of restrictive practices. First, it is widely known that restrictive practices are mainly a negative experience for both patients and staff (Butterworth et al., 2022; Chieze et al., 2019; Cusack et al., 2018; Martin, 2023). The findings of this thesis demonstrate this and extend the understanding of the experience by reporting on the importance of communication and supportive relationships to limit the psychological harm caused by restrictive practices. However, the current work extends this by demonstrating the importance of explaining decisions for less explicit restrictive practices (locked doors and ward rules) to avoid escalation. Research has also demonstrated that when communication is not prioritised and restrictive practices are generalised to patient behaviour, without individualised explanation, it can cause psychological harm (Bendall et al., 2022; Tully et al., 2022). This thesis expands on this by demonstrating that when a clear explanation for why restrictive practices are used (for example, restrictive practices will be used if there is a clear threat to the physical safety of people on the ward) and when staff build relationships with patients through informal communication, feelings of coercion and psychological harm can be reduced. It is important that staff make the time to effectively communicate with patients on wards outside of ward procedures (for example, ward or medication rounds).

Second, a key contribution of this thesis is the demonstration of the long-term harm that restrictive practices can cause when the opportunity for debrief and reflection is missing. This thesis uniquely incorporates perspectives from current patients and former patients,

with some participants having been discharged over 15 years prior to participation. This highlights that the psychological impact of restrictive practices can persist across decades. A review of the available evidence relating to post-incident debriefs suggests that their use could mitigate harm related to seclusion and restraint (Hammervold et al., 2019); however, research on the patient experience of debrief is limited in comparison to staff views and experiences. This thesis demonstrates this by reporting that all participants in Study 2 had not received an adequate debrief and some had not discussed their experience with anyone since discharge. This is particularly worrying considering post-incident debriefs (also referred to as post-incident reviews) are recommended as part of the NICE Quality Standards (QS154; National Institute for Health and Care Excellence [NICE], 2017).

Although some participants had not experienced restrictive practices for over a decade, they described the upset and trauma that still impacted their daily life. A priority for practice is the routine implementation for patients to have the opportunity to discuss incidents, either prior to discharge (as a post-incident debrief) or after with community services. This could be achieved by embedding structured debrief protocols into discharge plans and providing reflective opportunities to facilitate the processing of the patient experience and support the continuation of recovery.

The third key finding in relation to the experience of restrictive practice is the inclusion of former patients that have witnessed restrictive practices; an approach that is noticeably lacking from the patient literature (Wilson et al., 2018). The findings from this demonstrate that witnessing restrictive practices can impact the psychological safety of patients and that the added element of proximity perpetuated chaos on the ward, with staff prioritising confidentiality over reassurance. Confidentiality is important but when incidents happen in communal spaces, for example restraint or the administration of medication in shared spaces, patient experiences cannot be siloed. The novel contribution from these findings is that patients being dismissed about what they saw, can impact feelings of safety and trust due to fear that a similar incident could happen to them. A key priority for action is the

inclusion of witnesses in post-incident support processes. This could be implemented through brief ward-based check-ins following incidents that balance reassurance with confidentiality, and the integration of group or individual debrief opportunities for incidents that impact the whole ward. Embedding these practices into routine practice would represent a practical approach to improving psychological safety and rebuilding trust after restrictive practices are used on wards.

6.3.2 Defining Psychological Safety and Considerations for Practice

The findings of this thesis advance the literature around the patient perspective of psychological safety in three ways. First, an evidence informed working definition of psychological safety, developed by former patients and informed by the literature, has been developed. This was then refined with the HEER group and staff with experience of inpatient mental health settings. Prior to this, factors associated with psychological safety had been identified (Cutler et al., 2021a; Cutler et al., 2021b; Vogt et al., 2024) but were broad and required further exploration. This thesis moves the field forward by providing a practically grounded definition, informed by the ward context, that can be applied in both research and practice. A key priority is now to integrate this definition and understanding of psychological safety into policy frameworks and staff training. It is important that psychological safety is understood as an achievable component of care not as the aspiration that it is currently seen as.

Second, practical recommendations for how the psychological safety of patients can be supported when restrictive practices are used have been developed, grounded in patient voice and staff reality. For some, restrictive practices provide psychological safety and for others they diminish psychological safety. Previous research has demonstrated that physical safety and psychological safety are interlinked (Berzins et al., 2020). The findings of the current work support and enhance this by developing practical examples for how physical and psychological safety can be achieved, in the context of stretched healthcare environments. These recommendations demonstrate priorities for practice, including the

need for improved communication before, during and after restrictive practices are used and greater involvement of patients in safety planning and decision-making. These priorities could feasibly be implemented through culture change as they do not require additional resource.

Third, positive therapeutic relationships between staff and patients are interpreted as psychologically safe care. Positive relationships with care providers, supported by communication about decisions, are known to positively impact patient outcomes. Reported improved outcomes in the literature include wellbeing, recovery and engagement with services (Hartley et al., 2020; McAndrew et al., 2014; Moran et al., 2014). The current work provides an explanation for how positive relationships relate to improved patient outcomes and reduced adverse events. Taking a traditional approach to patient safety, whereby reduction of risk and quantifiable incidents is the priority (Delaney & Johnson, 2008; Thibaut et al., 2019) means that restrictive practices could be used without further thought for the impact they can have on the people involved (both patient and staff). Instead, when therapeutic relationships are formed and patients feel safe with the person providing their care, honest disclosure and de-escalation can be achieved. Similarly, improved patient trust in care providers, where an understanding that decisions are made for the purpose of physical safety and the best interest of the patient could mean that treatment is better accepted and alternatives to restrictive practices can be used. Supporting the psychological safety of patients to communicate with, and trust, the staff responsible for their care needs to be a priority to reduce the use of restrictive practices and iatrogenic harm. The work in this thesis provides practical and acceptable recommendations for how this can be achieved in practice.

6.3.3 Best Practice Guidance for Mental Health Services

Several of the developed recommendations align with already published National Institute for Health and Care Excellence (NICE) guidance and provide support for the Culture of Care standards (NHS England, 2024). This includes: shared decision making (QS15,

National Institute for Health and Care Excellence, 2019; NG197, National Institute for Health and Care Excellence [NICE], 2021a), debriefing (QS154, National Institute for Health and Care Excellence [NICE], 2017), individualised care (CG138, National Institute for Health and Care Excellence [NICE], 2021b; NG108, National Institute for Health and Care Excellence [NICE], 2018; Culture of Care commitments one and seven, NHS England, 2024a), moving away from traditional risk assessment (NG225, National Institute for Health and Care Excellence [NICE], 2022) and therapeutic engagement (Culture of Care commitments four and seven; NHS England, 2024a). These areas are also consistent with national policy initiatives aimed at reducing restrictive practices generally driven by organisations such as NHS England (NHS England, 2025) and the Restraint Reduction Network (Restraint Reduction Network, 2022). The published best-practice guidance emphasises prevention over reaction, least restrictive approaches and relational and trauma-informed approaches to care.

Several NICE recommendations have been published for over five years. The experiences of both staff and former patients in this thesis demonstrate that guidance is not consistently translated into practice. This implementation gap reflects wider concerns where restrictive practices continue to be used despite national guidance and regulatory priorities focusing on their reduction. This could be due to policies and best-practice guidelines not written or disseminated in a way that is accessible to staff working in busy, demanding environments, or a lack of organisational support for relational ways of working being implemented at ward level, as demonstrated in Chapter 4. Knowledge sharing, grounded in evidence-based practice, is needed for the future of mental health care. Greater alignment policy and implementation strategies is needed. Developing training based on the Culture of Care commitments and the Restraint Reduction Network standards could support this.

The work presented in this thesis demonstrates the need to update the NICE guideline focused on the management of violence and aggression in mental health settings (NG10; National Institute of Health and Care Excellence [NICE], 2015). The guidance uses

the phrase ‘least restrictive’ without providing a definition of what this means. The current work and previous literature suggest that ‘least restrictive’ or ‘last resort’ is often not defined and can mean different things for different people, for example differing between patients and staff (Chieze et al., 2021; Lindekilde et al., 2024; Riahi et al., 2020). The findings of Study 3 extend this literature by demonstrating that without clear definitions and shared understandings, inconsistencies between staff’s approaches are created. This reinforces calls for clearer operationalisation of restrictive practice and improved staff training to ensure consistency within and between services.

Additionally the use of communication and more relational approaches to minimising violence and aggression is missing from the NG10 recommendation. The review and interview study with former patients (Griffin et al., 2025a; Griffin et al., 2025b) demonstrate that open communication, where patients can express frustration, and therapeutic support are accepted as effective reducers of aggression and violence that leads to restrictive practices. NG10 also includes the recommendation of searching and removing patient belongings. Blanket restrictions and removal of belongings have been shown to be detrimental to psychological safety and perpetuate power dynamics between patients and staff (Griffin et al., 2025b). The current NG10 standards contrasts with the findings and with policy guidance, including the Culture of Care standards, which emphasise dignity, autonomy, and shared-decision making. Ensuring that any searches or removals are based on a collaborative decision and informed risk assessment, rather than being implemented as standard procedure is important.

The findings demonstrate the importance of culture and working relationships to support the integration of new ways of working. New ways of working cannot be implemented on inpatient wards if there is not buy-in and motivation from staff and leadership (Sekhon et al., 2017; Skivington et al., 2021). Encouraging consistency through collaboration with other wards and trusts by sharing ideas and what works in practice will move the field beyond siloed ways of working. Integrating this into the culture of mental

health working could improve accountability and avoid closed wards and generational nursing, where practice is based on what other staff do, rather than evidence-based practice (Halliwell, 2021). NHS England's Culture of Care standards (NHS England, 2024a) are ambitious and will require organisational buy-in to be adopted into practice. The current work supports the identified standards and demonstrates that both staff and patients recognise a need for the standards to be implanted in practice, particularly in relation to moving towards psychologically safe care grounded in relational and trauma-informed approaches.

6.4 Strengths of the Thesis

6.4.1 Lived Experience Input

A key strength of this thesis is the involvement of key stakeholders from inpatient mental health services. The aim of this thesis from the outset was to share the experience of patients in inpatient mental health settings, and to ensure that any developed recommendations could be feasible in practice. To ensure the research was grounded in patient voice and organisational need, advice was sought from people with lived experience throughout the project.

Consultation included an expert by experience (a person who has experience in inpatient mental health and provides input into research projects) that helped set direction for Study 2 as well as providing feedback on the topic guide and research materials. Key decisions for the comfort of participants, including providing the topic guide to participants prior to the interviews, the offer of a telephone interview and the option to view the results of the study before submission, were made as a result. The HEER group have been involved with this work since 2023 and helped to refine the definition of psychological safety and the developed recommendations. Their input has helped to focus the definition and recommendations to patient need and has supported my reflections of inclusive and

accessible language. The developed recommendations are strengthened through the PPI work completed through this programme of research.

6.4.2 Publication and Impact of Findings

Together the studies presented in this thesis provide an important contribution to the literature on the psychological safety of patients and the experience of restrictive practices in inpatient mental health settings. Two of the studies have been published in mental health nursing-related journals, Journal of Mental Health and International Journal of Mental Health Nursing. As such, they have been reviewed and critiqued by international experts in the field. The publication of these papers and presentation at academic conferences, has received praise from experts in the area. The research has also outlined key recommendations for improving practice and identified specific areas where current NICE guidelines for patient management could be improved. The findings and recommendations discussed in this thesis, resonate with clinicians, service users and researchers in inpatient mental health, demonstrating the importance and significance of this work.

6.4.3 The use of the Theoretical Domains Framework (TDF)

Study 3 and Study 4 use the TDF to demonstrate the key areas in healthcare practice associated with providing psychologically safe care in inpatient mental health services. These are the first studies to use the theoretically grounded TDF to demonstrate the importance of supporting the psychological safety of patients alongside protecting and maintaining physical safety in practice. The use of the TDF in this work allowed for the facilitators, barriers and practical recommendations to be organised in a way that

organisations can clearly address. This also provides the groundwork for future interventions addressing psychological safety and alternatives to restrictive practices.

6.5 Limitations of the Thesis

6.5.1 The Sample and Sampling Methods

The developed recommendations are based on interviews with 38, mostly white participants, and have not been subjected to wider consensus beyond the input from the HEER group. Whilst this thesis did not aim to explore the impact that ethnicity has on the experience of inpatient mental healthcare, it has to be recognised that the participants in Study 3 (Chapter 4) were mostly female and white and are not entirely representative of the UK patient population or the NHS mental healthcare workforce (GOV.UK, 2023). The lack of representation within the sample of these studies should be considered when interpreting findings. It would be valuable to explore any difference in priorities between different demographic groups in future research.

Due to the exploratory nature of this programme of research, volunteer sampling was used in both Study 2 and 3 to recruit participants. Snowball sampling was also used in Study 3, whereby participants shared the study poster with their colleagues and teams. The use of non-stratified methods to sample participants, coupled with using social media to advertise the study could introduce sampling bias where people who had more negative experiences are more likely to participate in the study. Similarly, the use of snowball sampling meant that staff that worked in the same trust participated which also could have impacted the findings. In summary, it is important that future work addresses this by assessing consensus on the developed recommendations from this thesis.

This limitation reflects the extent to which this research was able to engage communities that are often underrepresented in mental health research, primarily minority ethnic groups and men who have experienced inpatient mental health services. Although efforts were made to disseminate study information through professional networks and social

media, these routes may not have effectively reached individuals who are less connected to such platforms or who do not relate to the social media profile of the author (a white female). Reflecting on this, a targeted engagement strategy incorporating charities, advocacy groups and service-user-led network (such as Restraint Reduction Network) may have improved inclusivity. The use of peer-to-peer or co-produced approaches could also have increased participation from individuals who are less likely to engage with research. Peer-led research, where individuals with lived experience are involved in all aspects of the research can increase trust and reduce power imbalance (Centre for Mental Health, N.D). Incorporating these approaches in future work could support more diverse participation and generate findings that better reflect the breadth of experiences within inpatient mental healthcare.

6.5.2 Terminology

As highlighted in Chapter 1, there are several terms and definitions used in inpatient mental healthcare to describe the same concepts, for example the interventions that constitute restrictive practices. While this thesis aimed to include a wide range of interventions within restrictive practices, it is possible that interventions were inadvertently excluded. The definition of restrictive practices for this work was developed in 2022 based on collating policy guidance, literature and discussion with experts in the area. Recently, NHS England have published guidance on interventions considered restrictive practices, including the addition of surveillance and cultural restraint (NHS England, 2025). Cultural restraint, beliefs and organisational structures that can result in people acting against their personal beliefs or engaging in cultural or religious activities (Quinn, 2025), was not considered in this research. Surveillance, whilst considered as an adaptation to reduce incidents, was not viewed as a restrictive practice and has since received attention for its harmful impacts for patients (Griffiths et al., 2024). As such, it was not explicitly labelled as a

restrictive practice in the study adverts which could have meant that most participants did not discuss surveillance during their interviews.

It is important that researchers avoid adding complexity to the area by using a range of phrases and definitions that complicates the evidence base. There is an element of subjectivity to be considered, where a specific restrictive practice could be experienced differently (i.e., observations not been seen as restrictive but as a standard part of inpatient care) and organisations could also measure and categorise these differently. However, researchers exploring the experiences of restrictive practices should be transparent about the interventions that they have not considered.

6.6 Recommendations for Future Research

There are six specific recommendations for future research based on the work presented in this thesis. First, the findings of this thesis are based on the perspective of 18 former patients and refined with a group of former patients and carers providing the groundwork for future interventions. However, future research needs to consider the perspectives of different groups and settings within inpatient settings to support the meaningful future implementation of developed interventions across services. For example, eating disorder and forensic services, as well as including the perspectives of autistic people and people with learning disabilities that have experience in inpatient mental health settings.

Second, wider consensus of the definition of psychological safety and recommendations presented in this thesis should be sought. Consensus methodologies, such as Nominal Group Technique or Delphi Technique, allow for idea generation and ranking to reach a consensus that can be used to determine priorities, solve problems or generate ideas (McMillan et al., 2016). The use of these methods could generate new ideas and integrate them within the current recommendations before ranking what is important to

patients. These methods could also be used to further explore what staff believe are feasible in practice.

Third, further research investigating the experience of witnessing restrictive practices is needed. In comparison to research exploring first-hand and staff experience, research to understand the experience and how patients can be supported is lacking (Wilson et al., 2018). While Study 2 (Chapter 3) aimed to also explore the experience of witnessing restrictive practices, there was limited discussion of this in comparison to the first-hand experience and the discussion mainly focused on witnessing restraint. Understanding how to support people that have witnessed restrictive practices is important for improving overall safety in inpatient mental health services.

Fourth, investigating the barriers to the implementation of evidence-based practice and guidance in inpatient mental healthcare is imperative. Several of the recommendations suggested by former patients and staff in Study 4 (Chapter 5) align with NICE guidelines; specifically recommendations on implementing debriefs, involvement of patients in decision-making and staff training needs (NG10; National Institute of Health and Care Excellence [NICE], 2015) and recommendations on using collaborative approaches to risk assessment (NG225; National Institute for Health and Care Excellence [NICE], 2022). Research should identify how healthcare professionals are interacting with best-practice guidance and policy and identify barriers for this translation into practice. Additionally, the persistence of these gaps suggests that the barriers to implementing evidence-based practice should also be addressed at the organisation level. Key barriers at an organisational level could be resource constraints, staffing pressures and leadership priorities which could filter down to ward staff not prioritising engagement with evidence and policy. Organisational implementation theories and frameworks (for example, Normalisation Process Theory (May & Finch, 2009) or the Integrated Promoting Action on Research Implementation in Health Services Framework (Harvey & Kitson, 2015)) could be used to address organisational barriers to implementing

evidence-based practice, by identifying the work that is needed to embed new ways of working whilst considering contextual factors (i.e., culture and processes).

Fifth, field research, through ethnographic methods could be used to further investigate the identified key areas of practice that require improvement. The use of these methodologies could help to understand how psychologically safe care is currently provided, as well as building on the identified areas for improvement. For example, research questions such as, “How does the admission process impact the psychological safety of patients?” and “How could improvements to identified priority areas prevent incidents and restrictive practice?” could be answered using ethnographic methods. Similarly, using these methods to investigate what the discharge process looks like for someone that has experienced restrictive practices and how this relates to readmission rates could advance the research area.

Sixth, an understanding of the training available to staff, is needed. Study 3 demonstrated the fragmented way that NHS trusts operate, with not only different trusts receiving different levels of training but also hospitals within trusts. Within this, an understanding of what training is available to whom within a ward is lacking. Healthcare assistants and agency staff expressed the lack of training they receive, despite having patient facing roles, compared to opportunities available to permanent nursing staff. An exploration of what is available between trusts and the feasibility of training being implemented at all levels is important for the skills, empowerment and culture of staff in inpatient mental health services.

6.7 The Author’s Reflections on Conducting Inpatient Mental Health Services Research

6.7.1 The Role of the Researcher

Conducting qualitative research with people that have experienced inpatient mental health services, a place where the people that have received care are at their most

vulnerable and unwell, requires a recognition of the potential power imbalance between researcher and interviewee. Without engaging with service users and having meaningful conversations of the adaptations needed to research this topic, there is a risk of causing more harm to vulnerable people. It is important that steps are taken to reduce burden on participants generally but especially so when discussing potentially upsetting and traumatising experiences like the experience of restrictive practices. Specific considerations within this thesis included taking steps to ensure participants were prepared for the topics discussed, including offering the topic guide in advance and suggesting that participants think about how participation could make them feel and whether they require additional support.

The main learning throughout the PhD project, was the importance of honesty and reflexivity when researching inpatient mental healthcare. I knew I was not the expert in the interview and disclosed this to participants prior to the interviews. It was my aim to empower participants to share their experience and reassure them that what would be reported after their interview would be reflective of their experience. All participants had the option to receive and comment on the findings prior to development of this thesis or submission to journals. Having this rapport with participants, both former patients and staff, enriched the conversations. At times, it allowed former patients to educate me on terminology and rules that happen on inpatient wards, a role that they felt they did not have when communicating with mental health professionals. Interactions with staff, felt genuine and they made clear the passion they had for the field, despite frustrations at the restrictions they experienced. I hope that the work presented in this thesis represents the stories they shared with me and leads to the positive change that the participants desperately want to see.

6.7.2 Terminology and 'Buzzwords'

There are several terms and definitions used to describe the same concepts in inpatient mental health, for example restrictive practices and coercive practices. As such, practice and research often use different definitions and include different interventions.

When this work started, a decision to include any interventions that intentionally restricts a person's movement or freedom, for both voluntary and involuntary patients, was made. This meant interventions such as locked doors, segregation, blanket restrictions and coercive language was considered. This expanded the scope from previous work that traditionally focused on seclusion, physical restraint or chemical restraint (rapid tranquilisation). Understanding the experience of a range of restrictive practices, allowed for a better understanding of these incidents in practice and recognises that events do not happen in silo. The use of this definition, pre-dates the work done by NHS England (2025), despite completion of this thesis occurring after.

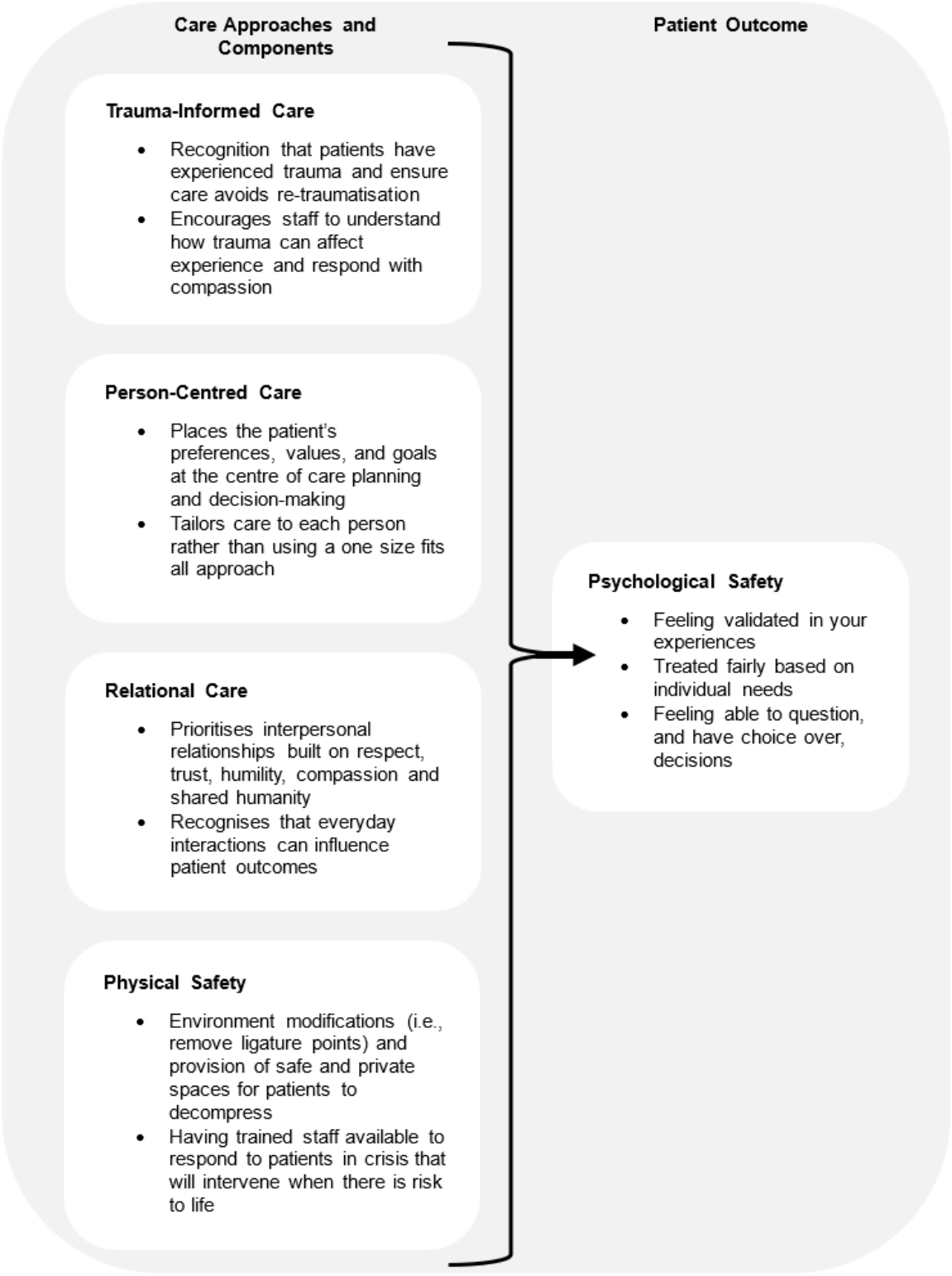
More broadly, several related concepts are used across policy and practice, including trauma-informed care (Saunders et al., 2023), person-centred care (World Health Organization, 2021b), relational care (Griffiths et al., 2025), restrictive practices and psychological safety. These concepts share commonalities around safety, autonomy, and therapeutic relationships but differ in purpose and conceptualisation. Primarily, psychological safety is something that is within patients and that can be fostered and supported by staff. Trauma-informed care, person-centred care and relational care are approaches that foster a culture of care (NHS England, 2024a). Psychologically safe care could be delivered through trauma-informed, person-centred, relational care but should more broadly focus on creating spaces and interactions that ensure patients feel validated and supported whilst receiving care to support their recovery and that enables patients to communicate preferences. This, in conjunction with explaining decisions about using restrictive practices when there is a risk to life, could lead to a patient feeling psychologically safe in inpatient mental health services. A conceptual diagram demonstrating how the combined approaches can contribute to psychological safety is presented in Figure 6.1. It is recognised that more work is needed to

fully explore the differentiation and overlap between concepts to create clear and consistent approaches for organisations and healthcare staff.

Concerns over ‘buzzwords’ (described as words that become popular within organisations, to the point of losing their initial meaning) were mentioned by both members of the HEER group and participants when discussing the definition of psychological safety. Terms such as ‘trauma-informed care’, ‘least restrictive’ and ‘safety’ were interpreted as phrases that organisations use to demonstrate they are working towards policy and guidelines, whilst not clearly defining what this means in practice. My reflections of buzzwords in inpatient mental health services, is that the use of them seems to arise from a lack of support and shared learning. Where one organisation actively works towards trauma-informed care, through formulations to actively understand a person’s experience prior to admission and incorporates lived experience input into procedures and routines on wards to support this, other organisations do not have the resources to support this. Instead, the phrase is used without proper training and knowledge of how to achieve this in practice. When this is seen by patients, it feels inauthentic and leads to a lack of faith in the skills of the people caring for them. There is a concern that psychological safety could become a ‘buzzword’ in the mental health space. To avoid this, shared learning and authenticity is needed from organisations aiming to improve the care they deliver to patients. For the former patients I have spoken to, honesty about what cannot be achieved in practice with a clear plan for improvements is preferred over inauthenticity.

Figure 6.1

Conceptual diagram demonstrating how existing concepts contribute to a patients psychological safety.



6.7.3 Priorities in Inpatient Mental Health Practice and Research

At the beginning of this programme of research, I was surprised to see the breadth of literature on staff experiences of restrictive practices and reduction initiatives compared to patient perspectives. While understanding the staff perspective for how these interventions are carried out in practice is needed, priorities should be based on the patient experience. Understandably, ethics committees may be more favourable to studies with staff as ensuring the wellbeing of patients participating in research is important. However, to fully understand and improve inpatient services, research needs to consider the needs of patients that are ultimately impacted by decisions.

A clear example of this was the discussion of priorities in inpatient mental healthcare with participants. Former patients and staff generally felt that the priorities of organisations do not match their own understanding of what is needed for patients. Similarly, staff discussed a disconnect between policy and practice. Measures such as length of stay and patient flow were described as important to organisations, which led to rushed discharge, particularly for patients with personality disorders (several staff discussed their organisations 'Borderline Personality Disorder Pathway'). Naively, I believed that patient turnover would not be a driving factor for discharge and that patients would be in hospital until they were well. I now realise that this cannot always be the case in inpatient mental health care. Logistically and realistically, there needs to be available beds for unwell patients experiencing a mental health crisis and to achieve that it means that patients are discharged when they are 'well enough'. However, there is a clear need for organisations to be more individualised in their messaging to staff, empowering them to consider the individual patients needs and challenging their organisation's policy if they deem it necessary in complex cases.

6.7.4 Subjectivity

While a definition of psychological safety has been developed through the studies within this thesis, it is recognised that psychological safety is a subjective term; what makes

one patient feel safe, might be different for another. The same could also be said for physical safety; what research sees as physical safety, could be different for different patients. For some of the participants in Study 2, restrictive practices and rules were needed to feel physically safe. When staff did not use observations or intervene in times of crisis, it led to them feeling neglected and unsafe. For others, the experience is always negative and punitive.

While it is acknowledged that rigid definitions in healthcare settings can be problematic and a flexible approach is often needed, the use of definitions provides a shared goal for staff to work towards. Consistency is needed in inpatient mental healthcare and is important for psychological safety, as demonstrated in Study 2. Therefore, the use of definitions should be caveated with the understanding that there is a degree of subjectivity in experiences and as such staffs' approach should be individualised and flexible to meet the needs of the people they are caring for. Alongside this, patient safety researchers need to be flexible in their approach when developing recommendations. This can only be achieved by speaking to people that experience these settings. It is important to acknowledge that rigid recommendations, without consideration of the wider context and staff input, might not be best suited to a setting like inpatient mental health, where the presentations of patients with the same diagnosis can vary greatly and organisations and different trusts vary in resource, environment and structure.

6.7.5 Views on Restrictive Practices over the Course of this Research

At the beginning of this programme of research, my understanding of restrictive practices in inpatient mental health services was limited and my perspective was shaped by secondary accounts rather than direct experience. I held the view that restrictive practices should not be used in healthcare settings and that the use of these measures would always be experienced negatively by patients, leading to physical and psychological harm. This was informed by reading service user blogs and social media narratives. As I had no first-hand

experience of restrictive practices being used in practice, my perspective lacked consideration of the contextual factors influencing their use.

After conducting this programme of research and speaking to former patients and staff, my viewpoint has changed significantly. I have developed a more nuanced understanding of the complexities associated with the use of restrictive practices. I now recognise that in certain situations when there is a serious risk to life, using restrictive practices are necessary. This is particularly evident in highly pressured care environments where staff do not have readily available alternatives and are facing resource issues such as insufficient staffing or a lack of training in de-escalation strategies.

Despite my change in perspective, I do continue to believe that restrictive practices have the potential to cause harm to patients. The findings of this programme of research reinforce the importance of how restrictive practices are implemented. For example, the presence of clear communication, compassion, engagement and the acknowledgement of the distress caused appears to significantly influence patient experiences. When these considerations are not made, restrictive practices may contribute to lasting trauma and could negatively impact a person's sense of psychological safety.

6.8 Concluding Comments

The work presented in this thesis provides a novel contribution to the literature by exploring restrictive practices and psychological safety in inpatient mental health services. The findings advance the literature on the experience of restrictive practices and what psychological safety means to patients. The findings from four studies have been triangulated, leading to the development of practical recommendations for how restrictive practices could be made more psychologically safe. The work presented in this thesis suggests the urgent need to develop interventions focused on delivering psychologically safe care to patients in inpatient mental health services, informed by psychological principles, as alternatives to reliance on restrictive practices. Further, knowledge sharing between and

within mental health trusts is needed to create a more consistent approach to care, and organisational buy-in is imperative to empower staff to support the integration of psychologically safe care initiatives into practice.

References

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

Akther, S. F., Molyneaux, E., Stuart, R., Johnson, S., Simpson, A., & Oram, S. (2019). Patients' experiences of assessment and detention under mental health legislation: systematic review and qualitative meta-synthesis. *BJPsych Open,* 5(3), e37. https://doi.org/10.1192/BJO.2019.19

Alderson, P. (2021). Health, illness and neoliberalism: an example of critical realism as a research resource. *Journal of Critical Realism, 20*(5), 542–556. https://doi.org/10.1080/14767430.2021.1995689;CTYPE:STRING:JOURNAL

Allikmets, S., Marshall, C., Murad, O., & Gupta, K. (2020). Seclusion: A Patient Perspective. *Issues in Mental Health Nursing, 41*(8), 723–735. https://doi.org/10.1080/01612840.2019.1710005

Aluh, D. O., Ayilara, O., Onu, J. U., Grigaitė, U., Pedrosa, B., Santos-Dias, M., Cardoso, G., & Caldas-de-Almeida, J. M. (2022). Experiences and perceptions of coercive practices in mental health care among service users in Nigeria: a qualitative study. *International Journal of Mental Health Systems, 16*(1), 1–11. https://doi.org/10.1186/S13033-022-00565-4/TABLES/1

Amara, P. (2023). Restrictive practices, psychological and physical, may breach patient rights. *Learning Disability Practice, 26*(5), 8–10.

Appenzeller, Y. E., Appelbaum, P. S., & Trachsel, M. (2019). Ethical and Practical Issues in Video Surveillance of Psychiatric Units. *Psychiatric Services, 71*(5), 480–486. https://doi.org/10.1176/APPI.PS.201900397

Ashcraft, L., & Anthony, W. (2008). Eliminating seclusion and restraint in recovery-oriented crisis services. *Psychiatric Services, 59*(10), 1198–1202. https://doi.org/10.1176/PS.2008.59.10.1198,

Asikainen, J., Vehviläinen-Julkunen, K., Repo-Tiihonen, E., & Louheranta, O. (2023). Patients' Perceptions of Safety and Debriefing in Forensic Mental Health Care in Finland. *Journal of Forensic Nursing, 19*(3), 187–196. https://doi.org/10.1097/JFN.0000000000000436

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

Askew, L., Fisher, P., & Beazley, P. (2020). Being in a Seclusion Room: The Forensic Psychiatric Inpatients' Perspective. *Journal of Psychiatric and Mental Health Nursing, 27*(3), 272–280. https://doi.org/10.1111/JPM.12576

Atkins, L., Francis, J., Islam, R., O'Connor, D., Patey, A., Ivers, N., Foy, R., Duncan, E. M., Colquhoun, H., Grimshaw, J. M., Lawton, R., & Michie, S. (2017). A guide to using the Theoretical Domains Framework of behaviour change to investigate implementation problems. *Implementation Science, 12*(1), 1–18. https://doi.org/10.1186/S13012-017-0605-9/TABLES/10

Atkins, S., Lewin, S., Smith, H., Engel, M., Fretheim, A., & Volmink, J. (2008). Conducting a meta-ethnography of qualitative literature: Lessons learnt. *BMC Medical Research Methodology, 8*(1), 1–10. https://doi.org/10.1186/1471-2288-8-21/TABLES/4

Azeem, M. W., Aujla, A., Rammerth, M., Binsfeld, G., & Jones, R. B. (2011). Effectiveness of six core strategies based on trauma informed care in reducing seclusions and restraints at a

child and adolescent psychiatric hospital. *Journal of Child and Adolescent Psychiatric Nursing, 24*(1), 11–15. https://doi.org/10.1111/J.1744-6171.2010.00262.X

Baker, J., Berzins, K., Canvin, K., Benson, I., Kellar, I., Wright, J., Lopez, R. R., Duxbury, J., Kendall, T., & Stewart, D. (2021). Non-pharmacological interventions to reduce restrictive practices in adult mental health inpatient settings: the COMPARE systematic mapping review. *Health Services and Delivery Research, 9(*5), 1–184. https://doi.org/10.3310/HSDR09050

Baker, J., Kendal, S., Sturley, C., Louch, G., & Bojke, C. (2024). Estimating the link between service-user patient safety perceptions, incidents and subsequent contagion in acute mental health wards. *BMC Psychiatry, 24*(1), 1–16. 10.1186/s12888-024-06261-6.

Bendall, C., Williams, C., & Huddy, V. (2022). Exploring experiences of restrictive practices within inpatient mental healthcare from the perspectives of patients and staff. *Journal of Psychiatric Intensive Care, 18*(1), 17–29. https://doi.org/10.20299/JPI.2022.005

Berry, K., Handerer, F., Bucci, S., Penn, G., Morley, H., Raphael, J., Lovell, K., Price, O., Edge, D., Drake, R. J., & Haddock, G. (2025). Ensuring that psychological interventions are delivered as intended on mental health inpatient wards. *British Journal of Clinical Psychology, 64*(2), 371–384. https://doi.org/10.1111/BJC.12510

Berzins, K., Baker, J., Brown, M., & Lawton, R. (2018). A cross-sectional survey of mental health service users', carers' and professionals' priorities for patient safety in the United Kingdom. *Health Expectations, 21*(6), 1085–1094. https://doi.org/10.1111/HEX.12805

Berzins, K., Baker, J., Louch, G., & Albutt, A. (2020). A qualitative exploration of mental health service user and carer perspectives on safety issues in UK mental health services. *Health Expectations, 23*(3), 549–561. https://doi.org/10.1111/HEX.13025

Bhaskar, R., & Danermark, B. (2006). Metatheory, interdisciplinarity and disability research: A critical realist perspective. *Scandinavian Journal of Disability Research, 8(*4), 278–297. https://doi.org/10.1080/15017410600914329

Bigwood, S., & Crowe, M. (2008). "It's part of the job, but it spoils the job": a phenomenological study of physical restraint. *International Journal of Mental Health Nursing, 17*(3), 215–222. https://doi.org/10.1111/J.1447-0349.2008.00526.X

Boland, A. M., Cherry, G., & Dickson, R. (2014). *Doing a Systematic Review* (1st ed.). SAGE Publications Ltd.

Bowers, L. (2014). Safewards: a new model of conflict and containment on psychiatric wards. *Journal of Psychiatric and Mental Health Nursing, 21*(6), 499. https://doi.org/10.1111/JPM.12129

Bowers, L., Haglund, K., Muir-Cochrane, E., Nijman, H., Simpson, A., & Van Der Merwe, M. (2010). Locked doors: A survey of patients, staff and visitors. *Journal of Psychiatric and Mental Health Nursing, 17*(10), 873–880. https://doi.org/10.1111/J.1365-2850.2010.01614.X,

Bowers, L., James, K., Quirk, A., Simpson, A., Stewart, D., & Hodsoll, J. (2015). Reducing conflict and containment rates on acute psychiatric wards: The Safewards cluster randomised controlled trial. *International Journal of Nursing Studies, 52*(9), 1412–1422. https://doi.org/10.1016/J.IJNURSTU.2015.05.001

Braun, V., & Clarke, V. (2013). *Successful Qualitative Research: A practical guide for beginners* (1st ed.). SAGE Publications Ltd.

Braun, V., & Clarke, V. (2021a). Can I use TA? Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches. *Counselling and Psychotherapy Research, 21*(1), 37–47. https://doi.org/10.1002/CAPR.12360

Braun, V., & Clarke, V. (2021b). *Thematic Analysis: A Practical Guide* (1st ed.). SAGE Publications Ltd.

Brickell, T. A., & McLean, C. (2011). Emerging Issues and Challenges for Improving Patient Safety in Mental Health: A Qualitative Analysis of Expert Perspectives A Qualitative Analysis of Expert Perspectives. *Journal of Patient Safety, 7*(1), 39–44. https://www.jstor.org/stable/26632801?seq=1

Briner, M., & Manser, T. (2013). Clinical risk management in mental health: A qualitative study of main risks and related organizational management practices. *BMC Health Services Research, 13(*1), 1–11. https://doi.org/10.1186/1472-6963-13-44

British Medical Association. (2024). *"It's broken": Doctors' experiences on the frontline of a failing mental healthcare system.* https://www.bma.org.uk/media/ddclsiii/bma-mental-health-report-2024-web-final.pdf

Buckley, C., Malcolm, R., & Hanlon, J. (2024). Economic impact of a vision-based patient monitoring system across five NHS mental health trusts. *PLOS Digital Health, 3*(9), e0000559. https://doi.org/10.1371/JOURNAL.PDIG.0000559

Butterworth, H., Wood, L., & Rowe, S. (2022). Patients' and staff members' experiences of restrictive practices in acute mental health in-patient settings: systematic review and thematic synthesis. *BJPsych Open, 8*(6), e178. https://doi.org/10.1192/BJO.2022.574

Cane, J., O'Connor, D., & Michie, S. (2012). Validation of the theoretical domains framework for use in behaviour change and implementation research. *Implementation Science, 7*(1), 1–17. https://doi.org/10.1186/1748-5908-7-37

Canvin, K., Brierley-Jones, L., Ramsey, L., Baker, J., & Berzins, K. (2024). Safety and contagion in acute psychiatric wards: How the milieu is implicated in the occurrence of clustered safety incidents. *Theory and Psychology, 34*(2), 214–232. https://doi.org/10.1177/09593543231225636

Care Quality Commission. (2018). *The State of Care in Mental Health Services 2014 to 2017.* http://www.cqc.org.uk/sites/default/files/20170720_stateofmh_report.pdf

Care Quality Commission. (2024a). *Safe.* https://www.cqc.org.uk/guidance-regulation/providers/assessment/single-assessment-framework/safe

Care Quality Commission. (2024b). *The state of health care and adult social care in England 2023/24.* https://www.cqc.org.uk/publications/major-report/state-care/2023-2024

Care Quality Commission. (2026). *Monitoring the Mental Health Act in 2024/25.* https://www.cqc.org.uk/publications/monitoring-mental-health-act/2024-2025

Celofiga, A., Kores Plesnicar, B., Koprivsek, J., Moskon, M., Benkovic, D., & Gregoric Kumperscak, H. (2022). Effectiveness of De-Escalation in Reducing Aggression and Coercion in Acute Psychiatric Units. A Cluster Randomized Study. *Frontiers in Psychiatry, 13*, 856153. https://doi.org/10.3389/FPSYT.2022.856153

Centre for Mental Health. (N.D). *Peer Research.* https://www.centreformentalhealth.org.uk/how-we-work/peer-research/

Chien, W. T., Chan, C. W. H., Lam, L. W., & Kam, C. W. (2005). Psychiatric inpatients' perceptions of positive and negative aspects of physical restraint. *Patient Education and Counselling, 59*(1), 80–86. https://doi.org/10.1016/J.PEC.2004.10.003

Chieze, M., Clavien, C., Kaiser, S., & Hurst, S. (2021). Coercive Measures in Psychiatry: A Review of Ethical Arguments. *Frontiers in Psychiatry, 12*, 790886. https://doi.org/10.3389/FPSYT.2021.790886

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

Chung, O. S., Dowling, N. L., Brown, C., Robinson, T., Johnson, A. M., Ng, C. H., Yücel, M., & Segrave, R. A. (2023). Using the Theoretical Domains Framework to Inform the Implementation of Therapeutic Virtual Reality into Mental Healthcare. *Administration and Policy in Mental Health and Mental Health Services Research, 50*(2), 237–268. https://doi.org/10.1007/S10488-022-01235-W/TABLES/4

Cooke, A., Smith, D., & Booth, A. (2012). Beyond PICO: The SPIDER tool for qualitative evidence synthesis. *Qualitative Health Research, 22*(10), 1435–1443. https://doi.org/10.1177/1049732312452938

Cox, A., Hayter, M., & Ruane, J. (2010). Alternative approaches to “enhanced observations” in acute inpatient mental health care: A review of the literature. *Journal of Psychiatric and Mental Health Nursing, 17*(2), 162–171. https://doi.org/10.1111/J.1365-2850.2009.01507.X

Cuomo, A., Koukouna, D., Macchiarini, L., & Fagiolini, A. (2020). Patient Safety and Risk Management in Mental Health. In L. Donaldson, W. Ricciardi, S. Sheridan, & R. Tartaglia (Eds.), *Textbook of Patient Safety and Clinical Risk* Management (pp. 287–298). Springer. https://doi.org/10.1007/978-3-030-59403-9_20

Cusack, P., Cusack, F. P., McAndrew, S., McKeown, M., & Duxbury, J. (2018). An integrative review exploring the physical and psychological harm inherent in using restraint in mental health inpatient settings. *International Journal of Mental Health Nursing, 27*(3), 1162–1176. https://doi.org/10.1111/INM.12432

Cusack, P., McAndrew, S., Duckworth, J., Cusack, F., & McKeown, M. (2023). Experiencing restraint: A dialogic narrative inquiry from a service user perspective. *International Journal of Mental Health Nursing, 32(*6), 1724-1734. https://doi.org/10.1111/INM.13212

Cutler, N. A., Halcomb, E., Sim, J., Stephens, M., & Moxham, L. (2021a). How does the environment influence consumers’ perceptions of safety in acute mental health units? A qualitative study. *Journal of Clinical Nursing, 30*(5–6), 765–772. https://doi.org/10.1111/JOCN.15614

Cutler, N. A., Sim, J., Halcomb, E., Moxham, L., & Stephens, M. (2020). Nurses’ influence on consumers’ experience of safety in acute mental health units: A qualitative study. *Journal of Clinical Nursing, 29*(21–22), 4379–4386. https://doi.org/10.1111/JOCN.15480

Cutler, N. A., Sim, J., Halcomb, E., Stephens, M., & Moxham, L. (2021b). Understanding how personhood impacts consumers’ feelings of safety in acute mental health units: a qualitative study. *International Journal of Mental Health Nursing, 30*(2), 479–486. https://doi.org/10.1111/INM.12809

de Looff, P., Noordzij, M. L., Moerbeek, M., Nijman, H., Didden, R., & Embregts, P. (2019). Changes in heart rate and skin conductance in the 30 min preceding aggressive behavior. *Psychophysiology, 56*(10). https://doi.org/10.1111/PSYP.13420

Debono, D., Taylor, N., Lipworth, W., Greenfield, D., Travaglia, J., Black, D., & Braithwaite, J. (2017). Applying the Theoretical Domains Framework to identify barriers and targeted interventions to enhance nurses’ use of electronic medication management systems in two Australian hospitals. *Implementation Science, 12*(1). https://doi.org/10.1186/S13012-017-0572-1

Deering, K., Pawson, C., Summers, N., & Williams, J. (2019). Patient perspectives of helpful risk management practices within mental health services. A mixed studies systematic review of primary research. *Journal of Psychiatric and Mental Health Nursing, 26*(5–6), 185–197. https://doi.org/10.1111/JPM.12521

Deering, K., Wagstaff, C., Kyle, R. G., Bermingham, I., Williams, J., & Pawson, C. (2025). Safety for Recovery During Admission to Acute Mental Health Hospitals: A Constructivist Grounded Theory Study to Support Safety-Focused Recovery-Oriented Care in the Context of Risk Management Constraints. *International Journal of Mental Health Nursing, 34*(4), e70104. https://doi.org/10.1111/inm.70104

Deering, K., Williams, J., & Williams, R. (2022). The risk of risk management: adopting critical theories to explore clinical risk concerns in mental health care. *Mental Health and Social Inclusion, 26*(2), 124–133. https://doi.org/10.1108/MHSI-09-2021-0061

Delaney, K. R., & Johnson, M. E. (2008). Inpatient Psychiatric Nursing: Why Safety Must be the Key Deliverable. *Archives of Psychiatric Nursing, 22*(6), 386–388. https://doi.org/10.1016/j.apnu.2008.09.003

Department of Health. (2014). *Positive and proactive care: reducing the need for restrictive interventions.* https://www.gov.uk/government/publications/positive-and-proactive-care-reducing-restrictive-interventions

Department of Health. (2015). *Mental Health Act 1983: Code of Practice*. TSO (The Stationery Office). https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983

Department of Health and Social Care. (2021). *Mental Health Units (Use of Force) Act 2018: Statutory guidance for NHS organisations in England, and police forces in England and Wales.* https://www.gov.uk/government/publications/mental-health-units-use-of-force-act-2018

Department of Health and Social Care. (2023). *NHS Constitution for England.* https://www.gov.uk/government/publications/the-nhs-constitution-for-england

Department of Health and Social Care. (2024a). *Mental Health Bill 2025: fact sheet.* https://www.gov.uk/government/publications/mental-health-bill-2025-fact-sheet/mental-health-bill-2025-fact-sheet

Department of Health and Social Care. (2024b). *Rapid review into data on mental health inpatient settings: final report and recommendations.* https://www.gov.uk/government/publications/rapid-review-into-data-on-mental-health-inpatient-settings-final-report-and-recommendations/rapid-review-into-data-on-mental-health-inpatient-settings-final-report-and-recommendations#key-facts

Dewa, L. H., Murray, K., Thibaut, B., Ramtale, S. C., Adam, S., Darzi, A., & Archer, S. (2018). Identifying research priorities for patient safety in mental health: an international expert Delphi study. *BMJ Open, 8*(3), e021361. https://doi.org/10.1136/BMJOPEN-2017-021361

Dixon, M., & Long, E. M. (2022). An Educational Intervention to Decrease the Number of Emergency Incidents of Restraint and Seclusion on a Behavioral Health Unit. *Journal of Continuing Education in Nursing, 53*(2), 70–76. https://doi.org/10.3928/00220124-20220104-07,

D'Lima, D., Crawford, M. J., Darzi, A., & Archer, S. (2017). Patient safety and quality of care in mental health: a world of its own? *BJPsych Bulletin, 41*(5), 241–243. https://doi.org/10.1192/PB.BP.116.055327

Doedens, P., Wikman, S., Kuper, H., & Bilgin, H. (2024). Safety and Security: A Delicate Balance. In N. Hallett, R. Whittington, D. Richter, & E. Eneje (Eds.), *Coercion and Violence in Mental Health Settings: Causes, Consequences, Management, Second Edition* (pp. 237–263). Springer, Cham. https://doi.org/10.1007/978-3-031-61224-4_11

Downs, J. (2024). Whose trauma is it anyway? Creating more equitable mental healthcare in a system that harms. *BJPsych Bulletin, 4(*August 2025), 1–4. https://doi.org/10.1192/BJB.2024.103

Duxbury, J., Aiken, F., & Dale, C. (2011). Deaths in custody: the role of restraint. *Journal of Learning Disabilities and Offending Behaviour, 2*(4), 178–189. https://doi.org/10.1108/20420921111207873

Duxbury, J., Thomson, G., Scholes, A., Jones, F., Baker, J., Downe, S., Greenwood, P., Price, O., Whittington, R., & McKeown, M. (2019). Staff experiences and understandings of the REsTRAIN Yourself initiative to minimize the use of physical restraint on mental health wards. *International Journal of Mental Health Nursing, 28*(4), 845–856. https://doi.org/10.1111/INM.12577

Edmondson, A. (1999). Psychological Safety and Learning Behavior in Work Teams. *Administrative Science Quarterly, 44*(2), 350–383. https://doi.org/10.2307/2666999

Equality and Human Rights Commission [EHRC]. (2018). *The Human Rights Act .* https://www.equalityhumanrights.com/human-rights/human-rights-act

Evans, D., & FitzGerald, M. (2014). The experience of physical restraint: A systematic review of qualitative research. *Contemporary Nurse, 13*(2–3), 126–135. https://doi.org/10.5172/CONU.13.2-3.126

Evlat, G., Wood, L., & Glover, N. (2021). A systematic review of the implementation of psychological therapies in acute mental health inpatient settings. *Clinical Psychology & Psychotherapy, 28*(6), 1574–1586. https://doi.org/10.1002/CPP.2600

Ezeobele, I. E., Malecha, A. T., Mock, A., Mackey-Godine, A., & Hughes, M. (2014). Patients' lived seclusion experience in acute psychiatric hospital in the United States: a qualitative study. *Journal of Psychiatric and Mental Health Nursing, 21*(4), 303–312. https://doi.org/10.1111/JPM.12097

Faschingbauer, K. M., Peden-McAlpine, C., & Tempel, W. (2013). Use of seclusion: Finding the voice of the patient to influence practice. *Journal of Psychosocial Nursing and Mental Health Services, 51*(7), 32–38. https://doi.org/10.3928/02793695-20130503-01

Fletcher, A. J. (2017). Applying critical realism in qualitative research: methodology meets method. *International Journal of Social Research Methodology, 20*(2), 181–194. https://doi.org/10.1080/13645579.2016.1144401

Fletcher, J., Spittal, M., Brophy, L., Tibble, H., Kinner, S., Elsom, S., & Hamilton, B. (2017). Outcomes of the Victorian Safewards trial in 13 wards: Impact on seclusion rates and fidelity measurement. *International Journal of Mental Health Nursing, 26*(5), 461–471. https://doi.org/10.1111/INM.12380,

Francis, J. J., O'Connor, D., & Curran, J. (2012). Theories of behaviour change synthesised into a set of theoretical groupings: introducing a thematic series on the theoretical domains framework. *Implementation Science, 7*(1), 35. https://doi.org/10.1186/1748-5908-7-35

Fugger, G., Gleiss, A., Baldinger, P., Strnad, A., Kasper, S., & Frey, R. (2016). Psychiatric patients' perception of physical restraint. *Acta Psychiatrica Scandinavica, 133(*3), 221–231. https://doi.org/10.1111/ACPS.12501

Gale, N. K., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013). Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology, 13*(1), 1–8. https://doi.org/10.1186/1471-2288-13-117

Gerace, A., & Muir-Cochrane, E. (2019). Perceptions of nurses working with psychiatric consumers regarding the elimination of seclusion and restraint in psychiatric inpatient settings and

emergency departments: An Australian survey. *International Journal of Mental Health Nursing, 28*(1), 209–225. https://doi.org/10.1111/INM.12522

Gerace, A., Oster, C., O'Kane, D., Hayman, C. L., & Muir-Cochrane, E. (2018). Empathic processes during nurse–consumer conflict situations in psychiatric inpatient units: A qualitative study. *International Journal of Mental Health Nursing, 27*(1), 92–105. https://doi.org/10.1111/INM.12298

Gibbons, R. (2025). The 'Impossibility' of working in the current NHS: sacrifice to a primitive god. *Psychoanalytic Psychotherapy, 39(*2), 84-94. https://doi.org/10.1080/02668734.2025.2490626

Gibbons, R., & O'Reilly, J. (2021). *Seminars in the Psychotherapies (*2nd ed.). Cambridge University Press. https://doi.org/10.1017/9781108686976

Gill, S. L. (2020). Qualitative Sampling Methods. *Journal of Human Lactation, 36*(4), 579–581. https://doi.org/10.1177/0890334420949218

Gooding, P., McSherry, B., & Roper, C. (2020). Preventing and reducing 'coercion' in mental health services: an international scoping review of English-language studies. *Acta Psychiatrica Scandinavica, 142(*1), 27–39. https://doi.org/10.1111/ACPS.13152

Gotham, H. J., Cummings, J. R., Dolce, J. N., Druss, B., Gill, K. J., Kopelovich, S. L., Molfenter, T., Olson, J. R., Benson, F., & Chwastiak, L. (2022). Applying implementation science in mental health services: Technical assistance cases from the Mental Health Technology Transfer Center (MHTTC) network. *General Hospital Psychiatry, 75*, 1–9. https://doi.org/10.1016/J.GENHOSPPSYCH.2022.01.004

GOV.UK. (2023). *NHS workforce - GOV.UK Ethnicity facts and figures.* https://www.ethnicity-facts-figures.service.gov.uk/workforce-and-business/workforce-diversity/nhs-workforce/latest/

Griffin, B., Baker, J., Vogt, K. S., Rich, J., & Johnson, J. (2025a). 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, 34*(5), 624–640. https://doi.org/10.1080/09638237.2025.2478372

Griffin, B., Johnson, J., Vogt, K. S., Mizen, E., Keyworth, C., & Baker, J. (2025b). Exploring How the Psychological Safety of Patients Is Impacted by Restrictive Practices in Inpatient Mental Healthcare: A Qualitative Study. *International Journal of Mental Health Nursing, 34*(6), e70148. https://doi.org/10.1111/INM.70148

Griffiths, J. L., Foye, U., Stuart, R., Jarvis, R., Chipp, B., Griffiths, R., Jeynes, T., Mitchell, L., Parker, J., Rowan Olive, R., Quirke, K., Baker, J., Brennan, G., Lamph, G., McKeown, M., Lloyd-Evans, B., Trevillion, K., & Simpson, A. (2025). Quantitative Evidence for Relational Care Approaches to Assessing and Managing Self-Harm and Suicide Risk in Inpatient Mental Health and Emergency Department Settings: A Scoping Review. *Issues in Mental Health Nursing, 46(*6), 529–565. https://doi.org/10.1080/01612840.2025.2488335

Griffiths, J. L., Saunders, K. R. K., Foye, U., Greenburgh, A., Regan, C., Cooper, R. E., Powell, R., Thomas, E., Brennan, G., Rojas-García, A., Lloyd-Evans, B., Johnson, S., & Simpson, A. (2024). The use and impact of surveillance-based technology initiatives in inpatient and acute mental health settings: a systematic review. *BMC Medicine, 22*(1). https://doi.org/10.1186/S12916-024-03673-9

Griffiths, P., Saville, C., Ball, J., Jones, J., Pattison, N., & Monks, T. (2020). Nursing workload, nurse staffing methodologies and tools: A systematic scoping review and discussion. *International Journal of Nursing Studies, 103*, 103487. https://doi.org/10.1016/J.IJNURSTU.2019.103487

Grundy, A. C., Papastravrou Brooks, C., Johnston, I., Cree, L., Callaghan, P., & Price, O. (2024). Evaluation of a novel co-designed and co-delivered training package to de-escalate violence and aggression in UK acute inpatient, PICU and forensic mental health settings. *Journal of Psychiatric and Mental Health Nursing, 31*(6), 1145–1154. https://doi.org/10.1111/JPM.13074

Haglund, K., & Von Essen, L. (2005). Locked entrance doors at psychiatric wards – Advantages and disadvantages according to voluntarily admitted patients. *Nordic Journal of Psychiatry, 59*(6), 511–515. https://doi.org/10.1080/08039480500360781

Haines, A., Perkins, E., Evans, E. A., & McCabe, R. (2018). Multidisciplinary team functioning and decision making within forensic mental health. *Mental Health Review Journal, 23*(3), 185. https://doi.org/10.1108/MHRJ-01-2018-0001

Haines-Delmont, A., Goodall, K., Duxbury, J., & Tsang, A. (2022). An Evaluation of the Implementation of a “No Force First” Informed Organisational Guide to Reduce Physical Restraint in Mental Health and Learning Disability Inpatient Settings in the UK. *Frontiers in Psychiatry, 13*, 749615. https://doi.org/10.3389/FPSYT.2022.749615

Hallett, N., & McLaughlin, P. (2022). Restrictive interventions: understanding and reducing their use in mental health settings. *Mental Health Practice, 25*(6), 34–41. https://doi.org/10.7748/MHP.2022.E1620

Halliwell, A. (2021). Closed cultures in health and social care services. *Nursing and Residential Care, 23*(10), 1–5. https://doi.org/10.12968/NREC.2021.23.10.4

Hammervold, U. E., Norvoll, R., Aas, R. W., & Sagvaag, H. (2019). Post-incident review after restraint in mental health care -a potential for knowledge development, recovery promotion and restraint prevention. A scoping review. *BMC Health Services Research, 19*(2019), 235-. https://doi.org/10.1186/S12913-019-4060-Y

Hartley, S., Raphael, J., Lovell, K., & Berry, K. (2020). Effective nurse–patient relationships in mental health care: A systematic review of interventions to improve the therapeutic alliance. *International Journal of Nursing Studies, 102*, 103490. https://doi.org/10.1016/J.IJNURSTU.2019.103490

Harvey, G., & Kitson, A. (2015). PARIHS revisited: from heuristic to integrated framework for the successful implementation of knowledge into practice. *Implementation Science, 11*(33). https://doi.org/10.1186/s13012-016-0398-2

Hawton, K., Lascelles, K., Pitman, A., Gilbert, S., & Silverman, M. (2022). Assessment of suicide risk in mental health practice: shifting from prediction to therapeutic assessment, formulation, and risk management. *The Lancet Psychiatry, 9*(11), 922–928. https://doi.org/10.1016/S2215-0366(22)00232-2

Health and Social Care Act 2008, c.14. https://www.legislation.gov.uk/ukpga/2008/14

Health Services Safety Investigations Body [HSSIB]. (2025a). *Mental health inpatient settings: Creating conditions for the delivery of safe and therapeutic care to adults.* https://www.hssib.org.uk/patient-safety-investigations/mental-health-inpatient-settings/investigation-report/

Health Services Safety Investigations Body [HSSIB]. (2025b). *Mental health inpatient settings: overarching report of investigations directed by the Secretary of State for Health and Social Care.* https://www.hssib.org.uk/patient-safety-investigations/mental-health-inpatient-settings/fifth-investigation-report/

Hoekstra, T., Lendemeijer, H. H. G. M., & Jansen, M. G. M. J. (2004). Seclusion: the inside story. Journal *of Psychiatric and Mental Health Nursing, 11*(3), 276–283. https://doi.org/10.1111/J.1365-2850.2003.00710.X

Holmes, D., Kennedy, S. L., & Perron, A. (2004). The mentally ill and social exclusion: a critical examination of the use of seclusion from the patient's perspective. *Issues in Mental Health Nursing, 25*(6), 559–578. https://doi.org/10.1080/01612840490472101

Huber, C. G., Schneeberger, A. R., Kowalinski, E., Fröhlich, D., von Felten, S., Walter, M., Zinkler, M., Beine, K., Heinz, A., Borgwardt, S., & Lang, U. E. (2016). Suicide risk and absconding in psychiatric hospitals with and without open door policies: a 15 year, observational study. *The Lancet Psychiatry, 3*(9), 842–849. https://doi.org/10.1016/S2215-0366(16)30168-7

Huckshorn, K. A. (2004). Reducing seclusion & restraint use in mental health settings: Core strategies for prevention. *Journal of Psychosocial Nursing and Mental Health Services, 42*(9), 22–33. https://doi.org/10.3928/02793695-20040901-05

Hudays, A., Gary, F., Voss, J. G., Arishi, A., Alfar, Z. A., Algodimi, A. M., & Fitzpatrick, J. J. (2024). Factors Influencing Job Satisfaction among Mental Health Nurses: A Systematic Review. *Healthcare, 12(*20), 2040. https://doi.org/10.3390/HEALTHCARE12202040

Hunt, D. F., Bailey, J., Lennox, B. R., Crofts, M., & Vincent, C. (2021). Enhancing psychological safety in mental health services. *International Journal of Mental Health Systems, 15*(1), 1–18. https://doi.org/10.1186/S13033-021-00439-1

Indregard, A. M. R., Nussle, H. M., Hagen, M., Vandvik, P. O., Tesli, M., Gather, J., & Kunøe, N. (2024). Open-door policy versus treatment-as-usual in urban psychiatric inpatient wards: a pragmatic, randomised controlled, non-inferiority trial in Norway. *The Lancet Psychiatry, 11*(5), 330–338. https://doi.org/10.1016/S2215-0366(24)00039-7

Inglis, P., & Clifton, A. (2013). De-escalation: The evidence, policy and practice. *Journal of Intellectual Disabilities and Offending Behaviour, 4*(3), 100–108. https://doi.org/10.1108/JIDOB-01-2013-0001

Johnson, M. E. (1998). BEING RESTRAINED: A STUDY OF POWER AND POWERLESSNESS. *Issues in Mental Health Nursing, 19*(3), 191–206. https://doi.org/10.1080/016128498249024

Johnston, I., Price, O., McPherson, P., Armitage, C. J., Brooks, H., Bee, P., Lovell, K., & Brooks, C. P. (2022). De-escalation of conflict in forensic mental health inpatient settings: a Theoretical Domains Framework-informed qualitative investigation of staff and patient perspectives. *BMC Psychology, 10*(1), 1–17. https://doi.org/10.1186/S40359-022-00735-6/TABLES/3

Kanerva, A., Lammintakanen, J., & Kivinen, T. (2013). Patient safety in psychiatric inpatient care: a literature review. *Journal of Psychiatric and Mental Health Nursing, 20*(6), 541–548. https://doi.org/10.1111/J.1365-2850.2012.01949.X

Keyworth, C., Epton, T., Goldthorpe, J., Calam, R., & Armitage, C. J. (2019). 'It's difficult, I think it's complicated': Health care professionals' barriers and enablers to providing opportunistic behaviour change interventions during routine medical consultations. *British Journal of Health Psychology, 24*(3), 571–592. https://doi.org/10.1111/BJHP.12368

Kontio, R., Joffe, G., Putkonen, H., Kuosmanen, L., Hane, K., Holi, M., & Välimäki, M. (2012). Seclusion and restraint in psychiatry: patients' experiences and practical suggestions on how to improve practices and use alternatives. *Perspectives in Psychiatric Care, 48*(1), 16–24. https://doi.org/10.1111/J.1744-6163.2010.00301.X

Kuosmanen, L., Hätönen, H., Malkavaara, H., Kylmä, J., & Välimäki, M. (2007). Deprivation of liberty in psychiatric hospital care: the patient's perspective. *Nursing Ethics, 14*(5), 597–607. https://doi.org/10.1177/0969733007080205

Lanthén, K., Rask, M., & Sunnqvist, C. (2015). Psychiatric Patients Experiences with Mechanical Restraints: An Interview Study. *Psychiatry Journal, 2015*, 1–8. https://doi.org/10.1155/2015/748392

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

Lauge Andersen, L. (2023). A narrative journey into the borderland of patient safety: Toward an expanded, relational concept of safety. *Qualitative Research in Medicine & Healthcare, 7*(3), 11496. https://doi.org/10.4081/QRMH.2023.11496

Lawrence, D., Bagshaw, R., Stubbings, D., & Watt, A. (2021). Restrictive Practices in Adult Secure Mental Health Services: A Scoping Review. *International Journal of Forensic Mental Health, 21*(1), 68–88. https://doi.org/10.1080/14999013.2021.1887978

Le Boutillier, C., Leamy, M., Bird, V. J., Davidson, L., Williams, J., & Slade, M. (2011). What does recovery mean in practice? A qualitative analysis of international recovery-oriented practice guidance. *Psychiatric Services, 62*(12), 1470–1476. https://doi.org/10.1176/APPI.PS.001312011

Lean, M., Leavey, G., Killaspy, H., Green, N., Harrison, I., Cook, S., Craig, T., Holloway, F., Arbuthnott, M., & King, M. (2015). Barriers to the sustainability of an intervention designed to improve patient engagement within NHS mental health rehabilitation units: a qualitative study nested within a randomised controlled trial. *BMC Psychiatry, 15*(1), 1–10. https://doi.org/10.1186/S12888-015-0592-9

Li, S., Ye, J., Yuan, L., Wang, H., Wang, T., Wu, C., & Xiao, A. (2023). Perspectives on physical restraint in psychiatric hospital: A qualitative study of mentally ill patients. *International Journal of Mental Health Nursing. 32*(6), 1773-1778. https://doi.org/10.1111/INM.13205

Lindekilde, C. R., Pedersen, M. L., Birkeland, S. F., Hvidhjelm, J., Baker, J., & Gildberg, F. A. (2024). Mental health patients' preferences regarding restrictive interventions: An integrative review. *Journal of Psychiatric and Mental Health Nursing, 31*(6), 1057–1072. https://doi.org/10.1111/JPM.13057

Lombardo, B., & Eyre, C. (2011). Compassion fatigue: a nurse's primer. *Online Journal of Issues in Nursing, 16(*1), 3. https://doi.org/10.3912/ojin.vol16no01man03

Lynge, M. C., Dixen, S. T., Johansen, K. S., Düring, S. W., U.-Parnas, A., & Nordgaard, J. (2023). Patients' experiences with physical holding and mechanical restraint in the psychiatric care: an interview study. *Nordic Journal of Psychiatry, 77*(3), 247–255. https://doi.org/10.1080/08039488.2022.2087001

Mac Donald, B., Gustafsson, S. A., Bulik, C. M., & Clausen, L. (2023). Living and leaving a life of coercion: a qualitative interview study of patients with anorexia nervosa and multiple involuntary treatment events. *Journal of Eating Disorders, 11*(1), 1–9. https://doi.org/10.1186/S40337-023-00765-4

MacDonald, S., Sampson, C., Turley, R., Biddle, L., Ring, N., Begley, R., & Evans, R. (2020). Patients' Experiences of Emergency Hospital Care Following Self-Harm: Systematic Review and Thematic Synthesis of Qualitative Research. *Qualitative Health Research, 30*(3), 471–485. https://doi.org/10.1177/1049732319886566,

Maddox, L., Teoh, K., Baldoza, S., Clarkson, L., & Evans, R. (2025). Interventions to reduce empathy-based stress and enhance compassionate care in mental health wards: a systematic review. *BMC Health Services Research, 26*(1). https://doi.org/10.1186/s12913-025-13861-9

Maker, Y., & McSherry, B. (2019). Regulating restraint use in mental health and aged care settings: Lessons from the oakden scandal. *Alternative Law Journal, 44*(1), 29–36. https://doi.org/10.1177/1037969X18817592

Marcus, S. C., Hermann, R. C., & Cullen, S. W. (2021). Defining patient safety events in inpatient psychiatry. *Journal of Patient Safety, 17(*8), E1452–E1457. https://doi.org/10.1097/PTS.0000000000000520

Marshman, C., Hansen, A., & Munro, I. (2022). Compassion fatigue in mental health nurses: A systematic review. *Journal of Psychiatric and Mental Health Nursing, 29*(4), 529–543. https://doi.org/10.1111/JPM.12812

Martello, M., Doronina, O., Perillo, A., La Riccia, P., & Lavoie-Tremblay, M. (2018). Nurses' perceptions of engaging with patients to reduce restrictive practices in an inpatient psychiatric unit. *Health Care Manager, 37*(4), 342–353. https://doi.org/10.1097/HCM.0000000000000235

Martin, J. (2023). 'You have to be a certain sort of person': An interpretative phenomenological analysis of mental health support workers' experiences of physical restraint in inpatient settings. *International Journal of Mental Health Nursing, 32*(6), 1691-1700. https://doi.org/10.1111/INM.13195

Maslach, C., & Jackson, S. E. (1981). The measurement of experienced burnout. *Journal of Organizational Behavior, 2*(2), 99–113. https://doi.org/10.1002/JOB.4030020205

May, C., & Finch, T. (2009). Implementation, embedding, and integration: an outline of Normalization Process Theory. *Sociology.* 43(3):535–54. https://doi.org/10.1177/0038038509103320

Mayers, P., Keet, N., Winkler, G., & Flisher, A. J. (2010). Mental health service users' perceptions and experiences of sedation, seclusion and restraint. *The International Journal of Social Psychiatry, 56*(1), 60–73. https://doi.org/10.1177/0020764008098293

McAndrew, S., Chambers, M., Nolan, F., Thomas, B., & Watts, P. (2014). Measuring the evidence: Reviewing the literature of the measurement of therapeutic engagement in acute mental health inpatient wards. *International Journal of Mental Health Nursing, 23*(3), 212–220. https://doi.org/10.1111/INM.12044

McMillan, S. S., King, M., & Tully, M. P. (2016). How to use the nominal group and Delphi techniques. *International Journal of Clinical Pharmacy, 38*(3), 655. https://doi.org/10.1007/S11096-016-0257-X

Meehan, T., Vermeer, C., & Windsor, C. (2000). Patients' perceptions of seclusion: a qualitative investigation. *Journal of Advanced Nursing, 31*(2), 370–377. https://doi.org/10.1046/J.1365-2648.2000.01289.X

Melillo, A., Sansone, N., Allan, J., Gill, N., Herrman, H., Cano, G. M., Rodrigues, M., Savage, M., & Galderisi, S. (2025). Recovery-oriented and trauma-informed care for people with mental disorders to promote human rights and quality of mental health care: a scoping review. *BMC Psychiatry, 25*(1), 1–22. https://doi.org/10.1186/S12888-025-06473-4

Mellow, A., Tickle, A., & Rennoldson, M. (2017). Qualitative systematic literature review: The experience of being in seclusion for adults with mental health difficulties. *Mental Health Review Journal, 22*(1), 1–15. https://doi.org/10.1108/MHRJ-04-2016-0007

Mental Health Act 1983, c. 20. https://www.legislation.gov.uk/ukpga/1983/20

Mental Health Act 2007, c. 12. https://www.legislation.gov.uk/ukpga/2007/12

Mental Health Act 2025, c.33. https://www.legislation.gov.uk/ukpga/2025/33

Mental Health Units (Use of Force) Act 2018, c.27. https://www.legislation.gov.uk/ukpga/2018/27

Missouridou, E., Fradelos, E. C., Kritsiotakis, E., Mangoulia, P., Segredou, E., & Papathanasiou, I. V. (2022). Containment and therapeutic relationships in acute psychiatric care spaces: the

symbolic dimensions of doors. *BMC Psychiatry, 22*(1), 1–11. https://doi.org/10.1186/S12888-021-03607-2

Moghadam, M. F., Masoud, ;, Khoshknab, F., Pazargadi, M., & Khoshknab, M. F. (2014). Psychiatric Nurses' Perceptions about Physical Restraint; A Qualitative Study. *International Journal of Community Based Nursing and Midwifery, 2*(1), 20. https://pmc.ncbi.nlm.nih.gov/articles/PMC4201183/

Montgomery, A., Chalili, V., Lainidi, O., Mouratidis, C., Maliousis, I., Paitaridou, K., & Leary, A. (2025). Psychological safety and patient safety: A systematic and narrative review. *PLOS ONE, 20*(4), e0322215. https://doi.org/10.1371/JOURNAL.PONE.0322215

Moran, G., Mashiach-Eizenberg, M., Roe, D., Berman, Y., Shalev, A., Kaplan, Z., & Garber Epstein, P. (2014). Investigating the anatomy of the helping relationship in the context of psychiatric rehabilitation: The relation between working alliance, providers' recovery competencies and personal recovery. *Psychiatry Research, 220*(1–2), 592–597. https://doi.org/10.1016/J.PSYCHRES.2014.08.004

Morgan, J. (2015). Studying Organisations Using Critical Realism: A Practical Guide. *British Journal of Industrial Relations, 53*(3), 632–634. https://doi.org/10.1111/BJIR.12119

Muir-Cochrane, E., O'Kane, D., & Oster, C. (2018). Fear and blame in mental health nurses' accounts of restrictive practices: Implications for the elimination of seclusion and restraint. *International Journal of Mental Health Nursing, 27*(5), 1511–1521. https://doi.org/10.1111/INM.12451

Muir-Cochrane, E., & Oster, C. (2021). Chemical restraint: A qualitative synthesis review of adult service user and staff experiences in mental health settings. *Nursing and Health Sciences, 23*(2), 325–336. https://doi.org/10.1111/NHS.12822

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

Munn, Z., Peters, M. D. J., Stern, C., Tufanaru, C., McArthur, A., & Aromataris, E. (2018). Systematic review or scoping review? Guidance for authors when choosing between a systematic or scoping review approach. *BMC Medical Research Methodology, 18*(1), 1–7. https://doi.org/10.1186/S12874-018-0611-X

Nathan, R., Whyler, J., & Wilson, P. (2021). Risk of harm to others: subjectivity and meaning of risk in mental health practice. *Journal of Risk Research, 24*(10), 1228–1238. https://doi.org/10.1080/13669877.2020.1819389

National Institute for Health and Care Excellence [NICE]. (2019). *Patient experience in adult NHS services.* [NICE Quality Standard No. 15]. https://www.nice.org.uk/guidance/qs15

National Institute for Health and Care Excellence [NICE]. (2014). *Psychosis and schizophrenia in adults: prevention and management* [NICE Clinical Guideline No.178]. https://www.nice.org.uk/guidance/cg178

National Institute for Health and Care Excellence [NICE]. (2015). *Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges* [NICE Guideline No. 11]. https://www.nice.org.uk/guidance/ng11.

National Institute for Health and Care Excellence [NICE]. (2016). *Transition between inpatient mental health settings and community or care home settings.* [NICE Guideline No. 53]. https://www.nice.org.uk/guidance/ng53

National Institute for Health and Care Excellence [NICE]. (2017). *Violent and aggressive behaviours in people with mental health problems.* [NICE Quality Standard No. 154]. https://www.nice.org.uk/guidance/qs154.

National Institute for Health and Care Excellence [NICE]. (2018). *Decision-making and mental capacity* [NICE Guideline No. 108]. https://www.nice.org.uk/guidance/ng108

National Institute for Health and Care Excellence [NICE]. (2021a). *Shared decision making* [NICE Guideline No. 197]. https://www.nice.org.uk/guidance/ng197

National Institute for Health and Care Excellence [NICE]. (2021b). *Patient experience in adult NHS services: improving the experience of care for people using adult NHS services* [Clinical Guideline No.138]. https://www.nice.org.uk/guidance/cg138

National Institute for Health and Care Excellence [NICE]. (2022). *Self-harm: assessment, management and preventing recurrence* [NICE Guideline No. 225]. https://www.nice.org.uk/guidance/ng225

National Institute of Health and Care Excellence [NICE]. (2015). *Violence and aggression: short-term management in mental health, health and community settings* [NICE Guideline No. 10]. https://www.nice.org.uk/guidance/ng10

Ndebele, F., Wright, K., Gandhi, V., & Bayley, D. (2024). Non-contact monitoring to support care in acute inpatient mental health. *Journal of Mental Health, 33*(3), 320–325. https://doi.org/10.1080/09638237.2023.2245882

NHS (2022). *Mental Health Act*. https://www.nhs.uk/mental-health/social-care-and-your-rights/mental-health-and-the-law/mental-health-act/

NHS Confederation. (2026). *The Mental Health Act 2025: what you need to know.* https://www.nhsconfed.org/publications/mental-health-act-2025-what-you-need-know

NHS England. (2023). *Acute inpatient mental health care for adults and older adults.* https://www.england.nhs.uk/long-read/acute-inpatient-mental-health-care-for-adults-and-older-adults/#key-elements-of-the-inpatient-pathway

NHS England. (2024a). *Culture of care standards for mental health inpatient services.* https://www.england.nhs.uk/long-read/culture-of-care-standards-for-mental-health-inpatient-services/#our-vision-for-inpatient-care

NHS England. (2024b). *Definitions for restrictive interventions for use in Assuring Transformation - NHS England Digital.* https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/assuring-transformation/definitions-for-restrictive-interventions-for-use-in-assuring-transformation#physical-restraint-sometimes-referred-to-as-manual-restraint-

NHS England. (2025). *Identifying restrictive practice*. Mental Health. https://www.england.nhs.uk/long-read/identifying-restrictive-practice/

Ntsaba, G. N., & Havenga, Y. (2007). Psychiatric in-patients‘ experience of being secluded in a specific hospital in Lesotho. *Health SA Gesondheid, 12*(4). https://www.ajol.info/index.php/hsa/article/view/10367

Nyttingnes, O., Ruud, T., & Rugkåsa, J. (2016). ‘It’s unbelievably humiliating’—Patients’ expressions of negative effects of coercion in mental health care. *International Journal of Law and Psychiatry, 49*, 147–153. https://doi.org/10.1016/J.IJLP.2016.08.009

O’Donovan, R., De Brún, A., & McAuliffe, E. (2021). Healthcare Professionals Experience of Psychological Safety, Voice, and Silence. *Frontiers in Psychology, 12*, 626689. https://doi.org/10.3389/FPSYG.2021.626689

O'Dowd, A. (2024). Staff shortages have worsened safety of mental health patients by preventing therapeutic care. *BMJ, 387*, q2361. https://doi.org/10.1136/BMJ.Q2361

Paradis-Gagné, E., Pariseau-Legault, P., Goulet, M. H., Jacob, J. D., & Lessard-Deschênes, C. (2021). Coercion in psychiatric and mental health nursing: A conceptual analysis. *International Journal of Mental Health Nursing, 30*(3), 590–609. https://doi.org/10.1111/INM.12855

Paterson, B., Bradley, P., Stark, C., Saddler, D., Leadbetter, D., & Allen, D. (2003). Deaths associated with restraint use in health and social care in the UK. The results of a preliminary survey. *Journal of Psychiatric and Mental Health Nursing, 10*(1), 3–15. https://doi.org/10.1046/j.1365-2850.2003.00523.x

Pedersen, M. L., Gildberg, F., Baker, J., Damsgaard, J. B., & Tingleff, E. B. (2023). Ethnic disparities in the use of restrictive practices in adult mental health inpatient settings: a scoping review. *Social Psychiatry and Psychiatric Epidemiology, 58*(4), 505–522. https://doi.org/10.1007/S00127-022-02387-8

Pelto-Piri, V., Wallsten, T., Hylén, U., Nikban, I., & Kjellin, L. (2019). Feeling safe or unsafe in psychiatric inpatient care, a hospital-based qualitative interview study with inpatients in Sweden. *International Journal of Mental Health Systems, 13*(1), 1–10. https://doi.org/10.1186/S13033-019-0282-Y/TABLES/1

Phillips, C., Tai, S., & Berry, K. (2022). Experiences of acute mental health inpatient care in the UK: from admission to readmission. *Psychosis, 14*(1), 22–33. https://doi.org/10.1080/17522439.2021.1881596

Pilgrim, D. (2020). The utility of critical realism. In D. Pilgrim. *Critical Realism for Psychologists* (pp. 1–15). Routledge.

Polacek, M. J., Allen, D. E., Damin-Moss, R. S., Schwartz, A. J. A., Sharp, D., Shattell, M., Souther, J., & Delaney, K. R. (2015). Engagement as an Element of Safe Inpatient Psychiatric Environments. *Journal of the American Psychiatric Nurses Association, 21*(3), 181–190. https://doi.org/10.1177/1078390315593107

Power, T., Baker, A., & Jackson, D. (2020). "Only ever as a last resort": Mental health nurses' experiences of restrictive practices. *International Journal of Mental Health Nursing, 29*(4), 674–684. https://doi.org/10.1111/INM.12701

Price, O., Armitage, C. J., Bee, P., Brooks, H., Lovell, K., Butler, D., Cree, L., Fishwick, P., Grundy, A., Johnston, I., Mcpherson, P., Riches, H., Scott, A., Walker, L., & Papastavrou Brooks, C. (2024). De-escalating aggression in acute inpatient mental health settings: a behaviour change theory-informed, secondary qualitative analysis of staff and patient perspectives. *BMC Psychiatry, 24(*1), 1–15. https://doi.org/10.1186/S12888-024-05920-Y

Proctor, E. K., Landsverk, J., Aarons, G., Chambers, D., Glisson, C., & Mittman, B. (2009). Implementation research in mental health services: An emerging science with conceptual, methodological, and training challenges. *Administration and Policy in Mental Health and Mental Health Services Research, 36*(1), 24–34. https://doi.org/10.1007/S10488-008-0197-4

Proctor, E., Silmere, H., Raghavan, R., Hovmand, P., Aarons, G., Bunger, A., Griffey, R., & Hensley, M. (2011). Outcomes for Implementation Research: Conceptual Distinctions, Measurement Challenges, and Research Agenda. *Administration and Policy in Mental Health, 38*(2), 65. https://doi.org/10.1007/S10488-010-0319-7

Putkonen, A., Kuivalainen, S., Louheranta, O., Repo-Tiihonen, E., Ryynänen, O. P., Kautiainen, H., & Tiihonen, J. (2013). Cluster-randomized controlled trial of reducing seclusion and restraint in secured care of men with schizophrenia. *Psychiatric Services, 64*(9), 850–855. https://doi.org/10.1176/APPI.PS.201200393

Quinlivan, L., Littlewood, D. L., Webb, R. T., & Kapur, N. (2020). Patient safety and suicide prevention in mental health services: time for a new paradigm? Journal of Mental Health, 29(1), 1–5. https://doi.org/10.1080/09638237.2020.1714013

Quinn, A. (2025). Manufacturing a Monster: an autoethnographic analysis of enforced isolation, objectification and the destruction of self. *Frontiers in Psychiatry, 16*, 1694605. https://doi.org/10.3389/FPSYT.2025.1694605

Repper, J., & Perkins, R. (2013). *The team recovery implementation plan: A framework for creating recovery-focused services.* https://www.centreformentalhealth.org.uk/team-recovery-implementation-plan/

Restraint Reduction Network. (2022). *Resources: About Restraint. Working to Reduce Restraint.* https://restraintreductionnetwork.org/resources-about-restraint/

Rethink Mental Illness. (2022). *NHS Mental Health Teams Factsheet. NHS Mental Health Teams - Community, Crisis, and Early Intervention Support.* https://www.rethink.org/advice-and-information/living-with-mental-illness/treatment-and-support/nhs-mental-health-teams-community-crisis-and-early-intervention-support/

Riahi, S., Thomson, G., & Duxbury, J. (2020). A hermeneutic phenomenological exploration of 'last resort' in the use of restraint. *International Journal of Mental Health Nursing, 29*(6), 1218–1229. https://doi.org/10.1111/INM.12761

Richards, J. E., Whiteside, U., Ludman, E. J., Pabiniak, C., Kirlin, B., Hidalgo, R., & Simon, G. (2019). Understanding why patients may not report suicidal ideation at a health care visit prior to a suicide attempt: A qualitative study. *Psychiatric Services, 70*(1), 40–45. https://doi.org/10.1176

Richter, D. (2025). Human Rights in Psychiatry. In D. Richter. *Human Rights in Psychiatry*. Springer Nature Switzerland. https://doi.org/10.1007/978-3-031-98635-2

Ryan, G. S. (2019). Postpositivist critical realism: philosophy, methodology and method for nursing research. *Nurse Researcher, 27*(3), 20–26. https://doi.org/10.7748/NR.2019.E1598

Sambrano, R., & Cox, L. (2013). "I sang Amazing Grace for about 3 hours that day": understanding Indigenous Australians' experience of seclusion. *International Journal of Mental Health Nursing, 22*(6), 522–531. https://doi.org/10.1111/INM.12015

Sampath, R. (2022). When Is Iatrogenic Harm Negligent? *AMA Journal of Ethics, 24*(8), E735-739. https://doi.org/10.1001/AMAJETHICS.2022.735

Sattar, R., Johnson, J., & Lawton, R. (2020). The views and experiences of patients and health-care professionals on the disclosure of adverse events: A systematic review and qualitative meta-ethnographic synthesis. *Health Expectations, 23(*3), 571–583. https://doi.org/10.1111/HEX.13029

Sattar, R., Lawton, R., Panagioti, M., & Johnson, J. (2021). Meta-ethnography in healthcare research: a guide to using a meta-ethnographic approach for literature synthesis. *BMC Health Services Research, 21*(1), 1–13. https://doi.org/10.1186/S12913-020-06049-W/TABLES/2

Saunders, K. R. K., McGuinness, E., Barnett, P., Foye, U., Sears, J., Carlisle, S., Allman, F., Tzouvara, V., Schlief, M., Vera San Juan, N., Stuart, R., Griffiths, J., Appleton, R., McCrone, P., Rowan Olive, R., Nyikavaranda, P., Jeynes, T., K, T., Mitchell, L., … Trevillion, K. (2023). A scoping review of trauma informed approaches in acute, crisis, emergency, and residential mental health care. *BMC Psychiatry, 23*(1). https://doi.org/10.1186/s12888-023-05016-z

Schneeberger, A. R., Kowalinski, E., Fröhlich, D., Schröder, K., von Felten, S., Zinkler, M., Beine, K. H., Heinz, A., Borgwardt, S., Lang, U. E., Bux, D. A., & Huber, C. G. (2017). Aggression and

violence in psychiatric hospitals with and without open door policies: A 15-year naturalistic observational study. *Journal of Psychiatric Research, 95*, 189–195. https://doi.org/10.1016/j.jpsychires.2017.08.017

Scholes, A., Price, O., & Berry, K. (2022). Women's experiences of restrictive interventions within inpatient mental health services: A qualitative investigation. *International Journal of Mental Health Nursing, 31*(2), 379–389. https://doi.org/10.1111/INM.12966

Sekhon, M., Cartwright, M., & Francis, J. J. (2017). Acceptability of healthcare interventions: an overview of reviews and development of a theoretical framework. *BMC Health Services Research, 17*(1), 1–13. https://doi.org/10.1186/S12913-017-2031-8

Shields, M. C., Reneau, H., Albert, S. M., Siegel, L., & Trinh, N. H. (2018). Harms to Consumers of Inpatient Psychiatric Facilities in the United States: An Analysis of News Articles. *Issues in Mental Health Nursing, 39*(9), 757–763. https://doi.org/10.1080/01612840.2018.1451579

Simpson, A. (2023). Surveillance, CCTV and body-worn cameras in mental health care. *Journal of Mental Health, 32*(2), 369–372. https://doi.org/10.1080/09638237.2023.2194988

Skivington, K., Matthews, L., Simpson, S. A., Craig, P., Baird, J., Blazeby, J. M., Boyd, K. A., Craig, N., French, D. P., McIntosh, E., Petticrew, M., Rycroft-Malone, J., White, M., & Moore, L. (2021). Framework for the development and evaluation of complex interventions: gap analysis, workshop and consultation-informed update. *Health Technology Assessment, 25*(57), 1–132. https://doi.org/10.3310/HTA25570

Slovic, P. (2016). The Perception of Risk. In R. J. Sternberg, S. T. Fiske, & D. J. Foss (Eds.), *Scientists Making a Difference: One Hundred Eminent Behavioral and Brain Scientists Talk about their Most Important Contributions* (pp. 179–182). Cambridge University Press. https://doi.org/10.1017/CBO9781316422250.040

Snipe, J., & Searby, A. (2023). Elimination of restrictive interventions: Is it achievable under the current mental healthcare landscape? *International Journal of Mental Health Nursing, 32(*4), 1178–1185. https://doi.org/10.1111/INM.13180

Sturgiss, E. A., & Clark, A. M. (2020). Using critical realism in primary care research: an overview of methods. *Family Practice, 37*(1), 143–145. https://doi.org/10.1093/FAMPRA/CMZ084

Sustere, E., & Tarpey, E. (2019). Least restrictive practice: its role in patient independence and recovery. *The Journal of Forensic Psychiatry & Psychology, 30*(4), 614–629. https://doi.org/10.1080/14789949.2019.1566489

Szmukler, G. (2015). Compulsion and "coercion" in mental health care. *World Psychiatry, 14*(3), 259–261. https://doi.org/10.1002/WPS.20264,

Szmukler, G., & Rose, N. (2013). Risk Assessment in Mental Health Care: Values and Costs. *Behavioral Sciences & the Law, 31*(1), 125–140. https://doi.org/10.1002/BSL.2046

Tamarelli, C., Cao, A., & Grossman-Kahn, R. (2024). Should Patients' Boredom in Locked Inpatient Psychiatric Units Be Considered Iatrogenic Harm? *AMA Journal of Ethics, 26*(3), 219–224. https://doi.org/10.1001/AMAJETHICS.2024.219

Taylor, F., Galloway, S., Irons, K., Mess, L., Pemberton, L., Worton, K., & Chambers, M. (2024). Understanding organisational and nursing behaviour changes associated with a therapeutic engagement improvement tool in acute mental health inpatient settings: A qualitative analysis. *International Journal of Nursing Studies Advances, 6,* 100180. https://doi.org/10.1016/J.IJNSA.2024.100180

The Royal College of Psychiatrists. (2016). *Rethinking risk to others in mental health services.* https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr201.pdf?sfvrsn=2b83d227_4

Thibaut, B., Dewa, L. H., Ramtale, S. C., D'lima, D., Adam, S., Ashrafian, H., Darzi, A., & Archer, S. (2019). Patient safety in inpatient mental health settings: a systematic review. *BMJ Open, 9*(12), e030230. https://doi.org/10.1136/BMJOPEN-2019-030230

Tully, S. M., Bucci, S., & Berry, K. (2022). "My life isn't my life, it's the systems": A qualitative exploration of women's experiences of day-to-day restrictive practices as inpatients. *Journal of Psychiatric and Mental Health Nursing, 30*(1), 110–122. https://doi.org/10.1111/JPM.12855

United Nations. (2006). Convention on the Rights of Persons with Disabilities (CRPD). *Department of Economic and Social Affairs.* https://social.desa.un.org/issues/disability/crpd/convention-on-the-rights-of-persons-with-disabilities-crpd

Veale, D., Robins, E., Thomson, A. B., & Gilbert, P. (2023). No safety without emotional safety. *The Lancet Psychiatry, 10*(1), 65–70. https://doi.org/10.1016/S2215-0366(22)00373-X

Vears, D. F., & Gillam, L. (2022). Inductive content analysis: A guide for beginning qualitative researchers. *Focus on Health Professional Education: A Multi-Professional Journal, 23*(1), 111–127. https://doi.org/10.11157/FOHPE.V23I1.544

Verbeke, E., Vanheule, S., Cauwe, J., Truijens, F., & Froyen, B. (2019). Coercion and power in psychiatry: A qualitative study with ex-patients. *Social Science & Medicine, 223*, 89–96. https://doi.org/10.1016/J.SOCSCIMED.2019.01.031

Vogt, K. S., Baker, J., Kendal, S., Griffin, B. L., Mizen, E., Sharp, H., & Johnson, J. (2024). 'Safer, Not Safe': Service Users' Experiences of Psychological Safety in Inpatient Mental Health Wards in the United Kingdom. *International Journal of Mental Health Nursing, 33*(6), 2227-2238. https://doi.org/10.1111/INM.13381

Ward-Ciesielski, E. F., & Rizvi, S. L. (2020). The potential iatrogenic effects of psychiatric hospitalization for suicidal behavior: A critical review and recommendations for research. *Clinical Psychology: Science and Practice, 28*(1), 60-71. https://doi.org/10.1111/CPSP.12332

Williams, L., Rycroft-Malone, J., & Burton, C. R. (2017). Bringing critical realism to nursing practice: Roy Bhaskar's contribution. *Nursing Philosophy, 18*(2). https://doi.org/10.1111/NUP.12130,

Wilson, C., Rouse, L., Rae, S., & Kar Ray, M. (2018). Mental health inpatients' and staff members' suggestions for reducing physical restraint: A qualitative study. *Journal of Psychiatric and Mental Health Nursing, 25*(3), 188–200. https://doi.org/10.1111/JPM.12453

World Health Organization. (2021a). *Global Patient Safety Action Plan 2021-2030.* https://www.who.int/teams/integrated-health-services/patient-safety/policy/global-patient-safety-action-plan

World Health Organization. (2021b). *Guidance on Community Mental Health Services: Promoting Person-Centred and Rights-Based Approaches.* https://www.who.int/publications/i/item/9789240025707

World Health Organization. (2023a). *Mental health: Promoting and protecting human rights.* https://www.who.int/news-room/questions-and-answers/item/mental-health-promoting-and-protecting-human-rights

World Health Organization. (2023b). *Patient Safety.* https://www.who.int/news-room/fact-sheets/detail/patient-safety

Wynn, R. (2004). Psychiatric inpatients' experiences with restraint. *The Journal of Forensic Psychiatry & Psychology, 15(*1), 124–144. https://doi.org/10.1080/14789940410001655187

Yurtbasi, M. K., Melvin, G., Pavlou, C., & Gordon, M. (2023). Staff perspectives on the effects of seclusion in adolescent psychiatric inpatient care. *International Journal of Mental Health Nursing, 32(*2), 567–578. https://doi.org/10.1111/INM.13102

Appendices

Appendix A. Chapter 2 Supplementary Materials

A.1 Contents

A.2 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

A.3 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

A.4 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

A.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)										

A.6 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.

A.7 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)
	"We 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)"	Kontio et al. (2012) (8) - Patient experience during seclusion/restraint
	"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	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].	Bendall et al. (2022) (2) – Making sense of restrictive practice (Provocation)
	"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)	Aluh et al. (2022) (3) – Perception of coercion (Coercion as a vicious cycle, Anti-therapeutic and traumatic)
	"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).	Tully et al. (2022) (5) – Powerlessness (Restrictions perceived as punitive)
	"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)	Lanthen et al. (2015) (9) – Physical presence, instruction and composed behaviour can reduce discontent and trauma (Fear, powerlessness and feelings unreality)
	"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	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”	Wynn (2004) (15) - Patients’ experiences of the use of physical and pharmacological restraint
	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.	Hoekstra et al. (2004) (16) - Trust, Loneliness
	“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	

	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)

A.8 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
2. Allikmets, S., Marshall, C., Murad, O., & Gupta, K. (2020). Seclusion: A Patient Perspective. *Issues in Mental Health Nursing*, *41*(8), 723–735. https://doi.org/10.1080/01612840.2019.1710005
3. Aluh, D. O., Ayilara, O., Onu, J. U., Grigaitė, U., Pedrosa, B., Santos-Dias, M., Cardoso, G., & Caldas-de-Almeida, J. M. (2022). Experiences and perceptions of coercive practices in mental health care among service users in Nigeria: a qualitative study. *International Journal of Mental Health Systems*, *16*(1), 1–11. https://doi.org/10.1186/S13033-022-00565-4/TABLES/1
4. Bendall, C., Williams, C., & Huddy, V. (2022). Exploring experiences of restrictive practices within inpatient mental healthcare from the perspectives of patients and staff. *Journal of Psychiatric Intensive Care*, *18*(1), 17–29. https://doi.org/10.20299/JPI.2022.005
5. Chien, W. T., Chan, C. W. H., Lam, L. W., & Kam, C. W. (2005). Psychiatric inpatients' perceptions of positive and negative aspects of physical restraint. *Patient Education and Counseling*, 59(1), 80–86. https://doi.org/10.1016/J.PEC.2004.10.003
6. Cusack, P., McAndrew, S., Duckworth, J., Cusack, F., & McKeown, M. (2023). Experiencing restraint: A dialogic narrative inquiry from a service user perspective. *International Journal of Mental Health Nursing*. https://doi.org/10.1111/INM.13212
7. Ezeobele, I. E., Malecha, A. T., Mock, A., Mackey-Godine, A., & Hughes, M. (2014). Patients' lived seclusion experience in acute psychiatric hospital in the United States: a qualitative study. *Journal of Psychiatric and Mental Health Nursing*, *21*(4), 303–312. https://doi.org/10.1111/JPM.12097
8. Faschingbauer, K. M., Peden-McAlpine, C., & Tempel, W. (2013). Use of seclusion: Finding the voice of the patient to influence practice. *Journal of Psychosocial Nursing and Mental Health Services*, *51*(7), 32–38. https://doi.org/10.3928/02793695-20130503-01
9. Haglund, K., & Von Essen, L. (2005). Locked entrance doors at psychiatric wards – Advantages and disadvantages according to voluntarily admitted patients. *Nordic Journal of Psychiatry*, *59*(6), 511–515. https://doi.org/10.1080/08039480500360781
10. Hoekstra, T., Lendemeijer, H. H. G. M., & Jansen, M. G. M. J. (2004). Seclusion: the inside story. *Journal of Psychiatric and Mental Health Nursing*, *11*(3), 276–283. https://doi.org/10.1111/J.1365-2850.2003.00710.X
11. Holmes, D., Kennedy, S. L., & Perron, A. (2004). The mentally ill and social exclusion: a critical examination of the use of seclusion from the patient's perspective. *Issues in Mental Health Nursing*, *25*(6), 559–578. https://doi.org/10.1080/01612840490472101
12. Johnson, M. E. (1998). BEING RESTRAINED: A STUDY OF POWER AND POWERLESSNESS. *Issues in Mental Health Nursing*, *19*(3), 191–206. https://doi.org/10.1080/016128498249024
13. Kontio, R., Joffe, G., Putkonen, H., Kuosmanen, L., Hane, K., Holi, M., & Välimäki, M. (2012). Seclusion and restraint in psychiatry: patients' experiences and practical suggestions on how to improve practices and use alternatives. *Perspectives in Psychiatric Care*, *48*(1), 16–24. https://doi.org/10.1111/J.1744-6163.2010.00301.X
14. Kuosmanen, L., Hätönen, H., Malkavaara, H., Kylmä, J., & Välimäki, M. (2007). Deprivation of liberty in psychiatric hospital care: the patient's perspective. *Nursing Ethics*, *14*(5), 597–607. https://doi.org/10.1177/0969733007080205

15. Lanthén, K., Rask, M., & Sunnqvist, C. (2015). Psychiatric Patients Experiences with Mechanical Restraints: An Interview Study. *Psychiatry Journal*, *2015*, 1–8. https://doi.org/10.1155/2015/748392
16. Li, S., Ye, J., Yuan, L., Wang, H., Wang, T., Wu, C., & Xiao, A. (2023). Perspectives on physical restraint in psychiatric hospital: A qualitative study of mentally ill patients. *International Journal of Mental Health Nursing*. https://doi.org/10.1111/INM.13205
17. Lynge, M. C., Dixen, S. T., Johansen, K. S., Düring, S. W., U.-Parnas, A., & Nordgaard, J. (2023). Patients' experiences with physical holding and mechanical restraint in the psychiatric care: an interview study. *Nordic Journal of Psychiatry*, *77*(3), 247–255. https://doi.org/10.1080/08039488.2022.2087001/SUPPL_FILE/IPSC_A_2087001_SM9812.DOCX
18. Mac Donald, B., Gustafsson, S. A., Bulik, C. M., & Clausen, L. (2023). Living and leaving a life of coercion: a qualitative interview study of patients with anorexia nervosa and multiple involuntary treatment events. *Journal of Eating Disorders*, *11*(1), 1–9. https://doi.org/10.1186/S40337-023-00765-4/TABLES/3
19. Mayers, P., Keet, N., Winkler, G., & Flisher, A. J. (2010). Mental health service users' perceptions and experiences of sedation, seclusion and restraint. *The International Journal of Social Psychiatry*, *56*(1), 60–73. https://doi.org/10.1177/0020764008098293
20. Meehan, T., Vermeer, C., & Windsor, C. (2000). Patients' perceptions of seclusion: a qualitative investigation. *Journal of Advanced Nursing*, *31*(2), 370–377. https://doi.org/10.1046/J.1365-2648.2000.01289.X
21. Ntsaba, G. N., & Havenga, Y. (2007). Psychiatric in-patients' experience of being secluded in a specific hospital in Lesotho. *Health SA Gesondheid*, *12*(4). https://www.ajol.info/index.php/hsa/article/view/10367
22. Nyttingnes, O., Ruud, T., & Rugkåsa, J. (2016). 'It's unbelievably humiliating'—Patients' expressions of negative effects of coercion in mental health care. *International Journal of Law and Psychiatry*, *49*, 147–153. https://doi.org/10.1016/J.IJLP.2016.08.009
23. Sambrano, R., & Cox, L. (2013). "I sang Amazing Grace for about 3 hours that day": understanding Indigenous Australians' experience of seclusion. *International Journal of Mental Health Nursing*, *22*(6), 522–531. https://doi.org/10.1111/INM.12015
24. Scholes, A., Price, O., & Berry, K. (2022). Women's experiences of restrictive interventions within inpatient mental health services: A qualitative investigation. *International Journal of Mental Health Nursing*, *31*(2), 379–389. https://doi.org/10.1111/INM.12966
25. Tully, S. M., Bucci, S., & Berry, K. (2022). "My life isn't my life, it's the systems": A qualitative exploration of women's experiences of day-to-day restrictive practices as inpatients. *Journal of Psychiatric and Mental Health Nursing*, *30*(1), 110–122. https://doi.org/10.1111/JPM.12855
26. Verbeke, E., Vanheule, S., Cauwe, J., Truijens, F., & Froyen, B. (2019). Coercion and power in psychiatry: A qualitative study with ex-patients. *Social Science & Medicine*, *223*, 89–96. https://doi.org/10.1016/J.SOCSCIMED.2019.01.031
27. Wynn, R. (2004). Psychiatric inpatients' experiences with restraint. *The Journal of Forensic Psychiatry & Psychology*, *15*(1), 124–144. https://doi.org/10.1080/14789940410001655187

A.9 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
2. Haglund, K., Von Knorring, L., & Von Essen, L. (2003). Forced medication in psychiatric care: patient experiences and nurse perceptions. *Journal of Psychiatric and Mental Health Nursing*, *10*(1), 65–72. https://doi.org/10.1046/J.1365-2850.2003.00555.X
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
4. Kjellin, L., Andersson, K., Bartholdson, E., Candefjord, I. L., Holmstrøm, H., Jacobsson, L., Sandlund, M., Wallsten, T., & Östman, M. (2004). Coercion in psychiatric care – patients' and relatives' experiences from four swedish psychiatric services. *Nordic Journal of Psychiatry*, *58*(2), 153–159. https://doi.org/10.1080/08039480410005549
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
7. Olofsson, B., & Norberg, A. (2001). Experiences of coercion in psychiatric care as narrated by patients, nurses and physicians. *Journal of Advanced Nursing*, *33*(1), 89–97. https://doi.org/10.1046/J.1365-2648.2001.01641.X
8. Tooke, S. K., & Brown, J. S. (1992). Perceptions of seclusion: comparing patient and staff reactions. *Journal of Psychosocial Nursing and Mental Health Services*, *30*(8), 23–26. https://doi.org/10.3928/0279-3695-19920801-09
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
9. Poulsen, H. D. (1999). Perceived Coercion Among Committed, Detained, and Voluntary Patients. *International Journal of Law and Psychiatry*, *22*(2), 167–175. https://doi.org/10.1016/S0160-2527(98)00042-9
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

A.10 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	✓	✓		✓	

Appendix B. Chapter 3 Supplementary Materials

B.1 Contents

Appendix S1. Topic guide

Appendix S2. Analysis considerations and procedure

Appendix S3. Iterations and development process of the definition of psychological safety.

Appendix S4. Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

B.2 Appendix S1. Topic guide

Exploring the impact of restrictive practice on psychological safety: a qualitative study of the service user experience

This study aims to explore your experience of restrictive practice and how this impacted your psychological safety. We would also like to know what you think could be done as an alternative to restrictive practice or how it could be made safer. By exploring what you and other people who have experienced or witnessed restrictive practice think, we hope to identify the impacts of restrictive practice on psychological safety to aid improvements to care on inpatient mental health wards. I am going to be recording the interview today, is that ok? Any questions before we get started?

Topic Guide

- Before we get started, please tell me a little bit about yourself and your time in inpatient mental health care…
    - Cover: Time spent in mental health wards, number of inpatient stays, type of ward, whether they have direct experience or witnessed restrictive practice.
- The main aspect of this research is the concept of psychological safety. Previous research within the team has shown that feelings of psychological safety in service users was influenced by:

1. Healthcare staff attitudes and behaviours towards them
2. Their relationships with other service users
3. Whether they felt they had any control over their environment and medical decision-making regarding their care
4. Their experiences of physical safety, feeling listened to and believed
5. Access to meaningful occupation on the wards

- In reference to an inpatient stay, what does psychological safety mean to you? Does the above resonate with you?

Restrictive practice experience

- Could you tell me about a time where you experienced or witnessed restrictive practice?
    - Who was involved? What happened before and afterwards? How did you feel?
- Do you think your psychological safety was impacted by this incident? Why?
    - Did it change how you felt about staff/ward/care?
- Did you discuss the incident with anyone afterwards?
    - Was there a chance to debrief?
- How do you think the incident could have been managed differently to help you feel safer?

Alternative approaches

- Thinking of the time/s you experienced/witnessed restrictive practice, do you think it was necessary in this/these situations? Why?
    - What do you think could've been done so this practice was less harmful to your sense of psychological safety?
- If you could speak to staff/policy makers, what suggestions would you give for making restrictive practice more psychologically safe in inpatient mental healthcare?
    - What could be implemented or changed on the ward to reduce the psychological harm of restrictive practice or make it unnecessary?

B.3 Appendix S2. Analysis considerations and procedure

Consideration of the Relationship Between Researcher and Participants

There has been much discussion around the potential power imbalance between interviewer and interviewee in qualitative research (Råheim et al., 2016). While the researcher acknowledges this, steps were taken to reduce the burden on participants. To build rapport with participants in the current study, there was initial contact over email. Here, participants had the opportunity to ask questions, state preferences, and request the topic guide in advance. Before the interview began, the researcher re-introduced themselves stating that they were a PhD student with no prior experience as an inpatient or as staff in mental health services. Participants were reassured that the interviewer wanted to hear their story and were happy for the participant to discuss any experience of restrictive practices that they felt comfortable with. Participants had the opportunity to view and comment on the results of the study once analysis was completed.

The first author of this study was a novice qualitative researcher with no experience of interviewing or working with the target population. As such, the first three interviews were carried out by a more experienced researcher with the first author present on the call. Participants were told from their first contact with the first author that one of her supervisors would be conducting the interview with her present on the call. This was also included in the consent process and reiterated at the beginning of the call. Participants were given the option to withdraw if they did not feel comfortable with this.

Positioning the research team

With the complexity of the research area, it is important to consider the research group's position during the analysis of the data. The lead researcher, a female PhD student does not have experience of working in or being a patient of inpatient mental healthcare. She has received extensive training of qualitative methods during her studies (BSc (Hons),

MSc and current PhD study). The research team has extensive experience working in and researching inpatient mental healthcare and restrictive practices.

It was important to consider the wider UK mental healthcare context and the participant's experience within this. As a result, a critical realist perspective was used throughout the analysis. Critical realism acknowledges the realities of the participant but considers that the experience of an individual does not exist in isolation and are because of relationships and interactions with external structures (i.e., ward environment, staff skills and policy) that have influenced those experiences and realities (Fletcher, 2017).

Reflexive Thematic Analysis

Phase One: Familiarisation with the Data. The lead researcher led the analysis. Familiarisation started with reviewing each participant's file, listening to the recording in full whilst reading the transcripts. On the second listen-through, notes on the participants', and the researcher's, emotions were made in the author's reflexivity journal. Transcripts were then printed and then re-read multiple times, making initial notes on contextual information (i.e., type of restrictive practices discussed) on the transcripts and reflections in the reflexivity journal.

Phase Two: Coding. The coding process started on paper, naturally taking a more semantic approach (example: realised they've been lied to, feeling upset). The qualitative data analysis software nVivo was then used, revisiting the first iteration of codes on paper and developing them. This incorporated more latent coding and reflecting on the initial interpretation. A systematic approach to coding was taken starting with the first interview, making initial codes on paper, moving to nVivo and then going on to the second interview and so on until all transcripts had been coded. It was important to not fit quotes into the codes created on another transcript, but rather naming them individually. Once a point where coding felt complete was reached, the codes were revisited to make sure the code labels

accurately reflected the contents. At this point, initial grouping of codes that held the same meaning (i.e., feeling isolated and left alone with feelings) was started.

Phase Three: Generating Initial Themes. Clusters were developed through identifying shared meaning across codes. During this process, the researcher reflected on the codes developed, their influence on the coding, and how the codes relate to the research question. An MS Word table was created with the headings: cluster description, codes, quotes and notes. An example cluster description was, “Patients feel punished by restrictive practices and see it as a reflection of staff’s feelings towards them”. Thirteen clusters were created and captured in the table, with quotes to support the cluster. A meeting with the supervisory team was then held to discuss the process and identified clusters. This allowed for a touchpoint on the interpretation of the codes and quotes before moving to developing the themes fully. The clusters and their reflections on their own experiences of certain stories was discussed. The supervisory team also gave feedback on whether the quotes identified represented that cluster and identified areas for further interpretation.

Phase Four: Developing and Reviewing Themes. All 13 clusters were revisited, splitting them apart and re-grouping through further interpretation. Similarly, the quotes to support the clusters were revisited, ensuring that the original meaning was maintained in the groupings. This process led to four candidate themes (CT), three of which contained potential subthemes (ST): CT1) physical risk and reactive care (ST 1: Decisions fuelled by physical risk, ST2: Reactive over proactive care), CT2) Chaos is not conducive to safety, CT3) Something around power dynamics (ST1: Power means staff behaviour is interpreted as punishment, ST2: Power in patients looks like rebelling) and CT4) Something about relationships in a closed environment (ST1: The closed nature of the ward, ST2: Relationships are a double-edged sword). The initial interpretations in the first iteration of categories were revisited to ensure that the developed candidate themes were representative of the data. Another meeting with the supervisory team, to discuss the ‘candidate themes’, was had. Feedback focused on whether each candidate theme was

reasonably developed, based on the categories discussed in the previous meeting, and that the identified quotes were represented well. Potential names and areas for further interpretation were also discussed.

Phase Five: Refining, Defining and Naming Themes. The contents of the themes were developed based on revisiting the developed MS Word tables. The codes and quotes of each category were revisited and cross-referenced to further develop the interpretation for each theme. The original transcripts were reviewed to ensure that the developed themes represented the original words of participants. Reflections during this process focused on the questions, “What story does this theme tell?” and “How does this fit into the overall story about the data?”.

Phase Six: Writing Up. The writing-up process began by drafting a synopsis for each theme and discussing how they are related to the research aims. The writing process was iterative in that the original categories were cross referenced, and the ordering of each concept was revisited several times. Once a full draft was written, it was shared with the supervisory team for feedback. This finalised the names of the themes. Several edits and drafts, with input from the research team, have been done to develop an analytic narrative and coherent story, accompanied by the participants quotes, to address the research question.

B.4 Appendix S3. Iterations and development process of the definition of psychological safety.

Iteration 1: Participants in the interview study described what psychological safety means to them. Below is what they said in the context of being an inpatient in mental healthcare.

- Being psychologically safe is being protected from lasting psychological damage by the environment. It's not just about feeling physically safe on the ward but being protected from things that are going to have lasting effects in the future (iatrogenic harm).
- Psychological safety is having your needs understood – having my diagnosis accepted and adjustments made to make me feel safe, having people not make adjustments repeatedly makes me feel unsafe.
- Providing psychologically safe care is about time, understanding, reflection and empathy. It's for someone to make you feel like what you're experiencing is valid.
- Psychologically safe care could be an umbrella term for care that is recovery focused, trauma informed and individualised to service users' needs.
- Trust that you're going to be cared for when you're distressed.
- Psychological safety is feeling safe in yourself, having trust in your own decisions. Providing psychologically safe care would involve encouraging independence and choice.
- Being psychologically safe is being informed about what is happening externally and being able to process and react.

Feedback and answers to questions from lived experience advisory group

- Being psychologically safe is being protected from lasting psychological damage by the environment. It's not just about feeling physically safe on the ward but being protected from things that are going to have lasting effects in the future (iatrogenic harm).
- Psychological safety is having your needs understood – having my diagnosis accepted and adjustments made to make me feel safe, having people not make adjustments repeatedly makes me feel unsafe.
- Providing psychologically safe care is about time, understanding, reflection and empathy. It's for someone to make you feel like what you're experiencing is valid.
- Psychologically safe care could be an umbrella term for care that is recovery focused, trauma informed and individualised to service users' needs.
- ~~Trust that you're going to be cared for when you're distressed.~~
- Psychological safety is feeling safe in yourself, having trust in your own decisions. Providing psychologically safe care would involve encouraging independence and choice.
- ~~Being psychologically safe is being informed about what is happening externally and being able to process and react.~~

1. Do you agree with any of the statements above?

- Like the idea of being validated, think it's the basis of feeling safe
- Reassurance that your experience and needs are valid are needed to feel safe

- Consideration of physical safety, two separate things but needed to feel psychologically safe

2. Is there any that you disagree with, or think could be changed in any way?

- Last bullet point is more of a suggestion for providing psychological safety rather than the feeling itself
- Trust one is separate – it's an element of being safe but is also a definition of itself. Also, shouldn't just be cared for when distressed

3. Is there anything that you think could be added?

- Validation that being an inpatient is ok, validation that feeling how you feel as an inpatient is ok.
- Reassurance that you will be cared for as you are, including disabilities, individual needs etc.

4. Do you have any suggestions for a clear, shortened definition for psychological safety?

- When you're presenting this to staff, it should be split into feeling psychologically safe is… and providing psychologically safe care means…

Iteration 2: A consolidated definition based on the interview study, incorporating feedback from the lived experience advisory group. The suggestion for providing psychologically safe care comes from the interview study and literature on psychological safety:

Psychological safety is feeling validated in your experience of the world and the belief you will be treated fairly based on your individual needs. Being psychologically safe provides protection from lasting psychological harm from your environment. It's not just about being physically safe on the ward but being protected from things that are going to have lasting effects in the future.

Providing psychologically safe care includes:

- Being recovery focused, trauma informed and providing individualised care for service users' needs.
- Fully explaining decisions and allowing space for patients to ask questions.
- Encouraging the independence and choice of patients.
- Providing a safe space for patients to express feelings and frustrations.
- Providing a physically safe environment.
- Providing access to meaningful occupation on the wards.

Feedback from lived experience advisory group

- Good that the underlying message of providing psychologically safe care is around relationships – important to be supported.
    - Element of mutual trust in self and others to enable confidence in patients but also staff to make decisions
- Changes:

1. Remove 'on the ward' from the definition – psychological safety refers to everyone/people and the bullet points cover psychological safety in that specific setting
2. Replace 'things' with events
3. Change 'are going to' to 'may'
4. Be consistent in terminology – 'patients'
5. Add a sentence – This definition recognises the need for individualised care. After speaking with a group of experts by experience we are using the term patients to refer to anyone who is receiving care.

Iteration 3:

Psychological safety is feeling validated in your experience of the world and the belief you will be treated fairly based on your individual needs. Being psychologically safe provides protection from lasting psychological harm from your environment. It's not just about being physically safe but being protected from events that may have lasting effects in the future.

Providing psychologically safe care in inpatient mental health includes:

1. Being recovery focused, trauma informed and providing individualised care for patients' needs.
2. Fully explaining decisions and allowing space for patients to ask questions.
3. Encouraging the independence and choice of patients.
4. Providing a safe space for patients to express feelings and frustrations.
5. Providing a physically safe environment.
6. Providing access to meaningful occupation on the wards.

After speaking with a group of experts by experience we are using the term patients to refer to anyone who is receiving care. We recognise that this is an individual preference and that some people use the terms 'service user' or 'client'.

B.5 Appendix S4. Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

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

No. Item	Guide questions/description	Reported on Page #
Domain 1: Research team and reflexivity		
Personal Characteristics		
1. Interviewer/facilitator	Which author/s conducted the interview or focus group?	5
2. Credentials	What were the researcher's credentials? E.g. PhD, MD	Title page
3. Occupation	What was their occupation at the time of the study?	Supplementary material S2.
4. Gender	Was the researcher male or female?	6 and supplementary materials S2.
5. Experience and training	What experience or training did the researcher have?	Inferred based on credentials (title page) and mentioned supplementary material S2
Relationship with participants		
6. Relationship established	Was a relationship established prior to study commencement?	Supplementary material S2
7. Participant knowledge of the interviewer	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	Supplementary material S2
8. Interviewer characteristics	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	Supplementary material S2

Domain 2: study design		
Theoretical framework		
9. Methodological orientation and Theory	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	4
Participant selection		
10. Sampling	How were participants selected? e.g. purposive, convenience, consecutive, snowball	5
11. Method of approach	How were participants approached? e.g. face-to-face, telephone, mail, email	5
12. Sample size	How many participants were in the study?	7
13. Non-participation	How many people refused to participate or dropped out? Reasons?	7
Setting		
14. Setting of data collection	Where was the data collected? e.g. home, clinic, workplace	6
15. Presence of non-participants	Was anyone else present besides the participants and researchers?	N/A
16. Description of sample	What are the important characteristics of the sample? e.g. demographic data, date	7 and table 1
Data collection		
17. Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	6, supplementary material S1/2
18. Repeat interviews	Were repeat interviews carried out? If yes, how many?	N/A
19. Audio/visual recording	Did the research use audio or visual recording to collect the data?	6
20. Field notes	Were field notes made during and/or after the inter view or focus group?	Supplementary material S2
21. Duration	What was the duration of the inter views or focus group?	7
22. Data saturation	Was data saturation discussed?	N/A
23. Transcripts returned	Were transcripts returned to participants for comment and/or correction?	N/A
Domain 3: analysis and findings		
Data analysis		

24. Number of data coders	How many data coders coded the data?	Supplementary material S2
25. Description of the coding tree	Did authors provide a description of the coding tree?	N/A
26. Derivation of themes	Were themes identified in advance or derived from the data?	Analysis method reported page 5 and supplementary material S2
27. Software	What software, if applicable, was used to manage the data?	Supplementary material S2
28. Participant checking	Did participants provide feedback on the findings?	Supplementary material S2
Reporting		
29. Quotations presented	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	8-15
30. Data and findings consistent	Was there consistency between the data presented and the findings?	Yes
31. Clarity of major themes	Were major themes clearly presented in the findings?	Yes
32. Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	N/A

N/A = Not applicable

Appendix C. Chapter 4 Supplementary Material

C.1 Contents

C.2 S1. Topic guide

Defining psychological safety

While psychological safety is a recognised concept in mental healthcare, to the author's knowledge, there is no clear, widely recognised definition in literature or practice. As such, a working definition was devised for the study informed by literature, interviews with former inpatients and input from a lived experience advisory group (LEAG): "*Feeling validated in your experience of the world and the belief you will be treated fairly based on your individual needs. Being psychologically safe provides protection from lasting psychological harm from your environment. It's not just about being physically safe but being protected from events that may have lasting effects in the future.*"

Introduction and definition

- Can you tell me a little bit about yourself and your role in inpatient mental health please?
    - Cover what role they are in, how long they have been in the role and what setting.
    - Use of restrictive practices at work and their opinion on this.
    - Previous experience, motivations for working in this area.
- We have asked former patients what psychological safety means to them; this is what they said: "*Psychological safety is feeling validated in your experience of the world and the belief you will be treated fairly based on your individual needs. Being psychologically safe provides protection from lasting psychological harm from your environment. It's not just about being physically safe but being protected from events that may have lasting effects in the future."*
    - Is psychological safety a term you have heard before taking part in this study?
    - Can you tell me what your general views are of this definition?
    - Do you agree with the definition?

Incorporating psychological safety into their role

- Thinking about yourself at work, have there been times in the past where you have tried to help patients feel more psychologically safe?
    - If so, how did you do this?
    - If not, why not?
- Is increasing psychological safety a priority on your ward?
    - If not (and they themselves have done it) where did you get the idea to work in this way?
    - If yes, how are you encouraged to do this? What resources are you provided with?

Using restrictive practices on the ward

- How do you think providing psychologically safe care aligns with the use of restrictive practices?
    - Do you think that the use of restrictive practices on the wards are always necessary? If yes/no, why?
- Thinking about a time when you have used restrictive practices on the ward, how did you incorporate providing psychologically safe care during this time?
    - If they didn't – on reflection, how could you have promoted the psychological safety of patients during that incident?
- Are you able to work in this way every time you use **X restrictive practice?**
    - Is there anything that hinders your ability to work in this way? – prompts: emotions of patients and staff, support by the organisation.
    - Do you think there are any particular skills needed to work in this way? Is this something you feel you can do well?

    - Do the people you work with prioritise the psychological safety of patients?

Alternatives and suggestions

- If you could speak to your trust's leadership and policy makers, what suggestions would you give for making restrictive practice more psychologically safe in inpatient mental healthcare?
    - What could be implemented or changed on the ward to reduce the psychological harm of restrictive practice or make it unnecessary?

C.4 S2. Additional quotes to provide support to the explanatory themes

Domain	Explanatory Theme	Example quotes
Environmental Context and Resources	Resource (facilitator)	I suppose if we don't really know much about the patients, then to get in that collateral history from the family. So speaking to the family or like the CPN or the social workers, or the professionals that the patient that was under before they came to me, because they might hold some vital information that then would aid us to make that. Therapeutic relationship quicker. - PARTICIPANT 11 / usually try to make sure that it's the member staff that they have a good relationship with, [they] will go and do the awkward, difficult conversation. - PARTICIPANT 10 / We need interventions for staff as well, staff feeling supported staff feeling psychologically safe because I don't think carers can offer compassionate, safe care if they're feeling vulnerable or burnt out, or that they don't feel supported. - PARTICIPANT 16 / We try and get the person who knows the patient the most, even if it is a short period of time. Who's got that relationship already to try and sort of like lead on that intervention? Whoever's got the best relationship, really and even if it is like ad hoc, we do try and drive like gender and what their preferences are. – PARTICIPANT 9 / When people say, restrictive practises are always last resort and it's just not. It's not because that would mean that we're optimising every other area and we're not. It's just last resort of what we have available to us, which isn't enough - PARTICIPANT 18 / I do feel there is a lack of experienced leadership on the ground that, you know, their roles involve other things that take them away from the wards for much of the time. These ideas of psychological safety and thinking holistically about somebody's care and managing risk in an appropriate way, there's something lacking at that kind of systemic level that there's these problems that are inherent - PARTICIPANT 1 / “When we lose people in our system, you've not got 10 people in the wings biting off someone's elbows to try and get their post. That doesn't happen. Those post quite often are unfilled for a really lengthy amount of time. So with under resourcing and lack of attractiveness to people, you're trying to create change in an already really high acuity, low resourced environment that's always very stretched and very taut. It means that proactive methods are often neglected.” – PARTICIPANT 18

	Creating Safe Spaces for Patients (facilitator)	I will still people away from meeting in bed areas so that they [patients] see that they have a right for that space to feel restorative and safe, and then actually, if we're about to have conversations that might at times be emotionally charged, doing that somewhere that's more neutral might be helpful. - PARTICIPANT 16 / There's small things that make the biggest impact…we've been reminding staff to knock and wait if you want to go into their [patient] bedroom. - PARTICIPANT 19 / Sometimes people would be admitted very, very unwell and have absolutely no idea what they were doing, where they were, who they were, and they'd just be quite free and going in and out of bedrooms and taking stuff and wandering on the wards. So I used to be quite protective over that because the bedroom should be there safe space. – PARTICIPANT 6 / We tried to sort of remain respectful and give people the choice if they want to be involved in it [activities] or not and have as little or as big part in that as they wanted. – PARTICIPANT 2 / I've talked about in supervision is like the helpers dance and saying that it takes the system, the person administering the intervention and the patient to collaborate and I'd say most often, it feels that, you know, the system wants to help, we want to help but the person doesn't want to collaborate…they're just too unwell. - PARTICIPANT 14 / We work psychologically within the limitations of that restriction. Between me and the rest of the AHPs we have 11 different groups or activities that we facilitate each week to try and continue to promote that psychological safety on the ward, even with the restrictions. - PARTICIPANT 17
	Ward Environment (barrier)	If we see somebody who's a self-harmer, who might have a EUPD and then we've got a really prolific self-harmer on the ward, they will trigger that person who's got EUPD to then have a relapse in their emotional journey. - PARTICIPANT 3 / When you're in inpatient services, people don't often build relationships with each other. They kind of just, like, coexist, don't they? - PARTICIPANT 2 / The whole dynamics of the ward can change with the addition of one patient. – PARTICIPANT 6 There's a lot of restrictive practices in terms of bedrooms being locked between certain time periods during the day. The kind of rationale for that sometimes is to avoid incidents. - PARTICIPANT 13 / I think the wards where people would just be like, well, this is how it is. And that's how it's done. And that's how we've always done it

		had the highest level of incidents and were psychologically unsafe. - PARTICIPANT 6 / I think the only thing I would change, which patients often say about is that because we have a mixture of formal and informal patients, the front door obviously has to be locked. I don't know how they would ever change that, but informal patients say, well, I can come and go as I want, you know, and I can't even get out the front door without having to be asked to be let out. - PARTICIPANT 9 / I think that mental health system as a whole probably doesn't support psychologically safety. Our environments are a huge [one]. - PARTICIPANT 5 / I think it's definitely something to aspire to, but I can see how inpatient mental health might fall short of that in certain situations. - PARTICIPANT 12 / No one in their right mind would go into this job if you didn't have a real passion and a real motivation to provide good quality care for the most traumatised individuals of society. I do truly believe in that. These jobs are not glamorous, they're minging. They're really awful pay in awful environments with really high acuity. It is grossly unpleasant. - PARTICIPANT 18
	Lack of time (barrier)	What's going to take up more of my time and resources giving an IM or sitting and having to chat with someone to deescalate them for half an hour to an hour? - PARTICIPANT 17 / To get people to be psychologically safe takes a lot longer than maybe being physically safe, and it feels like we've not got the time to sort of achieve that. - PARTICIPANT 15 / People don't have the time or the resources to talk to people for any length of time to actively engage people so much. - PARTICIPANT 1
	Staff Culture (barrier)	If systemically staff are always working in a culture of threat and feeling unsupported, then I feel that that drains their ability to offer that well-rounded care. You know, the core nursing team on shift most times are within two years of qualification. So for whatever reason a systems level, there's something happening where staff retention is having a real impact. - PARTICIPANT 16 / I think it's difficult to feel physically safe on the ward sometimes. I know sometimes psychiatrists use that as a question in ward reviews of like, do you feel safe on the ward to kind of probably more to inquire about kind of like feelings of psychosis and paranoia. But if someone says no, I kind of think well, no, I wouldn't either so. - PARTICIPANT 15 / We just don't have a lot of experience in working with people

		with mental health problems and they learn from other staff around them who probably also don't have a lot of experience and it just becomes this really negative culture of this is how we respond. - PARTICIPANT 13 / “I think on reflection probably the environments that I was working in in those situations were probably a little bit toxic. And psychological safety wasn't kind of like high on the agenda.” - Participant 2
Beliefs About Capabilities	Importance of Understanding Actual Risk (facilitator)	Lots of these restrictive practises are agreed with people and they understand the rationale for it. Sometimes it's not, but when it is, I think that's maybe when you get that psychological safety, when there's been a time when you can discuss those practises, when someone's not in distress. I think those conversations around restrictive practises are what helps people to feel psychologically safe. – PARTICIPANT 19 / This individual had a sock that they were pulling round their neck and making all sorts of gurgling noises and everything. I saw it wasn't tied but the young nurse was panicking, so I just sat down with the person. I said, what's going on? I can see you're really, really distressed. It's not going to work, but I recognise you're not having a really nice time here. What's happening for you? Is there anything that we can do here now? And it worked nobody had to lay a finger. - PARTICIPANT 20 / We have to risk assess each patient daily to make sure that the level of risk that they present is sort of counteracted in what we allow them to do on the ward as, as a free person, as an individual who's got autonomy over their own decisions. - PARTICIPANT 3
	Dealing with Complexity (facilitator)	So we want to move away from challenging behaviours because that feels quite blaming and that and actually we know that lots of our environments are challenging, which then in turn, you know people become distressed. - PARTICIPANT 5 / Some one patient is going to want to talk about it two hours after they've woken up. Another person isn’t ready to reflect until the next day or the day after, or even the week after. But at the time your reflections are different from what they are later so. I think that comes back around to sort of you know, when they are leaving we go out and have discussion around how not to come back here again in the nicest possible way. - PARTICIPANT 10
	Expectations vs Reality (barrier)	I think some people think that going to come to hospital, they're going to get a therapy every day and that it's going to be this marvellous kind of magic, onetime

		thing and that's not what it's like. That's not what we're able to do. I'd love to be able to do that. But we can't, and it's sort of managing those expectations around that. - PARTICIPANT 15 / I cannot make a massive difference like the sole recovery of this patient is not dependent on me. Like it's nice if you can, like offer them support and they can have like a trusting relationship with members of staff. But I can't save the world here like I can't make this better. Like you can't just have to get on with your job and just sort of do it. - PARTICIPANT 12 / There's pockets of opportunity where we will tap in and try make it therapeutic but at other times the individuals got a complete stranger looking over them you know. - PARTICIPANT 8
	Conflicting Priorities Limiting the Possibility of Psychologically Safe Care (barrier)	Our ward tries to stick to it quite closely to have 72-hour admissions for BPD diagnoses. But recently we really advocated and said I know this person has an EUPD diagnosis, but she's had a lot of acute stresses recently and would benefit from being in this environment that's safe for her for a little bit of a rest, a little bit of time to feel contained. We can't just discharge her yet. - PARTICIPANT 14 / I think it would my gut reaction is, no management and leadership do not prioritize psychological safety. It's that physical safety that's the priority. - PARTICIPANT 4 / I think probably the people you get on acute wards are different now to what they were then. I think they're more desperate so I wonder if it's actually got slightly worse because of the press pressure to get people out more quickly. Just patched up. - PARTICIPANT 1 / It seems inhumane to lock people out of their rooms all day. Even if you are saying it's for a certain reason, when you try and find out the reason behind it, it's often all we don't want incidents to happen, so they'll lock someone out of their room between the hours of nine and five. - PARTICIPANT 13 / I think sometimes we're a bit like too well-oiled of a machine with it and it's sometimes you know, we're the people that have to say, hang on, we need to think about this person, although they've got this diagnosis and this history, let's think about it again. - PARTICIPANT 14
Knowledge	Healthcare Professional – Patient Relationship (facilitator)	Rather than getting het up on what they said, knowing them well enough to know that that is an indication of illness, and actually, if he's started speaking like that again, we need to do something about the treatment plan, because that's that's a sign of his illness - PARTICIPANT 10 / We ask them to complete a Safewards

		plan. So it's asking them like what they like, what they don't like, how do they like to be approached? And any sort of like specific gender that they prefer to work with. It ranges from absolutely everything, do they prefer a room with a toilet or without a toilet, just sort of things like that. - PARTICIPANT 9 / But when they're engaging in self harm, communicating with them, giving that autonomy, not just going straight in like I did in my first year in the NHS of someone head banging, just going in and restraining them, and then it just turning into a brawl. - PARTICIPANT 17 / If anything, it's more beneficial to be providing that sort of in depth, bespoke, sort of therapeutic interventions. Otherwise, people tend to get stuck and then it's sort of like prolonged in terms of the amount of time that they spend in segregation and also just in general by a person being put into inpatient mental health services and then being admitted for a stay. - PARTICIPANT 2
	Knowledge Gaps (barrier)	Quite a lot of misunderstanding from staff. A lot of the time [they think] that patients are just being difficult because they don't want to eat or they're just acting up and that it's just behavioural - PARTICIPANT 13 / You could put them on every training course in the world, but unless they sort of see certain things first hand and experience certain things first hand. Say for example, working in a trauma informed way, psychological safe way they have to understand actually what that means in practice. - PARTICIPANT 2 / "It leaves me with a kind of sense of anxiety that I'm missing something and not supporting my team as much- you know I'm missing a key element or key understanding about it [psychological safety]." - PARTICIPANT 4
Social/Professional Role and Identity	Professional Confidence to Make and Explain Decisions (facilitator)	We've been trying all the methods of communication with her as well. So we use like symbol based communication we've been trialling that with her instead so using other avenues of people to communicate or. Trying different things as well, so continually making sure that offer is there reminding them of that or trying to support them with like basic needs on the ward and having a dialogue about that. - PARTICIPANT 6 / I mean, we have done a lot of things on a PICU that people would be like you absolutely should not have done that, that was way too risky. But I know because of the therapeutic relationships that I build with patients that I can risk assess that. - PARTICIPANT 11 / I think in terms of creating that culture change. One person acting differently could have sort of like broken that cycle a

		little bit, so I think. Now I confidently speak out and professionally challenge things. - PARTICIPANT 2
	Staff Can Add Value to Ward Processes (facilitator)	If you're talking more than half the time, then you're talking too much. Shut up. Listen to the patient and find a way of communicating the bits of information you want to get across to the patient through a question rather than through direct information. - PARTICIPANT 4 / What helps you to get alongside somebody and think together about what's going on for you in a way that feels contained and safe and not overwhelming and intrusive. - PARTICIPANT 19 / Her key worker, who's our main nurse on the ward, she never gets involved with any restraint and any feeds because actually, we felt that that would really impact on her relationship with her. So she feels quite psychologically safe with [name removed] the nurse that that is her key worker. - PARTICIPANT 7 / She was the activity coordinator, so her point was to make nice things for the patients to do between their therapy. [She'd say] "We're having a pamper session next, I'd love to go out and pay £50 to get this done, but sure, come on in the NHS will fund it". The patients picked up on her incredibly cynical approach and then she'd be like, "well, they don't come to the groups anyway". And I'm like, I wonder why! - PARTICIPANT 17
	Inconsistency in Ways of Working (barrier)	It's management dependent but I do think that everyone tries in their own way, but without the proper definition or training, then everyone's doing their own concept of it. - PARTICIPANT 6 / She had every skill under the sun and when she'd escalate, the staff would resort to either this PRN or we're going to IM you instead of encouraging her to use any of the skills she'd learned over 18 weeks of DBT. I don't tend to work outside the hours of 8:00 AM till 6:00 PM. And you'd often find that escalations happened after 6:00 PM when we weren't on the ward to sort of influence or support with the situation…it would just be straight to PRN or straight to IM. - PARTICIPANT 17 / When people don't stick to boundaries you hear patients say, oh, but last night, so and so said I could do whatever. Inconsistent use of boundaries is really unhelpful because that's really difficult to then implement the same boundary the next time. - PARTICIPANT 10 / It's really hard to kind of remain consistent in that care and they say that is what is most beneficial, like especially for people like that might have autistic spectrum conditions you need consistency. They need to know what to expect. They need to

		know what's coming at them. So I think it's very difficult to kind of feel like you're doing your job and feel like you're doing your best for the patient when you're getting conflicting things all the time. - PARTICIPANT 12
Social Influences	Collaboration and Shared Priorities (facilitator)	I think you know you need people,staff team doing the day-to-day work who are fully bought into these ideas and may be accountable for putting these ideas into practise or not. - PARTICIPANT 16 / The meetings that we have are just really great because it shows that we are looking at how we can reduce that [restrictive practices] every month. I think collectively it's great for different professionals from different backgrounds to go and different age ranges and [people from] different services because it gives you the opportunity to share ideas and you pick up a lot from there like oh, that sounds good. We're going to do that. - PARTICIPANT 9
	Staff vs Patients: Preventing Engagement with Care (barrier)	Sometimes we find that when somebody is on a one to one or a two to one, it will trigger somebody else because they're not getting that same attention, so have to put something in place to obviously make sure that we're not then going to end up with two patients on a two to one because of their triggers and emotions. - PARTICIPANT 3 / So we're like, it's more or less like punishing them for having an incident, which people then will say like, oh, they need to take responsibility. There needs to be like a consequence, but like we're actually in a hospital and we're looking after people. - PARTICIPANT 11
	Resistance to Change (barrier)	Some staff that see psychological safety as a kind of a woolly and hippie idea, I think, because it's not what they've always delivered, they will be the knuckle draggers, that kind of the last to adapt to any of that makes sense. - PARTICIPANT 4 This- psychological safety is seen as extra stuff but it isn't, this should be absolute bread and butter. So I'm a little bit of a stickler, so when I hear kind of management say well if we can't deliver on this, we can't do the bells and whistles and I'm like this stuff isn't bells and whistles pet like this stuff is like is what you should be delivering. It should be non-negotiable. - PARTICIPANT 18 / They listened to us a lot more and I don't know whether that's also because we've changed consultants. I don't know whether that's a part of it. And different views of different consultants and that can have a big impact on that as well. – PARTICIPANT 14 / I have very little autonomy on the ward. You know, I might well

		try and persuade the consultant to think about a different treatment plan. But if he's not going to go with that, I have no autonomy. I can't undermine the consultant, I know I just need to accept that on the chin and move on. - PARTICIPANT 4 / Especially as a loan psychologist in those settings you're pushing back against a culture that is really quite opposite to what you're trying to trying to embody and what you're trying to offer. - PARTICIPANT 16 / I do find it is very consultant or psychiatrist dependent on how psychology is received on the ward and how driven the medical model is in comparison to any other models of care. - PARTICIPANT 17
Emotions	Empathy and Compassion (facilitator)	It's just about seeing the person in front of you. Seeing a person, not a diagnosis. Asking the question what happened rather than what's wrong. - PARTICIPANT 20 / I can't imagine being a patient on a ward and already feeling. So ill and so confused and and then having these awful things happen like it's just heartbreaking. You know it's more intrusive sometimes than the mental illness. I think the level of scrutiny that you're under on the wards and everything that you do is written about, whether you like it or not. - PARTICIPANT 6 / You wouldn't go to someone in distress on the street here have a lorazepam. You just wouldn't. You'd talk to them. You'd sit with them. If your daughter was having a tantrum, you wouldn't be like quick Calpol like it just wouldn't happen. - PARTICIPANT 17 / You can keep her at home and look after her. Just keep her at home and I said do not let her go into that system because she'll just be bouncing around for years. - PARTICIPANT 6 / "I don't think they [colleagues and organisations] recognize the impact that just being in an inpatient unit has on a person. It's almost like the impact of being around so many other people who are unwell, is forgotten...there just isn't that understanding that actually a person can go into an inpatient unit with no trauma and come out with a shed load just because they've been in that place." - PARTICIPANT 13
	Burnout and Compassion fatigue (barrier)	Like it'll be really acute, and staff will be really burnt out. Definitely sort of psychological safety will go down like just in effort to sort of like get through the day almost like, get everything done that needs to be done. -PARTICIPANT 12 / I think you see a lot of compassion fatigue. And you see a lot of this towards patients who are frequent users of healthcare - PARTICIPANT 6 / We are in the

		middle of a colossal staffing crisis at the moment in mental health services. I think while we have made gains up to about 12 years ago, I really worry about where we're at at the moment because staff are exhausted. - PARTICIPANT 4 / But those nursing assistants, are the ones doing the observations, and at the very minimum, we'll have a patient on an hourly observation and the very most would have them one to ones. But if you've got a 10 minute observation and you're constantly going around checking on an individual and you find that they've ligatured and they're blue and you kind of kind of set your alarm off and then work on that individual. And you know, you spend some time with that individual. And then 20 minutes later, you go and do your check and find exactly the same situation. And over the course of your shift it's going to have a psychological impact and it is going to increase burnout, you know and as someone that has to manage colleagues with sickness and absence have definitely seen a spike on that. - PARTICIPANT 8
	Fear and Personal Opinions Driving Decisions About Patient Care (barrier)	I can't bring that person out of seclusion because if something happens, I'm going to be told off. I can't reduce that person's observation levels because God forbid something happens. It's on my head. So that then and for me, they are the individuals who don't feel like they've got psychological safety because it's that blame if something goes wrong. - PARTICIPANT 5 / The priority is saving everyone's skin, saving everyone's reputation and not wanting to take positive risks because of the potential. - PARTICIPANT 13 / you did see staff members that probably did enjoy it more than they should. Maybe that patient had annoyed them or they didn't like them. - PARTICIPANT 6 / Maybe like the Matron and other people who are really just push and say, no, we need that borderline out, that kind of thing. You know, because I think they just see the diagnosis. They don't necessarily look beyond that and I think we're often reminding people now it is a person. - PARTICIPANT 14 / “It feels like there's more of a concern over reputation than there is about how the patients feel because currently it feels like no matter what patients do they don't have any rights, like they're not really involved in their care. They're all sectioned.” - PARTICIPANT 13

Appendix D. The Full Process for Developing the Working Definition of Psychological Safety

Iteration 1: Participants in the interview study described what psychological safety means to them. Below is what they said in the context of being an inpatient in mental healthcare.

- Being psychologically safe is being protected from lasting psychological damage by the environment. It's not just about feeling physically safe on the ward but being protected from things that are going to have lasting effects in the future (iatrogenic harm).
- Psychological safety is having your needs understood – having my diagnosis accepted and adjustments made to make me feel safe, having people not make adjustments repeatedly makes me feel unsafe.
- Providing psychologically safe care is about time, understanding, reflection and empathy. It's for someone to make you feel like what you're experiencing is valid.
- Psychologically safe care could be an umbrella term for care that is recovery focused, trauma informed and individualised to service users' needs.
- Trust that you're going to be cared for when you're distressed.
- Psychological safety is feeling safe in yourself, having trust in your own decisions. Providing psychologically safe care would involve encouraging independence and choice.
- Being psychologically safe is being informed about what is happening externally and being able to process and react.

Feedback and answers to questions from lived experience group

NB: Highlighted sections reflect what was accepted by the group, strikethroughs reflect what was rejected as it referred to other aspects of care.

- Being psychologically safe is being protected from lasting psychological damage by the environment. It's not just about feeling physically safe on the ward but being protected from things that are going to have lasting effects in the future (iatrogenic harm).
- Psychological safety is having your needs understood – having my diagnosis accepted and adjustments made to make me feel safe, having people not make adjustments repeatedly makes me feel unsafe.
- Providing psychologically safe care is about time, understanding, reflection and empathy. It's for someone to make you feel like what you're experiencing is valid.
- Psychologically safe care could be an umbrella term for care that is recovery focused, trauma informed and individualised to service users' needs.
- ~~Trust that you're going to be cared for when you're distressed.~~
- Psychological safety is feeling safe in yourself, having trust in your own decisions. Providing psychologically safe care would involve encouraging independence and choice.
- ~~Being psychologically safe is being informed about what is happening externally and being able to process and react.~~

1. Do you agree with any of the statements above?
    - Like the idea of being validated, think it's the basis of feeling safe

- Reassurance that your experience and needs are valid are needed to feel safe
- Consideration of physical safety, two separate things but needed to feel psychologically safe

2. Is there any that you disagree with, or think could be changed in any way?
    - Last bullet point is more of a suggestion for providing psychological safety rather than the feeling itself
    - Trust one is separate – it's an element of being safe but is also a definition of itself. Also, shouldn't just be cared for when distressed
3. Is there anything that you think could be added?
    - Validation that being an inpatient is ok, validation that feeling how you feel as an inpatient is ok.
    - Reassurance that you will be cared for as you are, including disabilities, individual needs etc.
4. Do you have any suggestions for a clear, shortened definition for psychological safety?
    - When you're presenting this to staff, it should be split into feeling psychologically safe is… and providing psychologically safe care means…

Iteration 2: A consolidated definition based on the interview study, incorporating feedback from the HEER group. The suggestion for providing psychologically safe care comes from the interview study and literature on psychological safety:

Psychological safety is feeling validated in your experience of the world and the belief you will be treated fairly based on your individual needs. Being psychologically safe provides protection from lasting psychological harm from your environment. It's not just about being physically safe on the ward but being protected from things that are going to have lasting effects in the future.

Providing psychologically safe care includes:

- Being recovery focused, trauma informed and providing individualised care for service users' needs.
- Fully explaining decisions and allowing space for patients to ask questions.
- Encouraging the independence and choice of patients.
- Providing a safe space for patients to express feelings and frustrations.
- Providing a physically safe environment.
- Providing access to meaningful occupation on the wards.

Feedback from lived experience group

- Good that the underlying message of providing psychologically safe care is around relationships – important to be supported.
    - Element of mutual trust in self and others to enable confidence in patients but also staff to make decisions
- Changes:

1. Remove 'on the ward' from the definition – psychological safety refers to everyone/people and the bullet points cover psychological safety in that specific setting
2. Replace 'things' with events
3. Change 'are going to' to 'may'
4. Be consistent in terminology – 'patients'

5. Add a sentence – This definition recognises the need for individualised care. After speaking with a group of experts by experience we are using the term patients to refer to anyone who is receiving care.

Iteration 3:

Psychological safety is feeling validated in your experience of the world and the belief you will be treated fairly based on your individual needs. Being psychologically safe provides protection from lasting psychological harm from your environment. It's not just about being physically safe but being protected from events that may have lasting effects in the future.

Providing psychologically safe care in inpatient mental health includes:

1. Being recovery focused, trauma informed and providing individualised care for patients' needs.
2. Fully explaining decisions and allowing space for patients to ask questions.
3. Encouraging the independence and choice of patients.
4. Providing a safe space for patients to express feelings and frustrations.
5. Providing a physically safe environment.
6. Providing access to meaningful occupation on the wards.

Feedback from staff in Study 3:

Since then, I have done interviews with staff that work in inpatient mental healthcare about how they help patients to feel more psychologically safe. They gave feedback on the definition, thinking about how they could use it at work. They were mainly positive but had some feedback:

- "Can you add something about help seeking behaviours?"
- "Keeping people safe from future harm feels too naïve and like an aspiration"
- "There will be an individualised understanding of what it is"
- "What I perceive as my needs met, might be different to someone else"
- "Bit about lasting effects feels vague – what is it referring to?"
- "Could you mention how clinicians can't always protect patients but it's about setting them up to deal with events in the future?"
- "Being treated fairly doesn't mean being treated equally - look at the language and make sure that it is reflecting what you actually mean - 'treated equally' would probably work better"

Iteration 4:

Psychological safety is feeling validated in your experience of the world and the belief you will be treated ~~equally~~ based on your individual needs. Being psychologically safe provides protection from lasting psychological harm from your environment. It's not just about being physically safe but being protected from harm that may have lasting effects in the future.

Providing psychologically safe care in inpatient mental health includes:

1. Being recovery focused and trauma informed in your approach to patient care
2. Fully explaining decisions and allowing space for patients to ask questions.
3. Encouraging the independence and choice of patients through positive communication and relationships.
4. Providing a safe space for patients to express feelings and frustrations.

5. Providing a physically safe environment
6. Providing access to meaningful occupation on the wards.
7. Providing individualised care to meet patient need

After speaking with a group of experts by experience we are using the term patients to refer to anyone who is receiving care. We recognise that this is an individual preference and that some people use the terms ‘service user’ or ‘client’.

Feedback from lived experience group:

- Glad that staff views mostly align
- Don’t add in anything about help seeking behaviours, that’s just patients wanting care
- Don’t agree with change of fairly to equally. Should be equitably or fairly
- General preference was fairly as some people might not understand what equitably means

Final iteration:

Psychological safety is feeling validated in your experience of the world and the belief you will be treated fairly based on your individual needs. Being psychologically safe provides protection from lasting psychological harm from your environment. It’s not just about being physically safe but being protected from harm that may have lasting effects in the future.

Providing psychologically safe care in inpatient mental health includes:

1. Being recovery focused and trauma informed in your approach to patient care
2. Fully explaining decisions and allowing space for patients to ask questions.
3. Encouraging the independence and choice of patients through positive communication and relationships.
4. Providing a safe space for patients to express feelings and frustrations.
5. Providing a physically safe environment
6. Providing access to meaningful occupation on the wards.
7. Providing individualised care to meet patient need

After speaking with a group of experts by experience we are using the term patients to refer to anyone who is receiving care. We recognise that this is an individual preference and that some people use the terms ‘service user’ or ‘client’.