Critical Intelligence Unit

Evidence check

Reducing restrictive practices

28 May 2025

Evidence check question

What factor(s) influence the use of restrictive and coercive practices in healthcare settings for people with lived experience of mental health issues?

Summary

- A restrictive practice is "any practice or intervention that restricts a person's rights, including their freedom to move".[1] These include seclusion, restraint (chemical, mechanical, physical and environmental) and involuntary treatment with the primary purpose being influencing the person's behaviour and restricting or subduing a person's movement.[2]
- Coercive practice is often used interchangeably with restrictive practice in literature. Two broad categories of coercion are commonly described: formal and informal.[3-5]
  - Formal coercion includes restrictive practices such as seclusion, restraint, involuntary medications and treatment. It is the most commonly studied, regulated in legislation and professional guidelines, and monitored in healthcare settings.
  - Informal coercion includes any form of influence, pressure, threat or manipulation of the person's decisions. Informal coercion is often less visible, subtle and less likely to be formally decided or documented.
- This evidence check provides an overview of published systematic reviews and a synthesis of evidence on factors influencing the use of restrictive or coercive practices, staff attitudes and perceptions, and interventions aimed to reduce such practices. The characteristics of included systematic reviews include:
  - Most systematic reviews included either quantitative (cross-sectional or cohort) or qualitative primary evidence. They examined a broad range of topics relating to the use of restrictive or coercive practices, such as prevalence, usefulness or effectiveness, impact on patients or staff, influencing factors, interventions to address them, and staff and patient attitudes and perceptions. Few had a more targeted focus. Those reviews that were targeted examined either the relationship between factors and the use of restrictive practices based on observational analytical studies, or the effectiveness of interventions based on controlled trials, comparative cohort or pre-post studies).
  - There are significant ambiguities and variations in the definition of restrictive practices or coercion across the studies, with most reviews reporting on a mix of predominately formal coercive practices such as seclusion and restraint. One review specifically addressed informal coercive practice.

  - A wide range of settings were examined, ranging from psychiatric inpatient settings or acute wards to outpatient or community mental health settings or emergency departments. Some studies looked at a variety of settings and have not differentiated outcomes per the setting.
  - Four broad types of factors were reported across the systematic reviews as associated with staff use of restrictive measures or formal coercion:
    - **Patient or service user socio-economic factors** – in both adults and children, younger age, ethnic and racial minority status, and low socio-economic background were most consistently reported as risk factors. In adults, being male was reported as a risk factor in most studies except one, whilst in children, the findings were mixed (reporting either being male or female as a risk factor) depending on context and restraint type/s used.
    - **Patient or service user clinical factors** – diagnosis with certain psychiatric conditions such as psychotic disorders, schizophrenia, or in children eating disorders or developmental disorders were associated with a higher risk of being subjected to restrictive and coercive measures. Other factors included greater symptom severity, history of multiple prior hospitalisations, history of trauma and having multiple comorbidities or higher acuity of illness.
    - **Staff factors** – mixed findings for staff sex, level of education, work experience, and ethnicity. Lack of familiarity with procedures, lower knowledge base or favourable attitudes towards restrictive practices, lower empathy or leadership scores, feelings of lack of safety and prior experience of being assaulted were associated with an increased use of restrictive or coercive practice.
    - **Organisational factors** – mixed findings were reported for staff-to-patient ratio and geographical remoteness. However, a higher number of junior doctors is reported to be associated with a reduced practice of coercion. Access to the seclusion room was associated with increased use.
- Patient socio-economic factor was most commonly examined and reported. For most factors, the findings were consistent across the studies. However, for some factors such as patient sex, staff education level or staff-to-patient ratio, the findings are inconclusive or even conflicting.[6]
- The evidence on informal coercion is scarce, with only one systematic review noting most available evidence comprised low-quality studies examining staff attitudes. It reported on the staff use of informal coercion frequently during therapeutic interactions, a view that it is effective under certain circumstances and a need for continuous reflection on its use individually and as a team.[4]
- Multimodal interventions which incorporate various elements such as staff training, behavioural change techniques, risk assessment, and enhanced administrative review, are more likely to reduce aggressive behaviours and the use of restrictive practices.[7-10] Six Core Strategy–based interventions and Safewards has consistently been shown to be associated with positive outcomes in reducing the use of restrictive practices.[8, 11-13] The evidence for staff training (when examined as a single intervention rather than a component of a comprehensive intervention) and sensory rooms was mixed.[8, 9, 11, 14]
- Reported interventions are diverse in their methods, targets and procedures.[15] There is a lack of longitudinal data on the long-term outcomes of interventions or changes in attitude or practices over time.[16 10, 15] There is a lack of rigorous evaluations of interventions using high-quality randomised controlled trials or other comparative methods.[10, 11, 15, 17] The broader cultural context in which the studies were undertaken may influence study findings.[18]

Evidence

- The definition and measurement of the use of seclusion and restraint varied across studies.[19] There are a variety of risk factors reported across the literature, with individual or a cluster of risk factors often intersecting with each other.[19] Influencing factors are often context-dependent and therefore, the findings among studies about a specific factor were not homogenous.
- The following risk factors for seclusion and restraint were mainly drawn from systematic reviews of observational analytical studies and are reported to be associated with increased use of seclusion and restraint compared to their reference group. Most studies reported on the general use of restrictive or coercive practices without a clear distinction between the different types such as seclusion and restraint.

Patient socio-economic factors

Adults

- Being male – reported to be a risk factor in most studies.[19-21]
  - Some conflicting evidence regarding sex was reported in a minority of studies included within systematic reviews. For example, in a 2018 study from the United Kingdom, an association between being female and increased risk of seclusion was reported.[22] In another multi-centre study from 12 European countries, being female was associated with an increased risk of forced treatment and being male was associated with an increased odds of being physically restrained or secluded in patients with schizophrenia.[23]
  - For involuntary psychiatric hospitalisation, male sex was associated with an increased risk in a meta-analysis.[24]
- Younger age – some studies reported an association between younger age, e.g. under 45, and the use of seclusion, while others reported no significant association or an increased risk only among young patients who are male.[19] Younger patients were also reported to be at increased risk of being transferred to psychiatric intensive care unit.[19]
  - For restraint or composite measure of coercion, there are mixed findings of either increased or non-significant association between younger age and the risk.[19]
- Ethnic or racial minority status – is dependent on geographical location. Mixed findings were reported across the included studies for seclusion and it is likely to intersect with other risk factors such as age and legal status.[19]
- Migrant status – was associated with an increased risk of restraint and involuntary admission.[19, 25]
- Lower socio-economic status – associated with a higher risk of chemical restraint.[19]
- Having deafness or hard of hearing - associated with an increased risk of seclusion.[19]
- Lower education status, unemployment, receiving welfare benefits or living in areas with economic deprivation – associated with increased risk of involuntary admission.[25, 26]
- Police involvement in admission – associated with an increased risk of involuntary admission.[24]

Children and adolescents

- Younger age – was most consistently reported as a risk factor.[15, 27]

  - In a study from Australia, younger age was associated with an increased risk of restrictive interventions in a child and adolescent inpatient unit.[28]
- Male sex – mostly reported as a risk factor in studies conducted outside Europe including the one from Australia.[27] In studies conducted in Europe, girls in their late adolescence appear to be more at risk of being subjected to coercive practices than boys.[3, 27, 29] Females were also reported to have an increased risk of multiple restraints in one review.[30]
- Ethnicity or race – especially those other than White (especially Black or African American) in studies from the United States.[27]
- Being a victim of abuse.[27]
- Lower socio-economic status or receiving social service support.[27]

Patient clinical factors

Adults

- Diagnosis of certain conditions were found to be associated with increased subjection to restrictive practices, although there are some inconsistent findings for some conditions across the studies.
  - Psychotic disorder including schizophrenia – increased the risk of seclusion, restraint and involuntary admission in some studies, with some other studies reporting no significant association for seclusion.[19, 20, 24, 25]
  - Substance misuse – especially for seclusion.[19, 20]
  - Mood disorder – associated with an increased risk for physical restraint, chemical restraint and coercion.[19]
  - Bipolar disorder – reported as a risk factor for seclusion, transfer to psychiatric intensive care unit, or involuntary admission to psychiatric hospitals.[19, 24]
- Greater symptom severity or psychiatric load – for example greater severity of anorexia nervosa for involuntary treatment or greater symptom severity on the brief psychiatric rating scale (BPRS) for use of composite coercive measures.[19, 25, 31]
- History of previous psychiatric hospitalisations and a higher number of admissions.[19, 32]
- History of trauma in the lifetime.[20]
- Low satisfaction with previous treatments.[20]
- Comorbidities in patients with anorexia.[32]

Children

- Diagnosis of certain conditions were found to be associated with increased subjection to restrictive practices, although there are some inconsistent findings for some conditions across the studies.
  - Diagnosis of developmental disorder – including in a study from Australia.[27, 28, 30]
  - Diagnosis of psychotic disorder – inconsistent evidence with a mix of increased or decreased risk, or no significant association.[27, 30]
  - Externalising disorder including substance misuse, disruptive behaviour disorder and attention-deficit hyperactivity disorder (ADHD) – including in an Australian study, although some conflicting evidence from other countries exit.[27, 28, 30]

  - Diagnosis of eating disorders with higher comorbidities and longer duration of illness is associated with increased rates of use of physical restraint[27, 28, 31]
  - Multiple comorbid diagnoses – including in an Australian study.[28, 30]
  - Diagnosis with a condition in the ICD-10 F9 category (behavioural and emotional disorders, i.e. conduct disorders) – especially in studies from European countries.[29]
- Self-harming behaviours – increased the risk of being restrained.[30]
- History of multiple previous inpatient admissions or extended length of stay.[30, 31]
- History of trauma and aggression.[27, 30]
- Emergency and voluntary admission status compared to planned admission.[30]
- Extended length of stay and multiple admissions.[27, 30]
- Timing – increased likelihood of experiencing restrictive practices at the start of the week, in afternoons or evenings and during longer admission periods.[30]

Staff factors

- Male staff – most commonly reported as being associated with coercive practices, although some study findings were inconclusive or even conflicting, with some studies reporting female sex being a risk factor.[6, 18]
- Mixed findings for the level of education, with some studies reporting an association between higher level of education, i.e. qualified versus non-qualified nurses, and use of restrictive practices, while others reporting the opposite or no association.[6, 18, 21]
- Mixed findings for work experience, with some suggesting more experienced staff less likely to use restraint and others reporting no association.[18]
  - Experience, higher education or participation in training maybe associated with increased knowledge and favourable attitudes to avoiding seclusion.[16]
- Lack of familiarity with procedures or patient's cultural background leading to miscommunication or mistrust.[30]
- Mixed findings for ethnicity, one UK study reported a higher proportion of White staff members as a risk factor compared to African and other ethnicities, while other studies reported no association between religion, ethnicity and physical stature.[6, 33]
- Higher empathy scores amongst staff were less likely to use seclusion and restraint.[6]
- Higher leadership scores and a creative personality were found to be associated with less initiation of coercion.[6]
- Low therapeutic optimism scores were associated with approval of seclusion in response to challenging patient behaviour.[6]
- Lower subjective feelings of safety which can be influenced by lack of safety equipment, understaffing, patient characteristics, lack of communication about security, lack of training and work experience were likely to be associated with the use of coercive measures.[6, 33]
- Past experience of being assaulted or injured by patients.[6]

Staff attitudes and perceptions

- Staff views, attitudes and perceptions towards the use of restrictive practices were often measured using qualitative methods or cross-sectional study designs. A 2024 systematic review of staff attitudes towards the use of coercion in mental healthcare reported that:[34]
  - There is substantial variability in reported attitudes across studies depending on the setting and the types or indications of the coercive measures. The hospital tradition and availability of institutional support were associated with staff attitudes. Staff emotions, such as feelings of grief, guilt, anxiety, or power and control, as well as staff perception of the coercive measures as necessary or beneficial, can be relevant to attitudes towards the use of coercive measures.
  - Some studies report an association between positive attitudes toward coercive measures and the decision to use coercion or the actual use of coercion.
- For psychiatric settings, three broad categories of staff attitudes were reported:[18]
  - Transformers – in favour of other alternative strategies.
  - Maintainers – perceive safety considerations above ethical concerns and believe there is no need for a change.
  - Doubters – perceive the seclusion and restrictive practices to be necessary to ensure safety.
- Multiple reviews reported that the need for restrictive practices was often framed through the security lens or as a defensive mechanism, perceiving it as necessary or unavoidable to ensure safety and prevent harm, while also acknowledging the ethical and negative impact.[3, 6, 35-37] It was commonly expressed by the staff that the use of restrictive practices was 'the last resort' after trying alternatives with the aim of 'avoiding restraint'.[35, 38]
  - One review noted a shift from viewing the use of restrictive practices as a therapeutically beneficial option (treatment paradigm) to viewing it as a necessity to ensure safety for both the staff and patients.[6] Another also noted that the attitudes toward the use of containment methods appear to become more negative overtime among psychiatric nursing staff.[39]
- Multiple reviews reported staff predominately viewing the experience of using restrictive measures as negative, with many describing feelings of distress, mental or moral conflict and 'nobody to talk to'.[35, 40] They also viewed the use of restrictive practices as a shared experience with patients with a negative impact on therapeutic relationships.[41]
- The main factors perceived by staff members as influencing their decision to use restrictive measures were: 'risk assessment', 'availability of staff' and 'availability of alternatives'.[35, 40] They also expressed the need for alternative and less intrusive interventions.[6]
- Lower levels of knowledge and positive attitudes towards restrictive practices – associated with psychiatric nursing staff's increased use of containment methods.[39]
- Organisational factors that are perceived by staff to be influencing their use of restrictive practices included ward environment, i.e. lack of space or unsafe furniture, understaffing or regular use of agency staff, availability of protocols and appropriate training, and the subjective nature of the risk assessment.[38, 42]

Organisation and team or other factors

- Mixed findings for staff ratio, with some reporting higher numbers of qualified nurses per shift as a risk factor for seclusion, while others reporting lower staff-patient ratio as a risk factor or no association between the staff ratio and use of restrictive practice.[6, 19, 30]
  - Lower number of nurses and a higher number of junior doctors was associated with reduced use of coercion in psychiatric wards.[20]
- A larger physical stature of the nursing team was negatively associated with seclusion.[19]
- Areas with access to a seclusion room or another service with a seclusion room, such as a paediatric intensive care unit, or in locked-door wards, had higher rates of seclusion compared to areas without seclusion rooms.[19, 20]
- Mixed findings regarding geographical remoteness, with some reporting wards located in rural areas being a risk factor for seclusion while others reporting urban wards having higher incidence of restrictive practices potentially due to a higher prevalence of drug use, homelessness or lack of social support.[19, 20]
- Units treating eating disorders were associated with increased rates of use of physical restraint.[27]
- Policy factors - legislative changes, increased attention to the protection of human rights, court rulings and new treatment options are all factors that have contributed to influencing the incidence and applicability of psychiatric restraint measures.[43] A systematic review found legal and policy changes may reduce physical restraint use.[17]
- For **involuntary admissions**, the following factors were identified as potential risk factors:[44]
  - Service-related factors such as lack of less restrictive and efficient alternatives to inpatient treatment, availability of community-based services and complementary social services
  - Temporal and seasonal factors such as evenings and night during the day, weekends versus weekdays, seasons with higher sunshine intensity such as spring and summer or during hot or humid temperatures.
    - Seasonality has been linked to the onset and exacerbation of psychopathology of severe mental illness, and was found to influence the involuntary admission affective disorders and involuntary admission schizophrenia disorders.[45]
  - Impactful events such pandemic, economic downturn or public violence.
  - Lack of mental health legislations that protects greater autonomy and rights of patients are found to influence the use of involuntary admissions
- Two of the Six Core Strategies recommended for the organisation or team include:
  - Top-down directives from management and/or leadership that coercive practices should be reduced.
  - Use of data, e.g. posting the rates of coercive practices in different areas to promote ‘competition’ in efforts to reduce coercive practices.
  - Implementation of the Six Core Strategies were found to be associated with a decrease in rates of seclusion and restraint.[11, 46, 47]

Interventions to reduce restrictive practices

Adults

- A 2024 overview of reviews examining interventions to reduce aggression, conflict and restrictive practices in acute mental health settings synthesised findings from relevant systematic reviews on the following intervention categories.[11]
  - Alternative containment strategies such as equine-assisted therapy and occupational therapy were associated with positive outcomes about the use of seclusion and restraint.
  - Risk assessment was associated with favourable outcomes in most studies.
  - Safewards was associated with favourable outcomes in most studies such as reduction in conflict events and frequencies of seclusion and restraint.
  - Sensory rooms and equipment had mixed findings of positive, negative and no change in practice. Sensory rooms are considered an adjunct intervention and have been associated with distress reduction within a psychiatric inpatient unit, suggesting their success when it is one part of a larger, multi-pronged approach.[48]
  - Six Core Strategy-based interventions were predominately associated with positive findings.
  - Staff training had mixed findings, with studies on empathy and interpersonal communication showing no effect. Those with online resources for preventing aggression and management having a positive effect on reducing mechanical restraint.
- A 2021 systematic mapping review of non-pharmacological interventions to reduce restrictive practice in adult mental health inpatient settings identified 150 unique interventions under the following four categories.[10]
  - **Training interventions** involving staff were most commonly reported and often covered topics such as de-escalation and crisis management.[10]
    - Other strategies involving staff included role modelling through supervision, mentoring or identifying champions.[10]
  - **Alternative approaches** involved using sensory approaches, such as sensory modulation or comfort rooms, to respond to patient distress.[10]
  - **Incident-focused procedures** included retrospective chart audits, debriefing and rapid response.[10]
  - **Organisation-focused procedures** included changing staffing levels, reducing staff-to-patient ratio or staff availability, or changing nursing approaches for example to trauma-informed care or recovery-approach.[10]
  - **Involving service users** was also common and those included having service user representatives in the project team or advisory committees, or co-design of interventions or programs.[10]
- The 2021 systematic mapping review also noted that most studies report a favourable outcome of interventions in reducing restrictive practices, however, there appears to be a publication bias in the literature, with studies showing negative outcomes being less likely to be published.[15] In those that report no change in practices, the interventions are often multifaceted making it challenging to attribute a particular outcome to their use.[10] Among interventions with a single component,

the majority report positive findings for staff training and sensory methods, although contradictory findings are also evident.[10]

  - Staff training was associated with a reduction in the duration, but not the frequency, of physical restraint and adverse effects of physical restraint in one review.[14] When results from RCTs are pooled, no positive effect was evident.[49]
  - In another study, staff training on seclusion and restrictive practices were associated with a change in staff attitude – from doubters and maintainers to transformers.[18]

- Mixed findings for the link between improved attitude and the change in the use of restrictive practices, with some studies reporting no change in practice while others report a positive change.[16]
- Evaluations using an RCT design and with positive outcomes regarding the use of restrictive practices included Safewards, E-learning course, Six Core Strategies and structured risk assessment.[10]
- A 2024 Cochrane review of RCTs on risk assessment of aggressive behaviour in schizophrenia however concluded that there is no clear evidence of the benefits of this intervention in terms of reducing the number of people subjected to seclusion or the length of time spent in seclusion.[50]
- For post-incident review after restraint and as part of multicomponent interventions, a 2019 review examined the effectiveness and reported an association with a reduction in episodes of restraint and the seclusion in comparative studies.[51]
- For interventions involving environmental design features, a review found the following elements to be beneficial:[52]
  - Simple aesthetic improvements such as introducing warm colours or plants.
  - Increased ward space, privacy or natural lighting.
  - Access to garden or sports facility.
  - Availability of private, less crowded and calm spaces.
  - Introduction of sensory or comfort rooms, although it also often accompanied the other interventions such as staff training.
    - However, study findings varied, with some reporting an increase in the use of seclusion or ‘partial restraint’ after the introduction of sensory rooms.
- Trauma-informed care such as Six Core Strategies and the Sanctuary Model were found to be associated with a decrease in rates of seclusion and restraint in mental health settings, with staff reporting a need for training and feeling empathetic and having better understanding of trauma.[46]
- Other reviews further added potential benefits of systematic and regular evaluation of aggressive behaviour, counselling of staff, protocols, calm-down methods such as providing separate rooms for retreat or sensory aids, legal and policy change such as mandating approvals and assessment procedures and standardising monitoring and case reviews, shared decision-making for reducing involuntary admission, and patient and family involvement.[7, 9, 12, 13, 17, 46, 53, 54]

Children

- In children, a 2022 mapping review reported that most evaluations of interventions to reduce restrictive practice among children were of pre-and-post designs. Most reported improved outcomes in terms of reduced frequency, intensity and duration of restrictive practice.[15] Key findings include:

  - Staff training was the most applied intervention. Only a small number of interventions were delivered to both staff and the children.
    - Training components reported included goal setting, retrospective data review, introducing new resources or guidelines or policy change.
  - Most interventions were applied once only. Most evaluations did not report the timeframe for evaluation. Multi-strand interventions were common, such as 'Six Core Strategies'.
- Another 2022 review further examined the methods and strategies for reducing seclusion and restraint in children and found most reviewed interventions demonstrated favourable outcomes. These include:[47]
  - Trauma-informed care, including Six Core Strategies which are child-centred, trauma-informed, and strength-based care.
  - Collaborative Problem Solving and Child and Family Centred Care.
  - Behavioural management programs such as point and level systems, behavioural modification plans, and Modified Positive Behavioural Interventions and Supports.
  - Sensory rooms, mindfulness-based stress reduction and milieu nurses.

Informal coercion

- Compared to formal coercion, relatively few studies examine informal coercion and the factors influencing its use. A 2016 systematic review noted that there were no experimental or quasi-experimental studies examining informal coercion and most available studies comprised cross-sectional studies measuring staff attitudes.[4] It's key findings include:[4]
  - Informal coercion appears to be applied frequently during therapeutic interactions.
  - A perception among staff that informal coercion can be effective and useful in certain circumstances.
  - Perceived importance of continuous reflection on the use of informal coercion as a team and individually.
  - A preference for using possible alternatives.

Method

PubMed and Google searches were conducted on 15 October 2024. A total of 512 peer-reviewed studies (after removing duplicates) returned from PubMed search were screened using the Covidence software. See Appendix 1 for the search strategy and inclusion criteria.

Limitations

Only review studies with a systematic search strategy was included. Studies about recounts of staff experiences of using coercive practices and patient perspectives were excluded.

Evidence table

Note some information in this table has been copied directly from the source material.

Source	Summary
Use of Restraint and Seclusion in Psychiatric Settings[18] Al-Maraira, 2019	**Study type:** Literature review (of mixed study types) **Methods:** • Aim: To review studies on the use of restraint and seclusion in psychiatric settings globally and understand factors influencing their use worldwide. • Inclusion: Identified literature was discussed based on substantive topical themes regarding restraint and seclusion, including factors and staff attitudes. • Exclusion: Not reported (NR) • Dates Searched: NR **Setting:** Psychiatric settings **Results:** 62 articles • Population: Staff members • Intervention: Restraint and seclusion • Outcome: Factors nurses perceive restraint and seclusion as effective ways to control patient aggression and prevent harm. **Conclusion:** Suitable training for mental health staff, an assessment of the risk of disturbed behaviours, and adequate alternative measures are essential factors for enhancing staff attitudes toward reducing use of restraint and seclusion. One argument in favour of restraint and seclusion is that these measures are needed to ensure a safe environment.
Assessment of Nurses' Knowledge, Attitude and Practice Regarding Physical Restraint: A Scoping Review[16] Alsomali, 2024	**Study type**: Literature review **Methods**: • Aim: To determine the depth of nurses' awareness, perception and application of physical restraint, particularly in psychiatric units where it is frequently used. • Inclusion: Must be concerned with nurses' knowledge, attitude and practice. • Exclusion: Chemical restraints, editorials, case reports and letters • Dates Searched: 2017 to 2022 **Setting:** Psychiatric setting **Results: 12 articles** • Population: Nurses • Intervention: Mechanical and physical restraints • Outcome: Nurses' knowledge, attitude and practice **Conclusion:** Nurses had moderate knowledge, attitude and practice regarding physical restraint. The impact of educational interventions on nurses' knowledge, attitudes and practices were inconsistent. Experience, higher education, and continuous training sessions were found to be correlated with

Source	Summary
	better knowledge and more favourable attitudes towards physical restraint.
Evidence synthesis on coercion in mental health: An umbrella review[3] Aragonés-Calleja, 2023	**Study type:** Umbrella review (studies of any design) **Methods:** • Aim: To gather, evaluate and synthesise the existing evidence on mental health coercion provided by the systematic reviews found in the literature. • Inclusion: See population, intervention, comparator, outcome (PICO) • Exclusion: Reviews were excluded if they relied on theoretical sources, were not based on primary empirical studies, lacked a complete list of included studies, or did not detail the search strategy and inclusion criteria. • Dates searched: 29 April 2021 **Setting:** Any mental health setting **Results:** • Population: Comprised of mental healthcare providers, decision-makers and researchers • Intervention: Any type of coercion (formal, informal or perceived) or restriction • Outcome: The effects or consequences of restraint, including perceptions of those who use and to whom restraint is applied, health outcomes, ethical conflicts, policies and interventions to reduce restraint. **Conclusion:** Research shows that certain diagnoses, particularly schizophrenia and bipolar disorder during manic episodes, are associated with increased seclusion and restraint, especially in younger, traumatised, or self-harming children and adolescents. Mental health professionals may struggle with releasing patients from seclusion due to environmental stress and the belief that it enhances security. Effective interventions to reduce restraints include cognitive milieu therapy and patient-centred care, supported by strong leadership and staff training. In cases of forced treatment for anorexia nervosa, involuntary patients tend to experience longer treatment and more complications than voluntary ones. Chemical restraint may be necessary for managing agitation in specific situations. Coercion in mental healthcare is influenced by factors like sex, and staff attitudes often reflect a security-focused perspective. While recognising the need for safety, many professionals acknowledge the negative impact on therapeutic relationships and express a desire to explore alternative interventions before resorting to coercion.
Non-pharmacological interventions to reduce restrictive practices in adult mental health inpatient settings: the COMPARE systematic mapping review[10]	**Study type:** Systematic mapping study and analysis **Methods:** • Aim: to provide a mapping review of non-pharmacological interventions to reduce restrictive practices in adult mental health inpatient settings

Source	Summary
Baker, 2021	• Inclusion: See PICO • Exclusion: Children and child and adolescent mental health services, learning disability and organic conditions, pharmacological only • Dates Searched: 1999 – 2019 **Setting:** Inpatient settings (including acute, forensic and paediatric intensive care unit services) **Results: (221 studies)** • Population: Adult (including older people) mental health • Intervention: Non-pharmacological • Outcome: Reduce restrictive practices **Conclusion:** Behaviour change techniques found in the interventions were most likely to be those that demonstrated statistically significant effects. The most common intervention target was seclusion and restraint reduction. The most common strategy was staff training. Studies on interventions to reduce restrictive practices appear to be diverse and poor. Interventions tend to contain multiple procedures delivered in multiple ways. Behaviour change techniques showed the most promise.
Components of interventions to reduce restrictive practices with children and young people in institutional settings: the Contrast systematic mapping review[55] Baker, 2022	**Study type:** Systematic mapping review (all types, no RCTs) **Methods:** • Aim: To identify, standardise and report the effectiveness of components of interventions that seek to reduce restrictive practices • Inclusion: See PICO • Exclusion: Interventions that solely involved policy change and those that aimed to reduce the use of one type of restrictive practice by replacing it with another • Dates searched: 1989 - 2020 **Setting:** Institutional settings **Results: (121 studies)** • Population: Service staff in institutional settings • Intervention: Nonpharmacological interventions aimed at changing behaviour • Outcome: To reduce restrictive practices **Conclusion:** A variety of behaviour change techniques were identified across different intervention clusters, particularly in mental health settings, with a focus on staff training. Key techniques include providing instructions and restructuring social environments, which have shown promise in promoting behaviour change. Interventions tend to be complex; reporting is inconsistent and robust evaluation data are limited, but some behaviour change techniques seem promising.
Risk factors associated with use of coercive practices in adult mental health inpatients: A systematic review[19]	**Study type:** Systematic review **Methods:**

Source	Summary
Beames, 2022	• Aim: To examine the evidence concerning risk factors associated with use of coercive practices in adults admitted to inpatient psychiatric services • Exclusion: Participants were <18, or >65 years, had an organic diagnosis or brain injury, grey literature, case reports or book chapter • Dates searched: inception to 22nd February 2020 **Settings:** Acute inpatient or psychiatric intensive care **Results: (20 studies)** • Population: Adults • Intervention: Physical, chemical, environmental, mechanical or psychological restraint or seclusion • Outcomes: Risk factors **Conclusion:** Risk factors examined in the studies organised around four categories: patient socio-demographic; patient clinical; staff; and organisational factors. When considering all coercive practices together, the greatest consistency of evidence was within patient socio-demographic and clinical factors, specifically younger age, male sex, ethnic minority status, symptom severity and a mood disorder diagnosis. However, in general, findings were heterogeneous in nature and in most studies the methodological quality was poor.
Patients' and staff members' experiences of restrictive practices in acute mental health in-patient settings: systematic review and thematic synthesis[35] Butterworth, 2022	**Study type:** A systematic review and thematic synthesis (qualitative studies) **Methods:** • Aim: To undertake a systematic review of patients' and staff members' experiences of restrictive practices. • Inclusion: (a) Had the primary aim of exploring patients' or staff members' experiences of restrictive practices in acute psychiatric inpatient settings, (b) adopted a qualitative methodology, e.g. interviews and focus groups, and (c) recruited patients and/or staff members aged 18 years or over who had experience of restrictive practices. • Exclusion: Studies not published in English • Dates searched: Inception to Sept 2021 **Setting:** Acute psychiatric inpatient settings **Results:** Theme 1: The need for restrictive practices: staff members perceived the use of restrictive practices to be 'the last resort' after trying alternatives with the aim of 'avoiding restraint'. However, the most apparent view was that 'restraint is unavoidable'. Theme 2: The psychological impact: Administering restrictive measures was a negative experience for staff, and many described the psychological consequences. Theme 3: Decision-making: The three main factors contributed to staff members' decisions to employ restrictive practices were: 'risk assessment', 'availability of staff' and 'availability of alternatives.

Source	Summary
	Theme 4: Making changes: staff voiced dissatisfaction towards employing restrictive practices and worried about the psychological and physical harm to the patient, others and themselves. Subthemes were identified from staff suggestions on how to improve and reduce restrictive practices: 'somebody to talk to' and 'a safer alternative'. **Conclusion** This review has identified that staff find restrictive practices a negative and distressing experience. Staff acknowledged a need for restrictive practices. Psychological distress was also a dominant theme within staff experiences of restrictive practices. There is a need to provide appropriate reflective and emotional support for staff to manage the effects of restrictive practices.
A systematic review of the frequency, duration, type and effect of involuntary treatment for people with anorexia nervosa, and an analysis of patient characteristics[31] Clausen, 2014	**Study type:** Systematic review (all studies) **Methods:** • Aim: to investigate the characteristics of this group of patients (Involuntary treatment of anorexia nervosa) • Inclusion: Only keywords specified • Exclusion: Single case studies were excluded. • Dates Searched: all studies published up until August 2013 **Setting:** Inpatient setting **Results: (10 studies)** • Population: Anorexia nervosa (no age specification) • Intervention: Involuntary treatment • Outcome: Patient factors **Results and Conclusion:** Longer duration of illness, together with findings of higher psychiatric co-morbidity, more preadmissions, and more incidences of self-harm for involuntary patient groups, suggest that involuntary treatment is not a reaction to the severity of eating disorder symptoms alone, but is most likely a response to the complexity of the patient's situation as a whole.
Restraining good practice: Reviewing evidence of the effects of restraint from the perspective of service users and mental health professionals in the United Kingdom (UK)[38] Cusack, 2016	**Study type: Literature review (mixed methods)** **Methods:** • Aim: Review of available evidence that specifically focuses on the implications of using restraint from the perspective of users of mental health services and professionals delivering such services in the UK • Inclusion: See PICO • Exclusion: NR • Dates searched: Since 2000 **Setting:** Studies undertaken in mental health and/or an associated residential setting **Results: (7 studies)** • Population: Adults • Intervention or exposure: Restraint • Outcome: Professional perspectives of restraint **Conclusion:** At an organisational level, environmental factors were identified as precipitants of aggressive behaviour and an over-zealous

Source	Summary
	use of restraint. In the wider socio-political context, the balance of risk and safety is difficult.
Uncovering Complexities in Reducing Aggression, Conflict and Restrictive Practices in Acute Mental Healthcare Settings: An Overview of Reviews[11] Daguman, 2024	**Study type:** Overview of systematic reviews (all study types) **Methods:** • Aim: To identify nonpharmacological interventions to reduce conflict, aggression and restrictive practices in acute mental health settings, and their effects across different clinical outcomes • Inclusion: Aggregated or ward-level data from general mental health inpatient settings with service users of diverse demographic backgrounds and mental distress were included. As reduction interventions in the field take many forms, there was no limit on the intervention type to be covered, except that they were nonpharmacological interventions in an acute mental healthcare setting evaluated against within- or between-group comparators across several clinical outcomes. • Exclusion: not meet PICO • Dates searched: September 2013 to September 2023 **Setting:** Inpatient acute settings **Results:** • Population: Adolescent, adult and older adult • Intervention: Nonpharmacological interventions • Outcome: Reduce conflict, aggression and restrictive practices **Results and conclusion:** Six Core Strategy–based interventions and Safewards, which combine various reduction interventions, have effectively reduced aggression, conflict and restrictive practices. However, the effectiveness of sensory rooms and staff training remains inconclusive. Risk assessment and alternative containment strategies have evidence of reducing aggression, seclusion and restraints, suggesting professional expertise as a viable support.
Interventions for Reducing Seclusion and Restraint in Mental Health Care for Adults: A Systematic Review[53] Dahm, 2017	**Study type:** A systematic review (of RCTs) **Methods:** • Aim: Interventions for reducing seclusion and restraint in mental health care for adults. • Inclusion: Systematic reviews of high quality randomised controlled trials, prospective controlled trials and interrupted time series (see PICO) • Exclusion: Does not meet PICO • Dates searched: 2012 to 2017 **Setting:** Institutional settings **Results: (21 studies)** • Population: Adult patients with severe mental disorder (18 to 65 years).

Source	Summary
	• Intervention or exposure: All types of interventions meant to reduce compulsory admission or reduce the use of coercion for people in institutional setting. • Outcome: Involuntary treatment, mechanical or physical restraint, involuntary medication. **Results and conclusion:** Systematic evaluation of aggressive behaviour in acute psychiatric wards and counselling towards staff in high security wards may reduce the use of restraint and seclusion.
Influence of nursing staff attitudes and characteristics on the use of coercive measures in acute mental health services-A systematic review[6] Doedens, 2020	**Study type:** Systematic review (mixed study types) **Methods:** • Aim: a) What are the attitudes of psychiatric nurses towards use of coercive measures? And b) Which individual or team nursing staff characteristics are associated with the use of coercive measures and with the attitude of nurses towards coercive measures in acute mental health services? • Inclusion: Studies on the attitude of nursing staff towards coercive measures and/or the influence of nursing staff characteristics on the use of one or more coercive measures. • Exclusion: Studies performed solely in forensic, child, adolescent and geriatric psychiatry, in general hospital wards, emergency departments, nursing homes or with an outpatient patient population. • Dates searched: Inception to 14 March 2019 **Setting:** Inpatient services or psychiatric facilities **Results:** • Population: Nursing staff working with adult mental health • Intervention: Coercive measures • Outcome: Nursing staff attitude and characteristics, staff factors **Results and conclusion:** Nurses' attitudes towards coercive measures have shifted from a therapeutic paradigm focused on treatment to a safety paradigm prioritising protection for staff and patients. This change has led nurses to view coercive measures as necessary for safety, while also expressing a strong desire for less intrusive alternatives, recognising the negative consequences of such measures on patients. Research on the influence of nursing staff characteristics, such as sex and experience, remains inconclusive, although male nurses are often associated with higher rates of coercion. Ultimately, the sense of safety among nurses may be crucial in reducing the reliance on coercive practices in mental health settings.
A Scoping Review on Staff Attitudes towards the Use of Coercion in Mental Healthcare[34] Efkemann, 2024	**Study type:** Scoping review **Methods:** • Aim: (1) What do we know from research about staff attitudes towards coercion in mental healthcare since the Staff Attitude to Coercion Scale (SACS) was developed?

Source	Summary
	• Inclusion: qualitative and quantitative empirical studies that addressed the attitudes of professionals in mental healthcare towards the use of coercive measures • Exclusion: (1) Service users, informal carers, and students as study participants; (2) adolescent or juvenile settings, forensic or prison settings, and elderly care settings; (3) literature reviews, editorials, comments, letters, thesis, and book chapters; (4) studies published before 2008 • Dates Searched: 2008 – 2023 **Setting:** Adult psychiatry setting, and outpatient setting (not online) **Results: (80 studies)** • Population: mental health professionals and staff members • Intervention or exposure: Coercion • Outcome: Staff attitudes **Conclusion:** Studies have shown that staff perceptions of coercion including their attitudes and emotions are linked to various characteristics such as professional background, work experience, age and sex, though the direction of these associations is often unclear. There is evidence of a bidirectional relationship between attitudes towards coercion and its actual use in clinical practice, meaning that attitudes can influence how often coercive measures are applied, while the experience of using coercion can shape professionals' attitudes. This dynamic is crucial for strategies aimed at reducing coercion, as shifting mental health professionals' attitudes is often seen as key to minimising coercive practices. Additionally, staff attitudes are associated with factors like coping strategies, empathy, therapeutic optimism, job satisfaction, and emotional exhaustion. Notably, healthcare professionals show a higher acceptance of coercive measures compared to service users and their relatives.
Preventing and De-escalating Aggressive Behaviour Among Adult Psychiatric Patients: A Systematic Review of the Evidence[7] Gaynes, 2017	**Study type**: Systematic review (studies needed a control group) **Methods:** • Aim: What characteristics, such as race and ethnicity, modify either benefits or harms of the strategies above to prevent or de-escalate aggressive behaviour? • Inclusion: See PICO. Studies were required to have had a control group, potentially allowing for causal inferences to be made. Randomised controlled trials, cluster randomised controlled trials, nonrandomised controlled trials, and cohort studies were eligible • Exclusion: pre-post designs were not eligible • Dates searched: 1 January 1991 to 3 February 2016 **Setting:** Acute care setting **Results: (17 studies)** • Population: Adult psychiatric patients • Interventions: Decreasing use of seclusion and restraint (or both)

Source	Summary
	• Outcome: Reduced use of seclusion or restraint (decreased rate, amount, or duration) • Setting: Acute care settings **Conclusion:** Both risk assessment (involve clinical staff's use of structured assessment of individual patients' risk of becoming actively aggressive) and multimodal interventions (involve a combination of various intervention types, such as enhanced administrative review of patients with high restraint use and staff training in strategies to better manage patients' difficult behaviour; the goal of the programs is to decrease the occurrence of active aggression or use of seclusion or restraint for managing active aggression) may lower use of seclusion and restraint (as indicated by duration of seclusion or restraint and by use of forced treatment, including seclusion and restraint).
Preventing and reducing 'coercion' in mental health services: an international scoping review of English-language studies[8] Gooding, 2020	**Study type:** Scoping review **Methods:** • Aim: What practices, policies and laws help to reduce and prevent coercive practices in mental health settings? What alternative strategies, laws, policies and/or practices exist which could be positioned as 'alternatives' to or replacements for coercive practices? • Inclusion: Related to key words • Exclusion: Not explicit • Dates searched: 1990 to 31 September 2018 **Setting:** Clinical settings **Results: (99 studies)** • Population: Adults with mental health conditions and psychosocial disabilities • Intervention or exposure: Coercion • Outcome: Reduce or remove coercion **Conclusion:** In general terms, the studies that focused on explicit efforts to prevent or reduce coercion reported 'positive' results in almost every instance; that is, coercion was effectively prevented, reduced and even completely discontinued. Prominent practices included 'Six Core Strategies for Restraint Minimisation', 'No Force First' initiatives, advance planning to avoid or better respond to crises, 'open door' policies in hospitals and other facilities, the use of 'crisis respite houses', family-based interventions, measures to release people from communal settings and family homes in which they were deprived of liberty, the use of non-legal advocacy, and so on. There were very few neutral or adverse outcomes caused by such efforts (four studies reported neutral impact, and two reported adverse findings, all of which are discussed later in this article). Overwhelmingly, governments, service providers or community advocates have been effective – to varying degrees – when taking steps to prevent or reduce coercive practices. Hence, the evidence base is compelling, with most studies detailing

Source	Summary
	effective means under existing conditions to prevent or reduce coercive practices.
Post-incident review after restraint in mental health care - a potential for knowledge development, recovery promotion and restraint prevention. A scoping review[51] Hammervold, 2019	**Study type:** Scoping Review **Methods:** • Aim: What are patients' and care providers' experiences of post-incident review (PIR)? • Inclusion: Peer reviewed scientific journals and theses, Nordic languages or English, PIR after incidents including either restraint along or both restraint and seclusion, PIR participants and mental health care providers, • Exclusion: Theoretical articles, books, letters, commentaries, unpublished papers, studies not in English or Nordic, studies exploring PIR after seclusion alone. • Dates searched: September 2016 – May 2018 **Settings:** Institutions **Results:** • Population: PIR participants and mental health care providers • Intervention or exposure: PIR after restraint and/or seclusion • Outcome: Reduction of seclusion and restraint and provider experience **Results and conclusions:** Scientific literature directly addressing PIRs after restraint use is lacking. However, results indicate that PIR may contribute to more professional and ethical practice regarding restraint promotion and the way restraint is executed.
Nurses' and consumers' shared experiences of seclusion and restraint: A qualitative literature review[41] Hawsawi, 2020	**Study type:** Literature review (qualitative) **Methods:** • Aim: To explore consumers', carers and nurses' experiences during seclusion and restraint events while in mental health care through the analysis of qualitative research • Inclusion: See PICO • Exclusion: • Dates searched: from April 2014 to April 2019 **Setting:** Mental health and psychiatric care in inpatient, outpatient and emergency units **Results:** • Population: Adults mental health psychiatric consumer and nurses who used coercive practice • Intervention or exposure: Seclusion, mechanical, manual, and chemical restraint or PRN as forced medication • Outcome: Consumer and nurse shared experiences Shared experience - The restriction of coercive practices disrupted the process of providing care by nurses and receiving it by consumers, affected negatively on the therapeutic relationship and produced physical and psychological trauma

Source	Summary
	(disruption in care, disruption in the therapeutic relationship, shared negative impacts) Nurses' experience - Nurses experienced an internal struggle between feeling coercive practices were unethical, and their professional duty in managing aggression when no less coercive alternatives were available (absence of less coercive alternative). **Conclusion:** The findings demonstrated how consumers and nurses have some shared experiences. This review suggested that due to the shared experiences, consumers and nurses might best benefit through shared solutions.
Clinical Relevance of Informal Coercion in Psychiatric Treatment-A Systematic Review[4] Hotzy, 2016	**Study type:** A systematic review **Methods:** • Aim: Summarise literature on attitudes toward informal coercion, its prevalence, and clinical effects • Inclusion: Original data describing patients' and clinicians' attitudes toward and prevalence rates or clinical effects of informal coercion • Exclusion: Studies focusing on formal or legal coercion • Dates searched: After 2000 **Setting:** in- and outpatient settings. **Results:** • Population: Mental health professionals • Intervention or exposure: Informal coercion • Outcome: Attitudes and experience **Results and conclusions:** Professionals viewed informal coercion as effective and useful in certain situations, particularly when it involved less overt forms of coercion, although they considered it a critical intervention. Alternatives that minimise influence and coercion were generally preferred, yet informal coercion remains a common practice in therapeutic interactions within psychiatric care. Most mental health professionals and a significant portion of psychiatric patients held positive attitudes toward informal coercion, even when they had personal experiences with it. Notably, there is a lack of experimental studies assessing the clinical effects of informal coercion. In conclusion, both professionals and patients exhibited positive attitudes towards informal coercion, especially when it adhered to ethical guidelines emphasising respect for patient autonomy, procedural fairness, and transparency in communication.
Experiences of restrictive interventions in psychiatric health care from the perspectives of patients and health care professionals: Meta-synthesis of qualitative evidence[42] Kim, 2024	**Study type:** Systematic review (qualitative) **Methods:** • Aim: to gain an in-depth understanding of the restrictive intervention (RI) experiences of mental health inpatients and healthcare providers (HCPs) • Inclusion: Physical restraint or seclusion interventions as an RI method

Source	Summary
	• Exclusion: Non-medical personnel or where the intervention used as RIs was chemical restraint • Dates searched: 2010 and 2022 **Setting:** Psychiatric inpatient settings **Results:** • Population: Medical personnel • Intervention or exposure: Physical restraint or seclusion interventions as an RI method • Outcome: Experiences among HCP **Results and conclusions:** Two main subthemes influencing the implementation of restrictive interventions (RIs) are the competency of HCPs and systems. Effective interactions with patients require strong communication skills, a positive attitude, and the ability to provide accurate information. Additionally, thorough assessment of each patient's condition is crucial, including monitoring before, during, and after RIs to determine their necessity, alongside compassionate care that ensures comfort and dignity. The ward environment also plays a vital role, emphasising safety, clear protocols, and debriefing opportunities post-RIs, with a patient-friendly atmosphere being important to patients, while HCPs point out the need for adequate staffing to facilitate effective care. Together, these factors highlight that enhancing HCP competency and improving the ward environment can address patients' unmet needs, ultimately leading to better quality of care and safer practices in the use of RIs.
Psychiatric nursing staffs' attitudes towards the use of containment methods in psychiatric inpatient care: An integrative review[39] Laukkanen, 2019	**Study type:** Integrative review (mixed methods) **Methods:** • Aim: To identify, analyse, and synthesise the available research on psychiatric nursing staffs' attitudes towards containment methods in inpatient psychiatric care. • Inclusion: See PICO • Exclusion: Did not concern psychiatric nursing staff's attitudes towards containment methods • Dates searched: 1958–2018 **Setting:** Inpatient care **Results:** • Population: Nursing staff • Intervention or exposure: Any containment methods • Outcome: Attitudes **Conclusion:** Psychiatric nursing staff's attitudes toward containment methods vary globally. While coercion is often accepted, there is a growing trend of negative attitudes towards its use, reflecting a shift in psychiatric care practices. However, changes in attitudes among nursing staff have been minimal over the past decades. To effectively reduce reliance on containment methods, it is crucial to focus on changing these attitudes, highlighting the need for further research into nursing staff perspectives.

Source	Summary
Use of coercive measures in mental health practice and its impact on outcome: a critical review[20] Luciano, 2014	**Study type:** Literature review (of quantitative studies) **Methods:** • Aim: To review the existing literature on the predictors of the use of coercive measures and on the relationship between the use of coercive measures and patients' outcome. • Inclusion: Physical restraint, mechanical restraint, seclusion, forced medication, involuntary hospital admission, coercive measures, coercive treatments and perceived coercion • Exclusion: Reviews, case reports, editorials, letters to the editor and other non-research papers were also removed. • Dates searched: January 2007 to November 2013 **Setting:** Adult psychiatric settings **Results:** • Population: Adult mental health population • Intervention or exposure: Physical restraint, mechanical restraint, seclusion, forced medication, involuntary hospital admission, coercive measures, coercive treatments and perceived coercion • Outcome: Factors or predictors **Results and conclusion:** Three key factors predict the use of coercive measures in psychiatric settings: 1. Patients' characteristics: Factors such as male sex, diagnoses of psychotic disorders or substance abuse, a history of trauma, and low satisfaction with prior treatments are significant predictors. 2. Staff composition: Coercion is less common when there are fewer nurses and more junior doctors on staff. Junior doctors, being more accessible and providing consistent care, can effectively address patient complaints and needs, leading to lower rates of physical aggression and absconding. 3. Ward-related factors: Environmental aspects, such as locked wards and urban locations, may indicate a higher prevalence of complex issues among patients, including drug use and social challenges.
Coercion and Compulsory Treatment in Anorexia Nervosa: a Systematic Review on Legal and Ethical Issues[32] Minuti, 2023	**Study type:** Systematic review **Methods:** • Aim: Summarise attitude among mental health specialists and patients with anorexia nervosa to perform compulsory treatment or to respect patient autonomy • Inclusion: Survey investigating physician attitudes and propensity to compulsory treatment in patients suffering from anorexia nervosa • Exclusion: Case reports, book chapters, reviews, letters to editor and commentaries, diagnosis of bulimia or eating disorder • Dates Searched: Inception to 11 June 2023 **Results:** • Population: Physicians working with anorexia nervosa patients

Source	Summary
	• Intervention or exposure: Compulsory treatment • Outcome: Staff attitudes **Result and conclusion:** Although psychiatrists are in favour of protective compulsory treatment in the mentally ill, support if weaker in anorexia nervosa vs other mental illness in general or other severe and persistent mental disorders, i.e. schizophrenia and depression.
Rates and risk factors of coercive measure use in inpatient child and adolescent mental health services: a systematic review and narrative synthesis[27] Moell, 2024	**Study type:** Systematic review and narrative syntheses (quantitative studies) **Methods:** • Aim: Rates and risk factors for mechanical restraint, physical restraint, seclusion, pharmacological restraint and forced tube feeding in inpatient child and adolescent mental health services • Inclusion: see PICO • Exclusion: not explicit • Dates Searched: Jan 1, 2010, to Jan 10, 2024 **Setting:** Inpatient mental health services **Results:** 20 studies reported risk factors or variables • Population: child and adolescent mental health • Intervention or exposure: Mechanical restraint, physical restraint, seclusion, pharmacological restraint and forced tube feeding • Outcome: Risk factors **Conclusion:** This systematic review suggests that coercive measure use and risk factors in inpatient child and adolescent mental health services vary substantially across settings. Units treating eating disorders had the highest rates of coercive measure use, and younger age, male sex, ethnicity or race other than White (especially Black or African American), aggression, repeated admissions, and longer length of stay were the most consistent risk factors.
Chemical restraint: A qualitative synthesis review of adult service user and staff experiences in mental health settings[36] Muir-Cochrane, 2021	**Study type:** Systematic review and thematic synthesis (of qualitative studies) **Methods:** • Aim: to synthesise qualitative studies, published between 1996 and 2020, reporting on mental health service users' and staff's experiences of chemical restraint. • Inclusion: Qualitative peer-reviewed research, be published in English, and capture adult service user and/or staff experiences of chemical restraint. • Exclusion: Did not meet the inclusion criteria • Dates searched: 1 January 1996 to 16 March 2020 **Setting:** Inpatient and outpatient mental health settings and emergency departments **Results: (17 articles)** • Population: Mental health service users' and staff's experiences • Intervention or exposure: Chemical restraint

Source	Summary
	• Outcome: Experiences **Results and conclusion:** Three analytic themes were identified as synthesising the experiences of service users and staff. These were 1. "Unjustified versus justified,": Staff reported chemical restraint as a justified response to service users' sudden and unreasonable behaviour. A key justification for the use of chemical restraint was one of safety, that is, maintaining the safety of service users, visitors, and staff by quickly suppressing violence and aggression. 2. "Violence versus necessity,": Despite recognition that chemical restraint was not an ideal response, and should only be used as a last resort, staff overwhelmingly experienced a lack of choice with regard to chemical restraint. 3. "Reflecting back: Positives and negatives." Nurses and other staff similarly viewed chemical restraint as a negative experience for service users, yet in reflecting highlighted positive outcomes. In conclusion, staff generally viewed it as a justified response to "behaviours of concern" (particularly violence and aggression).
Safewards: An integrative review of the literature within inpatient and forensic mental health units[12] Mullen, 2022	**Study type:** Mixed-methods integrative literature review **Methods:** • Aim: What are the current perspectives from mental health nurses about adopting and implementing the Safewards model and its ten interventions? What is the current evidence around the effectiveness of Safewards? • Inclusion: Peer-reviewed qualitative and quantitative studies, as well as discussion papers. Articles needed to address the central topic of the Safewards model of care within adult inpatient mental health or forensic mental health units • Exclusion: Not in English and does not meet the PICO • Dates searched: 1 January 2014 to 31 December 2020 **Setting:** inpatient and forensic mental health units **Results: (19 articles)** • Population: Adult mental health patients • Intervention or exposure: Safewards • Outcome: Nurses' perspective (staff acceptability) and intervention effectiveness **Results and conclusion:** The results highlighted that Safewards can be effective in reducing containment and conflict within inpatient mental health and forensic mental health units, although this outcome varied across the literature. This review also revealed the limitations of fidelity measures and the importance of involving staff in the implementation.

Source	Summary
Physical restraint of children and adolescents in mental health inpatient services: A systematic review and narrative synthesis[30] Nielson, 2021	**Study type:** A systematic review and narrative synthesis (quantitative studies) **Methods:** • Aim: To systematically locate, appraise, analyse and synthesise literature pertaining to the physical restraint of children and adolescents in inpatient mental healthcare services. Specifically: Which children and adolescents are being physically restrained and why children and adolescents are being physically restrained • Inclusion: Availability in English, and reporting on physical restraint use with children and adolescents admitted to mental health services • Exclusion: If physical restraint was not independently reported from seclusion (a restrictive intervention which falls beyond the remit of the current study) • Dates Searched: No restriction **Setting:** Inpatient mental healthcare **Results: (16 studies)** • Population: Children and adolescents • Intervention/exposure: Physical restraint • Outcome: Patient characteristic and factors **Conclusion:** Which children and adolescents are being physically restrained? Age: younger children Sex: males (however, females have a greater risk of multiple restraint) Diagnosis: children and adolescents with a diagnosed developmental disorder, psychotic disorder, and externalising or internalising disorder (multiple comorbid diagnoses further increase likelihood) History: children and adolescents with multiple previous inpatient admissions, history of trauma, self-harm, and aggression Why children and adolescents are being physically restrained? Risky behaviours: agitation, aggression, threats and staff-directed assault, self-harm, opposition, disinhibition and absconsion. Admission status: emergency and voluntary admission status more likely to experience restraint. Timing: incidents more prevalent at the start of the week, in afternoons or evenings and during longer admission periods; however, incidents generally decrease across an admission period, sometimes after a spike following an initial 'honeymoon' period; incidents can 'cluster', whereby one physical restraint can spark others. Staff influences: lack of familiarity with procedures and cultural backgrounds can lead to miscommunication; implementation thresholds can increase over time to only the most dangerous behaviours.
Design features that reduce the use of seclusion and restraint in mental health facilities: a rapid systematic review[52] Oostermeijer, 2021	**Study type:** Rapid review **Methods:** • Aim: To provide an overview of the current research literature of architectural design features of mental health facilities that can help reduce the use of seclusion and restraint.

Source	Summary
	• Inclusion: See PICO • Exclusion: Did not meet PICO • Dates Searched: January 2010 and 28 August 2019 **Setting:** Mental health inpatient facilities **Results: (35 studies)** • Population: Adult and child and adolescent • Intervention or exposure: Seclusion and physical restraint. • Outcome: Physical design features (environment) **Results and conclusion:** The findings revealed several overarching themes in design efforts to reduce the use of seclusion and restraint: a beneficial physical environment; sensory and/or comfort rooms; and private and uncrowded/calm spaces. Overall, we found preliminary evidence that the physical environment can have a role in supporting the reduction in the use of seclusion and restraint. This is likely to be achieved through a multilayered approach, founded on good design features and building towards specific design features which may reduce occurrences of seclusion and restraint.
A systematic review of interventions to reduce mechanical restraint in adult mental health inpatient settings[17] Pedersen, 2024	**Study type:** Systematic review **Methods:** • Aim: To examine evaluated evidence-based interventions that seek to reduce the incidence of and/or time in mechanical restraint in adult mental health inpatient settings. • Inclusion: (I) peer-reviewed primary research literature, (II) studies describing evaluated interventions that seek to reduce the incidence of and/or time in mechanical restraint (MR) (or seclusion/MR reported simultaneously) in adult mental health inpatient settings and (III) studies available in full-text and English. Included study outcomes for assessing the effectiveness of the interventions were the incidence of and/or time spent in the practice. • Exclusion: The main exclusion criteria were the following: (I) studies that, in addition to adult settings, also included findings for children or adolescents, but which were not reported independently and (II) studies that, in addition to the practice of interest, also included findings for other types of restraint (or restrictive practices more generally), but which were not reported independently. • Dates searched: 1999 and 2023 **Setting:** Adult mental health inpatient settings **Results:** • Population: Adults • Intervention or exposure: Methods to reduce the use of mechanical restraint • Outcome: Reduced mechanical restraint **Conclusion:** Using content analysis, we grouped interventions into four categories: (I) calm-down methods, (II) staff resources, (III) legal and policy changes and (IV) changing staff culture. Interventions

Source	Summary
	to reduce mechanical restraint in adult mental health inpatient settings have shown some promise. Evidence suggests that a range of interventions can reduce the incidence of and/or time in mechanical restraint. However, controlled trials were lacking, and consensus was lacking across studies.
Methods and Strategies for Reducing Seclusion and Restraint in Child and Adolescent Psychiatric Inpatient Care[47] Perers, 2022	**Study type:** Systematic review **Methods:** • Aim: To summarise the last 10 years of literature regarding methods and strategies currently used for reducing seclusions and restraints in child and adolescent psychiatric inpatient units • Inclusion: Published articles that described methods or strategies aimed at reducing restraint or seclusion utilisation in child and adolescent psychiatric inpatient units, with full text articles in English. • Exclusion: The exclusion criteria were unpublished material, articles focusing on adult psychiatric units, and articles about other settings than child and adolescent psychiatric inpatient units, e.g. residential facilities. We also excluded articles that focused solely on pharmacological approaches to aggressive behaviour. Using an integrative approach, studies were not otherwise excluded due to methodology, e.g. experimental or non-experimental • Dates searched: May 2010 to May 2020 **Setting:** Child and adult psychiatric inpatient units **Results:** 18 studies were included • Population: Adults and children in inpatient psychiatric units • Intervention or exposure: Trauma-Informed Care (TIC), Six Core Strategies, Child and Family Centred Care (CFCC), Collaborative and Proactive Solutions (CPS), Strength-Based Care, Modified Positive Behavioural Interventions and Supports (M-PBIS), Behavioural Modification Program (BMP), Autism Spectrum Disorder Care Pathway (ASD-CP), Dialectical Behaviour Therapy (DBT), Sensory rooms, Mindfulness-Based Stress Reduction Training (MBSR) of staff, Milieu Nurse-Client Shift Assignments • Outcome: reducing seclusion and restraint **Results and conclusion:** The combination of Six Core Strategies and CPS, alongside CFCC or strength-based care, demonstrated significant effectiveness in reducing restraint use in psychiatric units. These approaches received strong leadership support and targeted restraint reduction, recognising psychiatric violence as a complex issue influenced by patient-staff interactions and unit culture. Benefits included increased job satisfaction, reduced staff turnover, enhanced patient and family satisfaction, and greater creativity within the unit. CPS alone achieved a 99% reduction in restraints for children aged 3-14 and a 97% reduction in a separate study involving children aged 4-12. Other studies also reported significant

Source	Summary
	decreases in restraints through behavioural management programs. Notably, two trauma-informed initiatives eliminated mechanical restraints. Overall, this review emphasises the importance of prioritising the reduction of coercive measures in psychiatric care.
Development and evaluation of a de-escalation training intervention in adult acute and forensic units: the EDITION systematic review and feasibility trial[56] Price, 2024	**Study type:** Systematic review, followed by an uncontrolled pre-post feasibility trial of the intervention **Methods:** • Aim: Objectives were to: (1) qualitatively investigate de-escalation and identify barriers and facilitators to use across the range of adult acute and forensic mental health inpatient settings; (2) co-produce with relevant stakeholders an intervention to enhance de-escalation across these settings; (3) evaluate the intervention's preliminary effect on rates of conflict, e.g. violence, self-harm, and containment, e.g. seclusion and physical restraint, and understand barriers and facilitators to intervention effects. • Dates Searched: systematic review (studies published since the last search in 2014) **Setting:** Adult mental health inpatient settings (acute and forensic) **Results:** • Population: Inpatients, clinical staff, managers, carers, relatives and training staff in the target settings. • Intervention or exposure: Enhancing de-escalation techniques in adult acute and forensic units: Development and evaluation of an evidence-based training intervention (EDITION) interventions included de-escalation training, two novel models of reflective practice, post-incident debriefing and feedback on clinical practice, collaborative prescribing and ward rounds, practice changes around admission, shift handovers and the social and physical environment, and sensory modulation and support planning to reduce patient distress. • Outcome: Feasibility, training outcomes, safety and clinical outcomes. **Results and conclusion:** Completion rates of the proposed primary outcome were very good at 68% overall (excluding remote data collection), which increased to 76% (excluding remote data collection) in the post-intervention period. Secondary outcomes had high completion rates for both staff and patient respondents. Regression analyses indicated that reductions in conflict and containment were both predicted by study phase (pre, embedding, post intervention). There were no adverse events or serious adverse events related to the intervention. This study highlights development of staff de-escalation training protocols may influence reduced rates of conflict and containment strategies

Source	Summary
Protocols to reduce seclusion in inpatient mental health units[13] Quinn, 2024	**Study type**: Systematic review **Methods:** • Aim: To determine the effectiveness of protocols to reduce seclusion on process outcomes, e.g. seclusion, restraint, patient outcomes, e.g. injuries, aggressive incidents, satisfaction, and staff outcomes, e.g. injuries, satisfaction. • Inclusion: Protocols, guidance documents, policies, multicomponent strategies recommended or already used as alternatives to seclusion. • Exclusion: Protocols designed for, or implemented in, institutionalised (e.g., adults ≥65 years old in nursing homes or long-term care facilities) or incarcerated populations • Dates Searched: from inception to 6 September 2022 **Setting:** Inpatient mental health units **Results:** 48 reports were included. • Population: Adult patients • Intervention or exposure: Protocols to reduce seclusion • Outcome: Seclusion restraint, patient injuries, aggressive incidences, satisfaction, and staff outcomes including injuries and satisfaction **Results and conclusion:** 48 reports addressed 5 approaches to reduce seclusion: hospital/unit restructuring (N=4), staff education/training (N=3), sensory modulation rooms (N=7), risk assessment and management protocols (N=7), and comprehensive/mixed interventions (N=22; N=6 without empirical data). The relationship between the various protocols and outcomes was mixed. Psychiatric units that implement architecturally positive designs, sensory rooms, the Brøset Violence Checklist, and various multicomponent comprehensive interventions may reduce seclusion events, though our certainty in these findings is low due to studies' methodological limitations. Future research and practice may benefit from standardised reporting of process and outcome measures and analyses that account for confounders**.**
An integrative review exploring decision-making factors influencing mental health nurses in the use of restraint[37] Riahi, 2016	**Study type:** Integrative review **Methods:** • Aim: To explore what influences mental health nurses' decision-making in the use of restraint. • Inclusion: Studies which explicitly included manual and or mechanical and seclusion as interventions • Exclusion: Studies which only explored seclusion were not included • Dates searched: published up to March 2014 **Setting:** Hospital setting **Results:** • Population: Mental health nurses • Intervention or exposure: Restraint • Outcome: Eight emerging themes were identified: 'safety for all', 'restraint as a necessary intervention', 'restraint as a last

Source	Summary
	resort', 'role conflict', 'maintaining control', 'staff composition', 'knowledge and perception of patient behaviours', and 'psychological impact'. **Conclusion:** Research to further understand the experience and actualisation of 'last resort' in the use of restraint and to provide strategies to prevent restraint use in mental health settings are needed.
Reducing coercion in mental healthcare[57] Sashidharan, 2019	**Study type:** Narrative literature review **Methods:** • Aim: To examine the extent and nature of coercive practices in mental healthcare and to consider the ethical, human rights challenges facing the current clinical practices in this area. We consider the epidemiology of coercion in mental health and appraise the efficacy of attempts to reduce coercion and make specific recommendations for making mental healthcare less coercive and more consensual • Inclusion: Articles relating to mental health and treatment, published from Jan 1980 to May 2018. • Exclusion: Reviews of non-psychiatric population, children under 16 years, and those pertaining exclusively to people with dementia were excluded. • Dates searched: January 1980 to May 2018 **Setting:** Mental healthcare **Results:** • Population: Mental health nurses • Intervention or exposure: Restraint • Outcome: Perceptions Eight emerging themes were identified: 'safety for all', 'restraint as a necessary intervention', 'restraint as a last resort', 'role conflict', 'maintaining control', 'staff composition', 'knowledge and perception of patient behaviours', and 'psychological impact'. 'Last resort' appears to be the mantra of acceptable restraint use. **Conclusion:** Research to further understand the experience and actualisation of 'last resort' in the use of restraint and to provide strategies to prevent restraint use in mental health settings are needed.
A scoping review of trauma informed approaches in acute, crisis, emergency, and residential mental health care[46] Saunders, 2023	**Study type:** A scoping review **Methods:** • Aim: This scoping review maps the trauma-informed care approaches delivered in these settings and reports related service user and staff experiences and attitudes, staff wellbeing, and service user outcomes. • Inclusion: Studies which focused on service users and staff, care delivered within acute, crisis, emergency settings or residential mental health settings, acute and crisis settings, trauma informed care interventions, studies reporting any positive or adverse outcomes and qualitative, quantitative and mixed methods study designs. • Exclusion: Studies that did not meet the above criteria.

Source	Summary
	• Dates searched: 24 February 2022 to 10 March 2022 **Setting:** Acute, crisis, emergency and residential mental health services **Results:** 31 studies were included. • Population: Service users, or people who support or care for service users • Intervention or exposure: Trauma informed care interventions. Programmes aiming to reduce restrictive practices in psychiatric settings were not included without explicit reference to trauma-informed care within the programme. • Outcome: mapping of trauma-informed care approaches, service user and staff outcomes **Results and Conclusion:** Authors identified few trials, limiting inferences that can be drawn from the findings. The Six Core Strategies (n=7) and the Sanctuary Model (n=6) were the most commonly reported trauma-informed care approaches. Rates of restraint and seclusion reportedly decreased. Some service users reported feeling trusted and cared for, while staff reported feeling empathy for service users and having a greater understanding of trauma. Staff reported needing training to deliver trauma-informed care effectively.
Using interventions to reduce seclusion and mechanical restraint use in adult psychiatric units: an integrative review[9] VÃkiparta, 2019	**Study type:** An integrative review **Methods:** • Aim: The aim of this integrative review was to describe interventions aimed at reducing seclusion and mechanical restraint use in adult psychiatric inpatient units and their possible outcomes • Inclusion: Patients or nursing staff of any adult psychiatric inpatient setting • Exclusion: All other settings, such as child and adolescent psychiatric or learning disabilities as well as studies which included both child and youth psychiatric units. Studies which evaluated effects on seclusion and mechanical restraint as a single outcome statistic. • Dates searched: 2008 to 2017 **Setting:** Adult psychiatric units **Results:** 28 studies were included. • Population: Patients or nursing staff of any adult psychiatric inpatient setting • Interventions to proactively address seclusion were environmental interventions, staff training, treatment planning, use of information and risk assessment. Interventions to respond to seclusion risk were patient involvement, family involvement, meaningful activities, sensory modulation and interventions to manage patient agitation. • Outcome: Outcomes of interventions aimed at reducing seclusion were related to interventions to proactively

Source	Summary
	address seclusion, to respond to seclusion and combined interventions. **Results and conclusions:** Staff training, treatment planning, use of information and risk assessment, environmental interventions to address seclusion lowered the use and duration of seclusion. Sensory modulation and intervention management to manage patient agitation, lowered incidents of seclusion in some cases after implementation of sensory modulation or interventions to manage patient agitation. Outcomes related to both seclusion and mechanical restraint reduction interventions were varied, with several interventions resulting in both reduced and unchanged or increased use. Outcomes were also reported for combinations of several interventions in the form of reduction programmes for both seclusion and mechanical restraint.
Risk assessment for aggressive behaviour in schizophrenia[50] Välimäki, 2024	**Study type:** Systematic review **Methods:** • Aim: To assess the effects of structured aggression or violence risk assessment methods for people with schizophrenia or schizophrenia-like illnesses. • Inclusion: Randomised controlled trials comparing structured risk assessment methods added to standard professional care with standard professional care for the evaluation of aggressive or violent behaviour among people with schizophrenia where at least 50% of participants had schizophrenia. Studies with structured risk assessment and standard professional care, studies that examined outcomes relative to specific behaviours, use of coercive measures, specific behaviours, global state, acceptance of treatment, satisfaction with treatment, service use. • Dates searched: February 2021 (presumably up to this date) **Setting:** Inpatient settings **Results:** Four studies were included in the study. • Population: Adults with schizophrenia or schizophrenia-like illnesses • Intervention or exposure: To participate in structured aggression or violence risk assessment methods • Comparison: Standard treatment • Outcome: Reducing aggression and seclusion **Results and conclusions:** There is no clear evidence that structured risk assessment is better at reducing numbers of people that are subjected to coercive measures (seclusion room), or the length of time people are placed in a seclusion room; however, these results were based on low-certainty evidence.

Source	Summary
Nurses' attitudes towards the use of physical restraint in psychiatric care: A systematic review of qualitative and quantitative studies[40] Wong, 2022	**Study type:** Systematic review of qualitative and quantitative studies **Methods:** • Aim: To examine nurses' attitudes towards the use of physical restraint in psychiatric care and the factors influencing these attitudes • Inclusion: Qualitative and quantitative studies, that examine nurses' attitudes towards the use of physical restraint and factors influencing their attitudes on the application of physical restraint to psychiatric inpatients in hospital settings. • Exclusion: Studies with mixed staff groups, mixed restraint methods and mixed health care settings. • Dates searched: 2000 – 2021. **Setting:** Psychiatric settings **Results:** 10 studies were included. • Population: Nurses • Intervention or exposure: Any type of restraint (physical, mechanical, containment measures, manual restraint). • Outcome: Nurse attitudes Five themes encapsulate nurses' attitudes towards physical restraint: Emotional responses, moral conflicts, ensuring safety for all, a necessary nursing intervention, a last resort. Three themes were identified for factors influencing attitudes: contextual demands, level of knowledge, alternatives to restraint. **Conclusion:** Nurses' attitudes were marked by negative feelings and moral conflict towards the use of physical restraint. However, nurses applied physical restraint as an ordinary nursing intervention. Educational interventions and the leadership role may facilitate the change of current practice to a restraint-free environment.
The Use of Physical Restraint in Norwegian Adult Psychiatric Hospitals[21] Wynn, 2015	**Study type:** Literature review **Methods:** • Aim: The purpose of this review was to search and appraise peer-reviewed scientific publications documenting the use of physical restraint in Norwegian hospital-based adult psychiatric services. • Inclusion: Articles published in peer-reviewed journals carried out with data from Norway and involving the use of physical restraint (including physical holding by staff) within adult psychiatric hospitals were considered for inclusion • Exclusion: Articles not specifically mentioning restraint or that examined coercion only as a general concept were excluded. Studies only involving municipal services, nursing homes, and services for the intellectually disabled were excluded. Studies without data from Norway were excluded, as were studies that did not include primary empirical data, i.e. literature reviews. • Dates searched: Date not specified; outlines search was run up to September 2015

Source	Summary
	Setting: Adult psychiatric hospitals **Results:** 28 studies included. • Population: Adult patients within psychiatric hospitals in Norway • Intervention or exposure: Physical restraint • Outcome: Factors **Results and conclusions:** • Factors that influenced rates, especially patient-related factors, such as patients' sex, age, ethnicity, diagnoses, level of aggression, legal status, and duration of stay • Studies described the importance of organisational or staff-related factors on rates of restraint, including staff-patient ratios, ward size, and staff education levels. • Studies suggested that staff believed that restraint was carried out correctly, although there were some differences in opinion between different groups of staff. There were also some differences in opinion as to when physical restraint should be used.
Staff Training Reduces the Use of Physical Restraint in Mental Health Service, Evidence-based Reflection for China.[49] Ye 2018	**Study type:** Systematic review with meta-analysis **Methods:** • Aim: To synthesise the evidence regarding the reduction of physical restraint, and to seek some practical recommendations based on the current situation in China. • Inclusion: Population: patients with mental illness. Intervention: relevant training for staff. Comparison: staff without specific training. Outcome: the use of physical restraint. The answerable question is: Does staff training reduce the use of physical restraint in mental health service? • Dates Searched: June 2013 to May 2017 **Setting:** Mental health services **Results:** Eight studies (four randomised controlled trials (RCTs) and four quasi-experimental studies) were included. • Outcome: The outcome of meta-analysis suggested staff training reduced the duration (IV = − 0.88; 95% CIs = − 1.65 to − 0.10; p = 0.03) of physical restraint, but there were no statistical change in the frequency of physical restraint (RR, 0.74; 95% CIs = 0.43 to 1.28; p = 0.28). Noticeably, the result of pooled estimates from 3 RCTs suggested staff training had no effects on the incidence of physical restraint. (RR, 1.01; 95% CIs = 0.45 to 2.24; Z = 0.02; p = 0.99). **Conclusion:** Staff training was an effective measure to minimise the duration and adverse effects of physical restraint.
Legislation and other approaches to reduce seclusion and restraint in adult inpatient mental health services: a systematic mapping review[58] Gray, date unknown	**Study type:** Systematic mapping study **Methods:** • Aim: Identify legislative approaches and interventions focused on eliminating (or reducing) rates of seclusion and restraint. Examine the association between legislation and rates of seclusion and restraint.

Source	Summary
	• Inclusion: See PICO • Exclusion: Did not meet PICO • Dates searched: 2000 to present **Setting:** Mental Health setting **Results:** • Population: Adults • Intervention: Reducing restraint and seclusion • Outcomes: Rates of seclusion and restraint **Results and conclusion:** There was no clear evidence that legislative change alone impacts rates of restrictive practice in adult inpatient mental health services. We found a large number of pragmatic multi-component interventions. Most other interventions and approaches studied seemed to be extremely effective at reducing rates of restrictive practices in adult inpatient mental health services.
Beyond patient characteristics: a narrative review of contextual factors influencing involuntary admissions in mental health care[44] Aluh, 2023	**Study type:** Systematic mapping study **Methods:** • Aim: Identify legislative approaches and interventions focused on eliminating (or reducing) rates of seclusion and restraint. Examine the association between legislation and rates of seclusion and restraint. • Inclusion: See PICO • Exclusion: Did not meet PICO • Dates searched: 2000 to present **Setting:** Mental health setting **Results:** • Population: Adults • Intervention: Reducing restraint and seclusion • Outcomes: Rates of seclusion and restraint **Results and conclusion:** There was no clear evidence that legislative change alone impacts rates of restrictive practice in adult inpatient mental health services. We found a large number of pragmatic multi-component interventions. Most other interventions and approaches studied seemed to be extremely effective at reducing rates of restrictive practices in adult inpatient mental health services.

Methods

PubMed search terms

("Mental Disorders"[MeSH Terms] OR "mental health"[Title/Abstract] OR "mental ill*"[Title/Abstract] OR "mental disorder*"[Title/Abstract] OR "psychiat*"[Title/Abstract] OR "psychological"[Title/Abstract]) AND ("restraint, physical"[MeSH Terms] OR "restraint"[Title/Abstract] OR "seclusion"[Title/Abstract] OR "coercive"[Title/Abstract] OR “coercion”[Title/Abstract]) AND 2014/01/01:3000/12/31[Date - Publication] AND (("review"[Publication Type] OR "systematic review"[Filter]) AND "english"[Language])

514 hits on 15 October 2024

Google search terms

Google and Google Scholar was searched using a combination of the following terms: mental health, restraint, seclusion or coercive practice. Only the first five pages of the search results were screened.

Inclusion and exclusion criteria

Peer reviewed sources	
• Published in English • Published since 2014 • **P**opulation: Healthcare professionals working with people with lived experience of mental health issues • **I**ntervention or **e**xposure: use of restrictive and coercive practices • Comparison: Nil • **O**utcomes: Description or evaluation of influencing factors, such as patient or staff characteristics, physical and policy environment etc, relating to the use of restrictive and coercive practices by the health professionals • **S**etting: All healthcare settings • Study types: – Review studies with systematic search strategy and methods – Grey literature such as guidelines and consensus statements	• Not in English • Published prior to 2014 • Studies that do not meet PICOS criteria, including: • Studies on restrictive practices on people without lived experience of mental health issues, i.e. older people with dementia, people with intellectual disability or autism • Letters, comments, editorials, study protocols, conference abstracts

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