International Journal of Mental Health Nursing

WILEY

International Journal of Mental Health Nursing

REVIEW ARTICLE OPEN ACCESS

Mental Health Nurses' Enforcement of Involuntary Care in Inpatient Settings: A Meta-Ethnography

Luke Molloy[1] | Paul Beckett[2] | Sherphard Chidarikire[3] | Natalie Cutler[4] | Sophie Isobel[2] | Gillian Murphy[5] | Joel Zugai[1]

[1]University of Wollongong, Wollongong, Australia | [2]University of Sydney, Sydney, Australia | [3]University of Newcastle, Newcastle, Australia | [4]University of Technology Sydney, Sydney, Australia | [5]Western Sydney University, Penrith, Australia

Correspondence: Luke Molloy (lmolloy@uow.edu.au)

Received: 6 December 2024 | **Accepted:** 28 March 2025

Funding: The authors received no specific funding for this work.

Keywords: coercion | involuntary care | mental health nursing | restrictive practices | trauma-informed care

ABSTRACT

Mental health nursing practices within inpatient care aim to empower consumers to lead their treatment and recovery. However, involuntary care may be justified for safety reasons. This practice can be traumatising and harmful. Our review explores the enforcement of involuntary care by mental health nurses in inpatient settings utilising meta-ethnography. Searches of articles published over a 10-year period (2014–2024) were conducted in Cumulative Index of Nursing and Allied Health Literature (CINAHL) and MEDLINE. The searches aimed to identify rich qualitative data on this area of mental health nursing practice. Six articles were selected for inclusion and a reciprocal translation synthesis was undertaken. Three key metaphors emerged: 'a necessary evil', 'the dilemmas of enforcement' and 'perturbed practice'. These metaphors illustrate the complex and often conflicting emotions nurses experience when enforcing involuntary care. Nurses viewed the enforcement of involuntary care as a necessary but difficult practice, justified by the belief that it ultimately benefits the person's safety and well-being. Despite justifying involuntary care as necessary, nurses faced ethical dilemmas balancing patient autonomy, safety and dignity. Enforcing involuntary care caused significant emotional distress for nurses, who experienced discomfort, guilt and moral conflict, questioning their actions and the impact on their relationships with consumers. The findings highlight the importance of minimising restrictive practices and developing supportive frameworks that prioritise patient dignity and autonomy while ensuring safety.

1 | Introduction

It is widely accepted that the best approach to mental health inpatient care involves minimal restrictive practices, enabling consumers to be the lead decision-makers of their care, treatment and recovery goals (Beckett et al. 2017; Fletcher et al. 2019). However, the compulsion of inpatient care is often justified by ethical and/or legal mandates (Szmukler 2020). Involuntary care is typically used when experiences of distress or illness severely interfere with a person's autonomy or pose an acute threat to safety (Szmukler 2020; Rienecke et al. 2023). For example, during experiences of psychosis, life-threatening anorexia nervosa or suicidal behaviour (Plahouras et al. 2020; Rienecke et al. 2023). The temporary suspension of autonomy is usually justified on the presumption that long-term wellbeing can only be secured by such means (Zugai 2023). Despite arguable defensibility, involuntary care may hazard safety and dignity, with consumers reporting punitive and humiliating experiences (Hawsawi et al. 2020). The enforcement of involuntary treatment by mental health nurses in inpatient settings is often a critical element of practice within inpatient mental health services, albeit a complex area (Wormdahl et al. 2020).

Using restrictive or coercive practices and interventions to enforce involuntary care is common in mental health nursing care (Lawrence et al. 2024; Muir-Cochrane et al. 2018) despite international calls for elimination (Belayneh et al. 2023; Bennetts et al. 2024; World Health Organization and United Nations 2023). Restrictive practice is 'an overarching term used to refer to the broader context of confinement, including the ward environment, dynamics, atmosphere and routines, which include restrictive interventions' (Lawrence et al. 2024, 1). Restrictive interventions are 'measures which intend to control or contain patients beyond the daily norms of their hospital environment' (Hui 2017, 1). Restrictive practices and interventions include hospital units with locked doors (Mann et al. 2021), physical, mechanical and chemical restraint such as compulsory medications. The use of seclusion is also a restrictive practice involving the use of quiet rooms or controlled areas (Belayneh et al. 2023; Mann et al. 2021; Hui 2017). Interventions such as one to one individual care which consumers may perceive as restrictive, should also be considered under the umbrella of restrictive practices and interventions (Mann et al. 2021).

Restrictive practices are known to be physically and emotionally traumatising for consumers (Doedens et al. 2019) and staff in mental health inpatient units (Muir-Cochrane et al. 2018). The implications of consumers exposed to restrictive practices include worsening of distress, traumatisation, physical health concerns and on occasions, death (Lawrence et al. 2024). Consumers may also experience several differing forms of restrictive practices (Belayneh et al. 2023) concurrently, such as compulsory medications and mechanical restraint (Mann et al. 2021), further compounding their distress and trauma.

2 | Aims

Alongside widespread recognition of the importance of minimising restrictive practices in mental health inpatient care and growing movements calling for their elimination, it is critical to explore what is known about mental health nurses' experiences of enforcing care. Understanding how nurses navigate this challenging area of practice can inform necessary service reforms and guide the development of more human rights based and effective approaches to involuntary care in mental health settings. Therefore, the aim of this review was to explore mental health nurses' enforcement of involuntary care in inpatient settings.

3 | Methods

A meta-ethnography was undertaken, guided by ideas of social analysis focused on contextualising multi-sited social phenomena (Marcus 1999). Existing qualitative research was used to develop insights into the 'shared world of a set of subjects' (Marcus 1999, 7), in this case, mental health nurses. A review protocol was registered with the Open Science Framework (osf.io/XXXX).

Meta-ethnography is an inductive interpretative method of knowledge synthesis (Noblit and Hare 1988). This established method interprets qualitative research studies to reveal the analogies between them (Noblit and Hare 1988). The seven steps of Noblit and Hare's method are: getting started (step 1), deciding what is relevant to the initial area of interest (step 2), reading (and rereading) studies to discover their main concepts (step 3), determining how the studies relate to one another (step 4), then translating the studies into one another (step 5), synthesising translations (step 6) and communicating the synthesis (step 7) (Noblit and Hare 1988). The reporting of this review has been guided by the eMERGe reporting guidelines for meta-ethnography (France et al. 2019). Step 1 is described in the aims and rationale for the review.

The reviewers sought qualitative data that could derive an understanding of nurses' perceptions of being the enforcer of involuntary care within acute inpatient mental health units for step 2. This included research studies published in English over a 10-year period (2014–2024). We excluded studies that did not contain qualitative data. We searched two bibliographic databases which contain mental health care-related research: MEDLINE and CINAHL. These databases were chosen as they provide comprehensive coverage of qualitative studies in nursing (Wright et al. 2015; Justesen et al. 2021). Titles and abstracts were purposively searched for the words: Involuntary or compulsory or coercive or mandatory or forced orunwilling or compelled andenforc* or impos* or coerc* or compel* or mandat* or impos* or requir* or pressur* and Mental health nurs* or psychiatric nurs*. LM and PB screened the titles and abstracts of the search results, followed by the full text of potential suitable studies. This search identified six qualitative research studies that were sufficiently similar in their findings to undertake a reciprocal translation synthesis (Sattar et al. 2021). This approach concentrated on iteratively translating the findings from one study to another, aiming to develop interpretative metaphors that best represent the connections across the studies, in alignment with the research objectives (Noblit and Hare 1988; Sattar et al. 2021). A flow diagram of the search is presented in Figure 1 and an overview of the studies included is provided in Table 1 (organised chronologically by year of data collection). For step 3, the studies that met the inclusion criteria were read and reread to develop an understanding of their key metaphors (LM). Data were extracted from the studies utilising NVivio 12 plus. This included participant's quotes as first-order concepts and the second-order concepts of the researcher's interpretations of their findings. The reader's observations were documented, and these led to the development of the review's third-order constructs and the interpretation of this meta-ethnography. A conceptual map of the process covering steps 4, 5 and 6 of the meta-ethnography is presented in Figure 2.

The National Institute for Health and Care Excellence (2012) critical appraisal guidelines for qualitative research were used to evaluate the methodological rigour of the studies included in the meta-ethnography. One of three assessments is made to indicate whether all (++), some (+) or few or none (−) of the quality appraisal criteria were fulfilled. The results of this critical appraisal are included in Table 1.

4 | Results

The review identified six studies that had rich qualitative data that provided insights in mental health nurses' enforcement of involuntary care in inpatient settings (see Table 1). Within these studies, three interpretative metaphors were identified that connected the studies and were relevant to the review's aims and

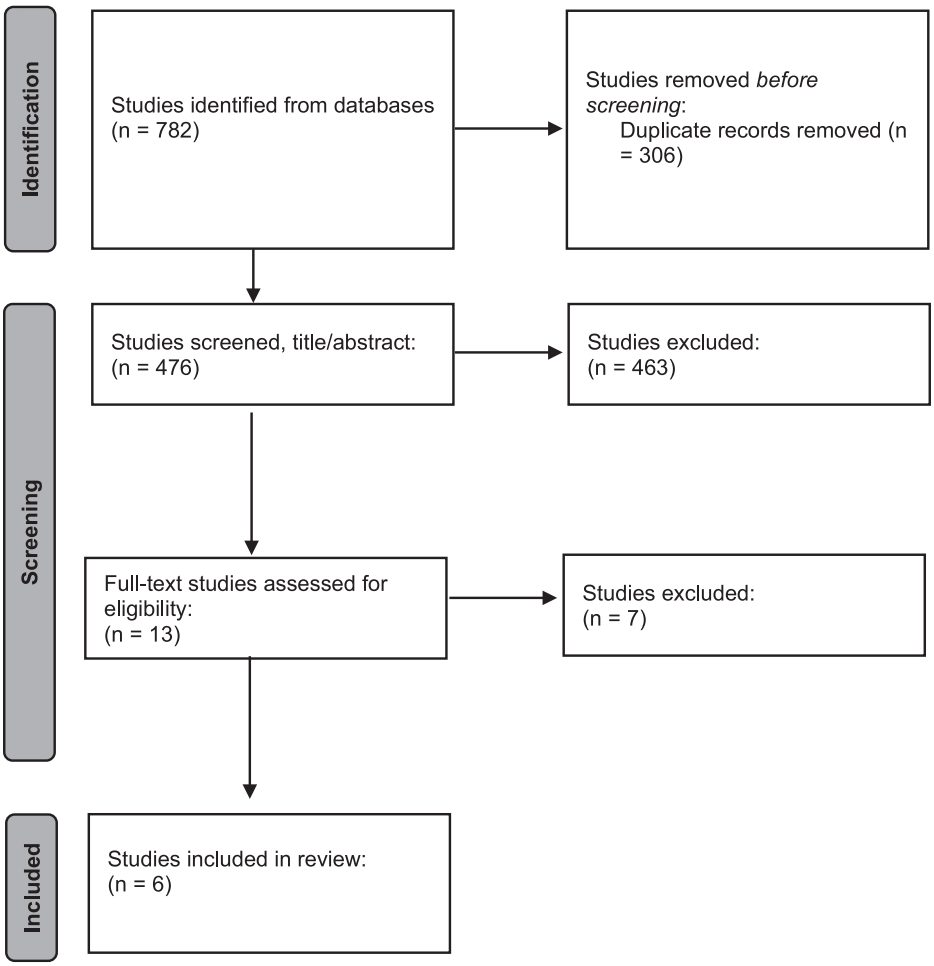

FIGURE 1 | PRISMA Flow diagram (Tricco et al. 2018).

rationale. Figure 1 shows how these third-order constructs link to the second-order concepts in the included studies. The metaphors identified were as follows:

1. A necessary evil: Mental health nurses viewed the enforcement of involuntary care as a necessary but difficult practice, justified by the belief that it ultimately benefits the person's safety and wellbeing, despite the ethical and emotional challenges involved.
2. The Dilemmas of Enforcement: Despite justifying involuntary care as necessary, mental health nurses faced ethical dilemmas in balancing patient autonomy, safety and dignity, often reflecting on their actions and advocating for ethical practices within coercive environments.
3. Perturbed practice: Enforcing involuntary care caused significant emotional distress for mental health nurses, who experienced discomfort, guilt and moral conflict, questioning their actions and the impact on their relationships with consumers.

4.1 | A Necessary Evil

Mental health nurses consider the enforcing of involuntary care as a 'necessary evil' (Andersson et al. 2020, 741; Bailey et al. 2021, 406) inherent to their practice. Across the studies, mental health nurses describe the need to reconcile their enforcement of care through coercive practice with their professional obligations.

> The patient should know that I do all this because the patient needs this care and not because I want to use my power.
>
> (Manderius et al. 2023, 7)

> [P]rofessional power is used by nurses to persuade the patient to accept interventions s/he disagrees with. As nurses, they "know what's best"...
>
> (Andersson et al. 2020, 748)

Nurses justify their role in involuntary care by emphasising the intended positive outcomes for the person receiving care. Involuntary care was enforced because ultimately it was hoped to be beneficial for the person.

> Forcing someone to do something... is not right... but if it's for their own good, then it's fine'
>
> (Aragones-Calleja and Sanchez-Martinez 2023, 988)

In accordance with mental health legislation, nurses understood that individuals receiving involuntary care were considered

TABLE 1 | Descriptive details of included studies and NICE quality scores.

Author	Year	Country	Methodology/ methods	Aim	Sample	NICE quality score
Chambers et al.	2015	United Kingdom	Qualitative design Focus groups	Explore nurses' experiences caring for distressed and/or disturbed service users.	12 nurses	++
Jansen et al.	2020	Norway	Qualitative design Interviews	To describe moral distress in acute inpatient settings.	16 nurses	++
Bailey et al.	2021	United Kingdom	Phenomenology Interviews	To understand how nurses perceived touch during physical restraint.	14 nurses	++
Andersson et al.	2020	Sweden	Qualitative, inductive design interviews	Describe nurses' experiences of informal coercion.	10 nurses	++
Calleja and Sánchez-Martínez	2023	Spain	Phenomenology Interviews	Explore the experiences, knowledge and perception of coercion among nurses.	28 nurses	++
Manderius et al.	2023	Sweden	Qualitative design interviews	Explore nurses' ethical considerations and other factors influencing coercive measures.	12 nurses	++

to have impaired judgement. In these circumstances mental health nursing was characterised as a paternalistic practice, underscored by the belief that enforcing involuntary care, though unpleasant, was necessary to protect the person's wellbeing.

> In that situation, something has to be done. It's like the car is going to roll over someone. All you're thinking of is just holding them from doing any more of that. So, I think of it as if it were a child going into a road, because you'd hold them, wouldn't you?'
>
> (Bailey et al. 2021, 406)

> They can't determine things and make decisions when they are in such a mental state. You must lead them to the right track
>
> (Andersson et al. 2020, 747)

Enforcing involuntary care was also a means to ensure the safety of both the person and other people in the inpatient environment. In this context, mental health nurses reluctantly engaged in practices which they recognised as potentially 'damaging' (Chambers et al. 2015, 292), rationalising their use as a last resort to prevent harm. Feeling compelled to act decisively to prevent danger they resorted to coercive measures only after non-coercive approaches had proven ineffective.

> Although they spoke of not wanting to restrain, they defended their actions on safety grounds for service users and staff, and they believed they had no other choice
>
> (Bailey et al. 2021, 405).

Despite being framed in terms of an emergency response, the enforcement of involuntary care was also understood to have potential benefits in the longer term. Nurses believed that the recipient might appreciate and understand the necessity of coercion once they experienced improvements in their mental state.

> Coercive measures are used for the benefit of the patient and to break various difficult conditions.... It's hard, but the patients may thank us afterwards because it's about alleviating suffering
>
> (Manderius et al. 2023, 5).

> Nurses also experience that 'talking to the patient when he has recovered might strengthen the relationship' (P10), as the patient can understand that the coercion was helpful and 'actually thank us for intervening'
>
> (Andersson et al. 2020, 749).

4.2 | The Dilemmas of Enforcement

Despite what seemed to be a clear sense of certainty around the justification for enforcing involuntary care, nurses experienced

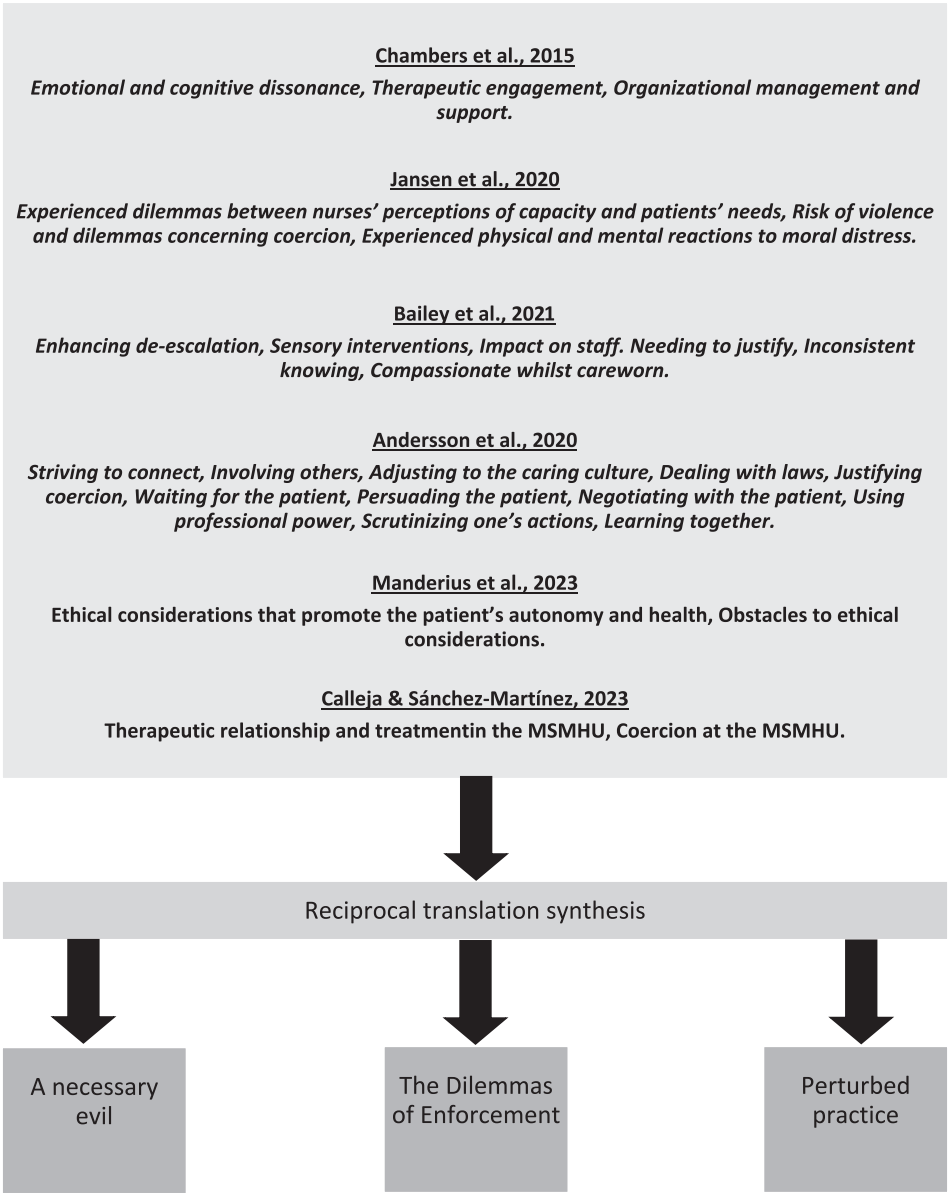

FIGURE 2 | Conceptual map of the reciprocal translation synthesis.

dilemmas associated with balancing complex ethics, autonomy, issues of safety and attempts to maintain dignity. Mental health nurses needed to reflect on the ethical tensions of involuntary care in enacting their roles, particularly when using practices such as physical restraint, seclusion and administering medications against a person's will.

> It emerged during the interviews that the participants felt that a high level of ethical awareness was required in order to provide psychiatric care
>
> (Manderius et al. 2023, 8)

Mental health nurses practiced in physical environments that were designed to enforce care and inpatient units in particular were inherently coercive, in which nurses and consumers had limited control.

> They have a restricted autonomy just by being here. They are locked in. We close the door behind them
>
> (Andersson et al. 2020, 746).

In inpatient care, mental health nurses are only one component within a broader, coercive system of treatment. Within these systems, the professional autonomy of mental health nurses is restricted, with nurses' identifying subordination to psychiatry as a major influence on their practice and the enforcement of involuntary care. This hierarchy, its expectations of compliance and the impact this had on decision-making, compounded the ethical quandaries for mental health nurses.

> Loyalty and adherence to instructions were emphasised: 'It is difficult to execute coercive

> [treatment measures] you do not agree with, but of course we do it... for me this is a moral dilemma'
>
> (Jansen et al. 2020, 1320).

With greater clinical experience, nurses develop more confidence to advocate and articulate concerns when faced with dilemmas in enforcing involuntary care.

> Some expressed that earlier in their professional careers, when less experienced, they valued duty higher than their own ethical convictions, in, for example, enforcing a doctor's compulsory prescriptions even though the participants did not consider it fair or in the patient's best interests.
>
> (Manderius et al. 2023, 7)

Paradoxically, enforcing care is viewed as an essential component of ethical mental health nursing. Despite this, mental health nurses face ethical dilemmas when using physical restraint, particularly in situations involving personal hygiene. In such situations, using coercive practices to limit a person's autonomy were deemed necessary to preserve that person's dignity.

> Andy expressed his concerns about the dilemma of using physical restraint in caring for and maintaining the dignity of the service user, who was highly distressed and incontinent of faeces: You can't leave a man in his own faeces. So, you clean them up and that's good, clean nursing. But it doesn't feel like that. You know you're doing it for the best... The other choice is to leave him floundering around the floor in his poo.
>
> (Bailey et al. 2021, 406).

As nurses plan and implement coercive practices, they also use their ethical awareness within the structuring and planning of interventions to support ethical principles of care. They approach enforcing care with a belief that they need to preserve the person's dignity and promote self-determination as much as possible within the limits of the situation.

> Ensuring that service users are treated with dignity and respect was part of the process of demonstrating that service users were valued as individuals according to nurses
>
> (Chambers et al. 2015, 292).

> Not exposing the patient's body more than necessary when giving forced injections, or only allowing female staff to be present in a coercive procedure if the patient had previously been mistreated by men, were examples of situations where the patient's vulnerability was considered
>
> (Manderius et al. 2023, 6).

4.3 | Perturbed Practice

The meta-ethnography highlights an emotional impact on mental health nurses as they enforce involuntary care, despite their beliefs about the rationale for coercive practices and ethical awareness related to their use. Mental health nurses expressed feelings of discomfort, guilt and shame related to their actions, prompting them to question their practice and highlighting dissonance in their understanding of their professional role.

> [W]hy did I do this? Even if they in a way agreed they should have been entitled to refuse?
>
> (Andersson et al. 2020, 749).

> It's not to be taken lightly when you put your hands on somebody. It's wrong really. It's like the opposite of therapeutic touch
>
> (Bailey et al. 2021, 405).

Nurses also experience moral distress in the use of coercive interventions, which contradicts their understanding of their therapeutic role, leading them to believe that what they were doing had the potential to damage the relationship they had with the person.

The use of coercive practices and their potential to cause harm also creates a moral tension for nurses and challenges their identity and understanding of their therapeutic role. They find it difficult to integrate the use of coercive practice while simultaneously trying to develop and sustain a therapeutic relationship.

> It's not a comfortable thing to do to the patient or yourself because it ruins the relationship
>
> (Chambers et al. 2015, 292).

This emotional impact was further exacerbated through the internal conflict that nurses experience as participants in the enforcing of involuntary care, particularly when they had doubts about its necessity. This again raised concerns and confusion about the impact of their actions on the relationship with the person.

> Although I deep inside perhaps understand that she had to have that medicine, it is abusive towards her when so many people enter... at times I find that some cases are doubtful
>
> (Jansen et al. 2020, 1320).

Nurses' distress at enforcing involuntary care is compounded by the need to navigate the conflicting obligations between professional duty and personal values. While recognising the necessity of the care for the person's well-being, they also struggle with feelings of moral ambiguity and a desire to practise in alignment with their own beliefs and values, rather than simply performing their role within the systems of coercion.

> [I]t felt more right to act on their own conscience than on the mere duty to implement a coercive measure that they felt could not be justified, especially if the purpose of the coercive measure did not correspond to a fair and humane treatment
>
> (Manderius et al. 2023, 6).

5 | Discussion

This study provides insight into the experiences of mental health nurses (MHNs) in enforcing mental health care. The enforcement of care in mental health contexts is different to any other area of health care. The findings of the review highlight the complex ethical, emotional and systemic challenges that enforced care creates for mental health nurses. Central to the findings is the concept of involuntary care as a 'necessary evil'. This finding is congruent with the extant literature, which suggests MHNs accept involuntary treatment in a hospital setting as necessary for managing acute mental health crises and ensuring the safety of consumers and staff (Aragones-Calleja and Sanchez-Martinez 2023; Hem et al. 2018; Paradis-Gagne et al. 2021). However, the experience of enforcing such treatment raises significant ethical tensions in the context of awareness of the harms that it can cause. Many MHNs grapple with the moral discomfort of enacting practices that may be seen to prevent some harm, yet simultaneously risk causing other forms of harm to consumers, particularly those with histories of trauma (Paradis-Gagne et al. 2021). Enforced treatment and hospitalisation are distressing for anyone but can replicate dynamics of disempowerment and helplessness for people who have experienced trauma, leading to re-traumatisation (Hennessy et al. 2023). It is also important to note that legitimising harmful actions based on a person's 'best interest' can further compound trauma (McKeown et al. 2019).

According to Hem et al. (2018), an ethical challenge arises when a person is unsure of the most appropriate actions to take, experiences discomfort or feels uncertain about how to respond to a situation. Despite the legitimisation of coercive practices through legal and professional mechanisms, MHNs often experience moral distress, characterised by emotional burdens of guilt, shame and discomfort when using restrictive interventions, which can then lead to emotional blunting or burnout (Aragones-Calleja and Sanchez-Martinez 2022; Hem et al. 2018). This internal conflict reflects a recurring theme around the ethical dissonance between nurses' professional obligations and the values of mental health nursing, which espouse the principles of person-centred, trauma-informed and recovery-oriented practice (Wilson et al. 2021).

There is a critical tension between nurses' roles in supporting consumers' autonomy and safety while simultaneously enforcing care (De Ruysscher et al. 2020). MHNs are required to uphold the values of autonomy and safety in acute care settings despite a prioritisation of risk minimisation (Aragones-Calleja and Sanchez-Martinez 2023). This balance is made more challenging by biomedical approaches to mental health care, where nurses may be required to enact medical directives (Traynor et al. 2010) and there is reliance upon pharmacological interventions. While the use of medication is often necessary in acute mental health settings, MHNs report feeling conflicted when consumers are opposed to taking medication or they observe that treatments may cause harm, further intensifying ethical dilemmas (Hem et al. 2018; Paradis-Gagne et al. 2021). Systemic factors compound this ethical complexity. Nurses work within hierarchical environments where their professional autonomy is limited by institutional protocols, often leading to resentment towards their lack of input into treatment decisions (Delgado et al. 2020; Salberg et al. 2022). Power dynamics are central to MHNs experiences within the multidisciplinary team where their professional power to enforce care is contradicted by their disempowerment in resisting systemic coercion (Haines et al. 2018). Duality is also apparent in their dual roles as protectors and enforcers, as well as conflicts between humanistic ideals and the 'harsh reality of their daily work' (Björkdahl et al. 2010, 511).

While some nurses prioritise adherence to organisational obligations and institutional protocols, others advocate for a more nuanced approach that integrates consumers' dignity and autonomy into care. This divergence in approaches highlights the ongoing need for reflective practice and heightened ethical sensitivity among mental health nurses, particularly in contexts where coercive measures are perceived as unavoidable yet ethically fraught. However, increasing nurses' ethical sensitivity may also amplify their experiences of moral distress. To address this, clinical supervision is recommended to foster reflective practice, helping to build resilience when confronting moral dissonance (Delgado et al. 2020). While supporting nurses to perform their roles with empathy and reducing vicarious traumatisation is important, it is questionable whether nurses need to learn to work effectively despite experiencing moral distress, or whether mental health institutions and systems need to reconcile coercive approaches to care that are endorsed in the name of safety. That is, by taking a critical eye to coercive practices which are deemed *safe* from the perspective of institutions and systems, but are deemed unsafe by, and for, consumers. It has been argued that nurses are carrying the moral load that more correctly sits with the institution and system (Jansen et al. 2022). While practices such as clinical supervision and reflective practice are helpful, there is also a need for overt acknowledgement of the pressures upon staff, including nurses, within existing mental health systems and the limitations of current models of care (Isobel 2021). This acknowledgement logically leads to consideration of what alternative approaches to care are possible that prioritise consumer autonomy and dignity, while still ensuring safe and therapeutic care is available to those who require it.

There are strong messages of power apparent throughout the findings. MHNs are seemingly aware of their professional power to influence care, their personal power to support individuals and the disempowerment both they and consumers experience within involuntary treatment. MHNs are known to also hold transformational power in mental health care (Gabrielsson et al. 2020). Thus, it is apparent that MHNs face choices between resisting or aligning with the system; however, such a simplistic perspective risks negating the efforts of the many MHNs working within inpatient settings who do what they can to deliver care in compassionate, trauma informed and least restrictive ways despite organisational pressures (Solomon et al. 2021; Wilson et al. 2024). It is likely that within coercive care there

is much unseen negotiation and kindness delivered by MHNs. However, it is also acknowledged that interpretations of events can differ tremendously, with people who receive coercive care reporting kindness in the context of coercion to simply further oxymoronic tensions (McKeown et al. 2019).

Beyond the experience of nurses and people who receive 'care', the voices of carers and families are also important. While there are clear and important arguments against involuntary care, there are also many carers and families struggling to support their loved ones who are experiencing mental health crises (Carbonell et al. 2020; Norvoll et al. 2018). This is reflective of an under-resourced system that relies upon 'necessary evils' to ensure basic care. Coercive care takes many forms across mental health services, including through short-term responses to overwhelming distress or agitation in inpatient settings, as well as community treatment orders and sustained restrictive practices (Haines et al. 2024). Many of the nurses in the included studies are reflecting on inpatient, acute responses but it is also important to know whether nurses view sustained restrictive practices such as recurring CTOs as restricting people's freedoms for their 'own good' or whether these forms of coercive care are more about meeting the expectations of society, families and communities, and a lack of funding for supportive and preventative services. When considering the wider context of coercive practices, removing coercion is ideal but can only happen with significant investment in other services and settings (Aluh et al. 2023; Molodynski et al. 2014).

6 | Conclusion

This meta-ethnographical study, undertaken by mental health nurses, raises critical issues for the profession of mental health nursing. The identified issues are not about the role of individual nurses in managing involuntary care and what efforts they should take to cope better, self-care better or build their personal resilience, but rather about the responsibility of institutions to restructure care towards non-coercive models that prioritise autonomy, dignity, and ethical integrity. Moving towards such models would improve the well-being of consumers and staff and relieve nurses of the moral weight of enforcing restrictive practices, more appropriately shifting it back to the systems and policies that shape mental health care. This would align to transformational moves towards human rights based mental health care, while also resonating with trauma informed and recovery-oriented approaches. This study highlights that as long as coercive care remains a 'necessary evil' in the delivery of mental health care, the rights and humanity of consumers and staff remain compromised.

7 | Relevance for Practice

As our findings show, enforcing involuntary treatment is an uncomfortable topic for nurses and a source of ethical tension. Nurses, as frontline providers of care in mental health care, occupy a trusted role in delivering therapeutic care. However, they often find themselves in a predicament as they try and navigate the delicate balance of safeguarding the well-being of the patient, protecting the rights of others and upholding human rights principles (Hawsawi et al. 2020). Nurses are often tasked with implementing restrictive practices and thus hold significant responsibility in ensuring that these practices are applied in a manner consistent with professional and ethical standards, legal frameworks and human rights obligations.

Endorsement of restrictive practice among the nursing profession is declining, with increasing calls that it should be minimised or, where possible, eliminated (Daguman et al. 2024; Havilla et al. 2024). This is in part possible due to mental health professionals and policymakers embracing the concepts of recovery-oriented practice. Recovery principles such as offering hope and optimism require autonomy and self-determination (Solomon et al. 2021). Nurses, and other mental health professionals, must continue to be educated and trained to recognise when enforcing involuntary care may violate a person's rights and explore alternative approaches that minimise coercion. The integration of trauma-informed care, which acknowledges the past experiences of those receiving care, is crucial in reducing the need for restrictive interventions and supporting the recovery and empowerment of people and building a more empathetic mental health service. Nurses are uniquely positioned to lead this change by leveraging their therapeutic relationships with patients and fostering environments that promote safety and trust without the need for coercive measures.

Author Contributions

L.M.: conceptualisation, methodology, data curation, investigation, formal analysis, visualisation, writing. P.B.: conceptualisation, investigation, validation, writing. N.C., S.I., G.M., J.Z: conceptualisation, validation, writing.

Acknowledgements

Open access publishing facilitated by University of Wollongong, as part of the Wiley - University of Wollongong agreement via the Council of Australian University Librarians.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

References

Aluh, D. O., J. U. Onu, O. Ayilara, et al. 2023. "A Qualitative Integrative Analysis of Service Users' and Service Providers' Perspectives on Ways to Reduce Coercion in Mental Health Care." *Social Psychiatry and Psychiatric Epidemiology* 58: 1353–1363.

Andersson, U., J. Fathollahi, and L. W. Gustin. 2020. "Nurses' Experiences of Informal Coercion on Adult Psychiatric Wards." *Nursing Ethics* 27: 741–753.

Aragones-Calleja, M., and V. Sanchez-Martinez. 2022. "Current State of Research on Coercion in Mental Health: Umbrella Review Protocol." *Journal of Psychosocial Nursing and Mental Health Services* 60: 49–55.

Aragones-Calleja, M., and V. Sanchez-Martinez. 2023. "Experience of Coercion Among Nursing Professionals in a Medium-Stay Mental

Health Unit: A Qualitative Study in Spain." *Journal of Psychiatric and Mental Health Nursing* 30: 983–993.

Bailey, J., R. F. Nawaz, and D. Jackson. 2021. "Acute Mental Health Nurses' Experience of Forcibly Touching Service Users During Physical Restraint." *International Journal of Mental Health Nursing* 30: 401–412.

Beckett, P., D. Holmes, M. Phipps, D. Patton, and L. Molloy. 2017. "Trauma-Informed Care and Practice: Practice Improvement Strategies in an Inpatient Mental Health Ward." *Journal of Psychosocial Nursing and Mental Health Services* 55: 34–38.

Belayneh, Z., J. Chavulak, D. A. Lee, M. Petrakia, and T. P. Haines. 2023. "Prevalence and Viability of Restrictive Care Practice Use (Physical Restraint, Seclusion and Chemical Restraint) in Adult Mental Health Inpatient Settings: A Systematic Review and Meta-Analysis." *Journal of Clinical Nursing* 33: 1256–1281.

Bennetts, S. L., G. Pepin, S. Moylan, et al. 2024. "Co-Designing Restrictive Practice Elimination: A Systems Thinking Approach With Mental Health Service Users and Practitioners in Rural/Regional Australia." *International Journal of Mental Health Nursing* 33: 1564–1574.

Björkdahl, A., T. Palmstierna, and G. Hansebo. 2010. "The Bulldozer and the Ballet Dancer: Aspects of Nurses' Caring Approaches in Acute Psychiatric Intensive Care." *Journal of Psychiatric and Mental Health Nursing* 17: 510–518.

Carbonell, A., J. J. Navarro-Pérez, and M. V. Mestre. 2020. "Challenges and Barriers in Mental Healthcare Systems and Their Impact on the Family: A Systematic Integrative Review." *Health & Social Care in the Community* 28: 1366–1379.

Chambers, M., X. Kantaris, V. Guise, and M. Välimäki. 2015. "Managing and Caring for Distressed and Disturbed Service Users: The Thoughts and Feelings Experienced by a Sample of English Mental Health Nurses." *Journal of Psychiatric and Mental Health Nursing* 22: 289–297.

Daguman, E. I., M. Hutchinson, and R. Lakeman. 2024. "Uncovering Complexities in Reducing Aggression, Conflict and Restrictive Practices in Acute Mental Healthcare Settings: An Overview of Reviews." *International Journal of Mental Health Nursing* 33: 1666–1686.

De Ruysscher, C., S. Vandevelde, P. Tomlinson, and S. Vanheule. 2020. "A Qualitative Exploration of Service Users' and Staff Members' Perspectives on the Roles of Inpatient Settings in Mental Health Recovery." *International Journal of Mental Health Systems* 14: 15.

Delgado, C., M. Roche, J. Fethney, and K. Foster. 2020. "Workplace Resilience and Emotional Labour of Australian Mental Health Nurses: Results of a National Survey." *International Journal of Mental Health Nursing* 29: 35–46.

Doedens, P., J. Vermeulen, L. Boyette, C. Latour, and L. Haan. 2019. "Influence of Nursing Staff Attitudes and Characteristics on the Use of Coercive Measures in Acute Mental Health Services – A Systematic Review." *Journal of Psychiatric and Mental Health Nursing* 27: 446–459.

Fletcher, J., B. Hamilton, S. Kinner, et al. 2019. "Working Towards Least Restrictive Environments in Acute Mental Health Wards in the Context of Locked Door Policy and Practice." *International Journal of Mental Health Nursing* 28: 538–550.

France, E. F., M. Cunningham, N. Ring, et al. 2019. "Improving Reporting of Meta-Ethnography: The eMERGe Reporting Guidance." *BMC Medical Research Methodology* 19: 25.

Gabrielsson, S., H. Tuvesson, L. Wiklund Gustin, and H. Jormfeldt. 2020. "Positioning Psychiatric and Mental Health Nursing as a Transformative Force in Health Care." *Issues in Mental Health Nursing* 41: 976–984.

Haines, A., E. Perkins, E. A. Evans, and R. McCabe. 2018. "Multidisciplinary Team Functioning and Decision Making Within Forensic Mental Health." *Mental Health Review Journal* 23: 185–196.

Haines, S., R. Stanton, C. Anderson, and A. Welch. 2024. "Ethical Challenges for Nurses Delivering Coercive Interventions in Community Mental Health Settings: A Scoping Review." *International Journal of Mental Health Nursing* 33: 750–759.

Havilla, S., F. K. Alanazi, B. Boon, D. Patton, Y. C. Ho, and L. Molloy. 2024. "Exploring the Impact of a Multilevel Intervention Focused on Reducing the Practices of Seclusion and Restraint in Acute Mental Health Units in an Australian Mental Health Service." *International Journal of Mental Health Nursing* 33: 442–451.

Hawsawi, T., T. Power, J. Zugai, and D. Jackson. 2020. "Nurses' and Consumers' Shared Experiences of Seclusion and Restraint: A Qualitative Literature Review." *International Journal of Mental Health Nursing* 29: 831–845.

Hem, M. H., E. Gjerberg, T. L. Husum, and R. Pedersen. 2018. "Ethical Challenges When Using Coercion in Mental Healthcare: A Systematic Literature Review." *Nursing Ethics* 25: 92–110.

Hennessy, B., A. Hunter, and A. Grealish. 2023. "A Qualitative Synthesis of Patients' Experiences of Re-Traumatization in Acute Mental Health Inpatient Settings." *Journal of Psychiatric and Mental Health Nursing* 30: 398–434.

Hui, A. 2017. *Least Restrictive Practices: An Evaluation of Patient Experiences*. University of Nottingham. https://nottingham-repository.worktribe.com/output/900983.

Isobel, S. 2021. "Is Trauma-Informed Care Possible in the Current Public Mental Health System?" *Australasian Psychiatry* 29: 607–610.

Jansen, T. L., M. H. Hem, L. J. Danbolt, and I. Hanssen. 2022. "Coping With Moral Distress on Acute Psychiatric Wards: A Qualitative Study." *Nursing Ethics* 29: 171–180.

Jansen, T. L., M. H. Hem, L. J. Dambolt, and I. Hanssen. 2020. "Moral Distress in Acute Psychiatric Nursing: Multifaceted Dilemmas and Demands." *Nursing Ethics* 27, no. 5: 1315–1326. https://doi.org/10.1177/0969733019877526.

Justesen, T., J. Freyberg, and A. N. Schultz. 2021. "Database Selection and Data Gathering Methods in Systematic Reviews of Qualitative Research Regarding Diabetes Mellitus-An Explorative Study." *BMC Medical Research Methodology* 21: 1–12. https://doi.org/10.1186/s12874-021-01281-2.

Lawrence, D., R. Bagshaw, D. Stubbings, and A. Watt. 2024. "The Maintenance Model of Restrictive Practices: A Trauma-Informed, Integrated Model to Explain Repeated Use of Restrictive Practices in Mental Health Care Settings." *Issues in Mental Health Nursing* 45: 1006–1021.

Manderius, C., K. Clintståhl, K. Sjöström, and K. Örmon. 2023. "The Psychiatric Mental Health Nurse's Ethical Considerations Regarding the Use of Coercive Measures–A Qualitative Interview Study." *BMC Nursing* 22: 23.

Mann, K., S. Groschel, S. Singer, et al. 2021. "Evaluation of Coercive Measures in Different Psychiatric Hospitals: The Impact of Institutional Characteristics." *BMC Psychiatry* 21: 419.

Marcus, G. E. 1999. "What Is at Stake – And Is not – In the Idea and Practice of Multi-Sited Ethnography." *Canberra Anthropology* 22: 6–14.

McKeown, M., A. Scholes, F. Jones, and W. Aindow. 2019. "Coercive Practices in Mental Health Services: Stories of Recalcitrance, Resistance and Legitimation." In *Madness, Violence and Power*, 263–285. University of Toronto Press.

Molodynski, A., L. Turnpenny, J. Rugkåsa, T. Burns, and D. Moussaoui. 2014. "Coercion and Compulsion in Mental Healthcare—An International Perspective." *Asian Journal of Psychiatry* 8: 2–6.

Muir-Cochrane, E., D. O'Kane, and C. Oster. 2018. "Fear and Blame in Mental Health Nurses' Accounts of Restrictive Practices: Implications for the Elimination of Seclusion and Restraint." *International Journal of Mental Health Nursing* 27: 1511–1521.

National Institute for Health and Care Excellence (NICE). 2012. *Methods for the Development of NICE Public Health Guidance*. 3rd ed.

NICE Process and Methods Guides. https://www.nice.org.uk/process/pmg4/chapter/appendix-h-quality-appraisal-checklist-qualitative-studies.

Noblit, G. W., and R. D. Hare. 1988. *Meta-Ethnography: Synthesizing Qualitative Studies*. Sage Publication.

Norvoll, R., M. H. Hem, and H. Lindemann. 2018. "Family Members' Existential and Moral Dilemmas With Coercion in Mental Healthcare." *Qualitative Health Research* 28: 900–915.

Paradis-Gagne, E., P. Pariseau-Legault, M. H. Goulet, J. D. Jacob, and C. Lessard-Deschenes. 2021. "Coercion in Psychiatric and Mental Health Nursing: A Conceptual Analysis." *International Journal of Mental Health Nursing* 30: 590–609.

Plahouras, J. E., S. Mehta, D. Z. Buchman, G. Foussias, Z. J. Daskalakis, and D. M. Blumberger. 2020. "Experiences With Legally Mandated Treatment in Patients With Schizophrenia: A Systematic Review of Qualitative Studies." *European Psychiatry* 63: e39.

Rienecke, R. D., G. Dimitropoulos, A. Duffy, et al. 2023. "Involuntary Treatment: A Qualitative Study From the Perspectives of Individuals With Anorexia Nervosa." *European Eating Disorders Review* 31: 850–862.

Salberg, J., L. Ekselius, T. Hursti, and C. Oster. 2022. "Staff Experiences Related to Implementation of a Recovery-Oriented Nursing Programme in Psychiatric Inpatient Care." *International Journal of Mental Health Nursing* 31: 731–742.

Sattar, R., R. Lawton, M. Panagioti, and J. Johnson. 2021. "Meta-Ethnography in Healthcare Research: A Guide to Using a Meta-Ethnographic Approach for Literature Synthesis." *BMC Health Services Research* 21: 50.

Solomon, B., D. Sutton, and B. McKenna. 2021. "The Experience and Meaning of Recovery-Oriented Practice for Nurses Working in Acute Mental Health Services." *International Journal of Mental Health Nursing* 30: 963–974.

Szmukler, G. 2020. "Involuntary Detention and Treatment: Are We Edging Toward a 'Paradigm Shift'?" *Schizophrenia Bulletin* 46: 231–235.

Traynor, M., M. Boland, and N. Buus. 2010. "Professional Autonomy in 21st Century Healthcare: Nurses' Accounts of Clinical Decision-Making." *Social Science & Medicine* 71: 1506–1512.

Tricco, A. C., E. Lillie, W. Zarin, et al. 2018. "PRISMA Extension for Scoping Reviews (PRISMA-ScR): Checklist and Explanation." *Annals of Internal Medicine* 169: 467–473.

Wilson, A., J. Hurley, M. Hutchinson, and R. Lakeman. 2021. ""Can Mental Health Nurses Working in Acute Mental Health Units Really Be Trauma-Informed?" An Integrative Review of the Literature." *Journal of Psychiatric and Mental Health Nursing* 28, no. 5: 900–923. https://doi.org/10.1111/jpm.12717.

Wilson, A., J. Hurley, M. Hutchinson, and R. Lakeman. 2024. "In Their Own Words: Mental Health Nurses' Experiences of Trauma-Informed Care in Acute Mental Health Settings or Hospitals." *International Journal of Mental Health Nursing* 33, no. 3: 703–713. https://doi.org/10.1111/inm.13280.

World Health Organization and United Nations. 2023. *Mental Health, Human Rights and Legislation: Guidance and Practice*. World Health Organization and United Nations.

Wormdahl, I., T. L. Husum, J. Rugkåsa, and M. B. Rise. 2020. "Professionals' Perspectives on Factors Within Primary Mental Health Services That Can Affect Pathways to Involuntary Psychiatric Admissions." *International Journal of Mental Health Systems* 14: 1–12.

Wright, K., S. Golder, and K. Lewis-Light. 2015. "What Value Is the CINAHL Database When Searching for Systematic Reviews of Qualitative Studies?" *Systematic Reviews* 4: 1–8. https://doi.org/10.1186/s13643-015-0069-4.

Zugai, J. S. 2023. "The Ethical Integrity of the Power Differential in Mental Health Nursing." *Issues in Mental Health Nursing* 44, no. 4: 343–346. https://doi.org/10.1080/01612840.2022.2148028.