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Carers' Perceptions of Seclusion and Restraints in Mental Healthcare: An Integrative Literature Review

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ABSTRACT

The use of seclusion and restraints in mental health care is a significant international concern. Although these practices are perceived to de-escalate volatile situations and provide physical protection for those involved, they raise critical issues such as the violation of human rights, physical and emotional harm. Despite the crucial role of carers in recovery, care and protection for persons with lived experience of mental health conditions, few studies have explored their perspectives on seclusion and restraints. This integrative literature review explored carers' perceptions of these practices. A systematic search of four electronic databases, following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines, was conducted without time limitations, resulting in 10 final studies. The synthesis of the literature revealed that carers and persons with lived experience of mental health conditions have negative experiences of seclusion and restraints. However, while carers desire the elimination of seclusion and restraints, some do support the limited use, such as a 'last resort'. Importantly, many carers want to be involved before, during and after these events. Current evidence suggests that empathy is a key in de-escalation that is planned with persons with lived experience and their carers. Healthcare providers should prioritise carers' needs for engagement, emotional support and access to related information for effective reduction and elimination of seclusion and restraints. Training on de-escalation should focus on empathy, therapeutic relationships and communication during crisis. Empirical research should explore the role of carers in developing de-escalation plans.

1 | Introduction

Collectively known as restrictive practices, restraints and seclusion are employed to manage the physical safety of persons with lived experience of mental health conditions, carers and healthcare providers in an acute care environment (Haugom et al. 2019; Muir-Cochrane et al. 2020; Muir-Cochrane and James 2020). However, the controversial use and therapeutic benefits of restrictive practices are questionable considering the risk of physical and psychological harm (World Health Organisation 2019). The international movement to eliminate or reduce the use of restrictive practices began after the United Nations (UN) General Assembly passed a

resolution advocating for their elimination in 1991 (World Health Organisation 2019; United Nations 1991). Restrictive practices are often used to restrict and control a person's movement or behaviour (Hawsawi et al. 2020; Spivakovsky et al. 2023; Lawrence et al. 2022). In the context of mental health, seclusion is defined as the confinement of a person with lived experience of a mental health condition into an empty room alone (World Health Organisation 2019). Restraints can be physical, chemical and mechanical. Physical restraint uses bodily force to restrict a person's movement. Chemical restraint involves the use of psychotropics or sedatives that are non-therapeutic. Mechanical restraint includes tools such as belts, vests and jackets, which are used to control

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movement (World Health Organisation 2019). These restrictive practices are often considered a last resort to control behavioural disturbance (Cole et al. 2023; Power et al. 2020).

Seclusion and restraints are forms of involuntary treatment that are frequently implemented in emergency departments during involuntary admissions or within inpatient units. Involuntary admission entails the compulsory treatment of persons with lived experience against their will (Australian Institute of Health and Welfare 2025). A scoping review of 57 studies identified involuntary admission as a predictive factor for the use of seclusion and restraints (Iudici et al. 2022). In Australia, involuntary treatment remains widespread, encompassing both involuntary admission and the use of restrictive practices. Data from the Australian Institute of Health and Welfare (2025) reveal that 45% of hospitalisations in acute care units and 29% in non-acute care units occur involuntarily. The 2024 Australian Social Justice Report highlighted that the use of restrictive practices remains widespread in inpatient units (Being Mental Health Consumers 2024). One in five persons with lived experience reported being physically restrained, while one in six reported being chemically restrained (Being Mental Health Consumers 2024). Overall, physical restraint was the most frequently employed restrictive practice, surpassing both seclusion rooms and mechanical restraint (Being Mental Health Consumers 2024). Internationally, involuntary treatment continues to be commonly used among persons with lived experience. In China, involuntary admissions (32%) outnumber voluntary admissions (30%), with particularly high rates (44%) among persons with lived experience of schizophrenia (Yang et al. 2020). Similarly, an observational study conducted in India found that 51 out of every 100 admitted patients were physically restrained each month (Danivas et al. 2016).

Persons with lived experience of mental health conditions and their carers describe seclusion and restraints as a traumatic event that can lead to serious adverse effects on mental and physical health. The physical and psychological harm caused by seclusion and restraints is well-documented, including severe pain, deep venous thrombosis, axillary lesions, psychological trauma, anxiety, sadness, fear and the experience of humiliation and punishment (Cusack et al. 2018; Hawsawi et al. 2020; Karroumi et al. 2024; Therasse et al. 2018; Guedes-Corrêa et al. 2018; Chieze et al. 2019). In emergency situations, carers who took their loved ones with mental health conditions for involuntary admission to inpatient units were fearful that healthcare providers might use coercive interventions (Bartl et al. 2024). Thus, for carers, experiencing inpatient care is considered traumatic, frightening and inappropriate for healing and recovery (Martin et al. 2019). Carers who witnessed the contentment of their loved ones with mental health conditions felt traumatised by seeing their loved ones being contained forcibly and detained against their autonomy (Bartl et al. 2024; Tingleff et al. 2019). Additionally, carers report feeling powerless unable to be involved in decision-making and prevent the use of seclusion and restraints practices (Tingleff et al. 2019; Kinner et al. 2017; Brophy et al. 2016a).

The coercive nature of seclusion and restraints is a violation of persons with lived experience's human rights of dignity

and autonomy (Zugai, Gill, Hay, and Ramjan 2024; Duffy and Kelly 2023; Chieze et al. 2021). Persons with lived experience perceived restrictive practices as humiliating, undignified, overpowering and a form of punishment for their disturbing behaviour (Hawsawi et al. 2020). During these coercive events, care was not provided, and the therapeutic relationship was disrupted (Hawsawi et al. 2020). Carers regarded resorting to seclusion and restraints as a failure in care where healthcare providers failed to provide effective management to persons with lived experience disrupting behaviour and fulfil their urgent needs (Brophy et al. 2016a, 2016b; Kinner et al. 2017; Martin et al. 2019). Therefore, carers advocated for eliminating seclusion and restraints to safeguard a person with lived experience's physical and psychological well-being and uphold their dignity and autonomy (Brophy et al. 2016a, 2016b; Kinner et al. 2017; Tingleff et al. 2019).

The use of coercion in inpatient and emergency care is against carers' compassionate and empathetic care that they provide daily to their loved ones with mental health conditions (Tingleff et al. 2019; Brophy et al. 2016b). Carers' closeness to their loved ones can create a bonding relationship, facilitating empathy and compassionate care (Hawsawi et al. 2024). This bonding relationship has been reported to empower carers to protect their loved ones against relapse, regulate their disturbing behaviour and fulfil their urgent needs (Hawsawi et al. 2024; Sin et al. 2021; Girón and Gómez-Beneyto 1998). Therefore, carers' involvement in care might provide essential historical information about triggers and effective de-escalation strategies (Tingleff et al. 2019). Carers suggested that coercion can be avoided when the timely involvement of carers in decision-making is achieved and healthcare providers show empathy to their loved ones with mental health conditions (Tingleff et al. 2019; Brophy et al. 2016b; Bartl et al. 2024).

Current safety programs have been ineffective in fully eliminating seclusion and restraints. While many alternatives claim to successfully reduce the use of restrictive practices, their effectiveness varies, with or without the involvement of carers (Havilla et al. 2024; Dike et al. 2021; Baker et al. 2021; Stensgaard et al. 2018). A systematic review of 122 studies analysing 109 behavioural change interventions found an overall reduction in the use of restrictive practices (Baker et al. 2021). Many of these interventions involve carers providing social support, information about their loved ones with mental health conditions, and recommendations on therapeutic environment design (Baker et al. 2021). However, carers were infrequently communicated with and minimally involved in care planning, as well as in post-seclusion and restraints debriefing (Baker et al. 2021). Additionally, concerns have been raised regarding publication bias in many of these studies, calling into question the reliability of reported outcomes (Baker et al. 2021).

Incorporating carers' perspectives on restrictive practices may provide valuable insights into effectively managing their loved ones before and during behavioural disturbances, ultimately contributing to the elimination of such practices. A multilevel safety intervention involving 12 healthcare providers led to a significant reduction in the use of restrictive practices, with sustained results over 18 months (Havilla et al. 2024). This

intervention included full carer involvement in developing treatment, care, recovery and safety plans through effective communication during weekly meetings (Havilla et al. 2024). Additionally, carers played a key role in co-designing, delivering and training for the intervention (Havilla et al. 2024). For the value of carers' involvement, this review explored carers' perceptions of seclusion and restraints, including their knowledge, attitude, perspective and experiences of witnessing these events.

2 | Aim and Objectives

This integrative literature review aimed to synthesise and analyse existing research on carers' perceptions of seclusion and restraints in mental health care settings. Specifically, it sought to:

1. Examine carers' experiences and attitudes regarding the use of seclusion and restraints.
2. Identify carers' views on alternatives to seclusion and restraints.
3. Explore carers' recommendations for improving practice when restrictive measures are deemed necessary.

3 | Method

This integrative review used the methodological framework developed by Whittemore and Knafl (2005), which encompasses five stages: Problem identification, literature search, data evaluation, analysis and presentation. The framework enables the inclusion of diverse methodologies to provide a comprehensive understanding of the phenomenon under study.

Initial scoping of the literature revealed a significant gap in synthesised knowledge regarding carers' perception of seclusion and restraints in mental health settings. While individual studies have explored this topic, no comprehensive review has previously been conducted to inform practice and policy development.

3.1 | Problem Identification

The lack of effective alternatives to seclusion and restraints is problematic. Exploring carers' perceptions of seclusion and restraints might offer insights for finding effective alternatives that eliminate their use in mental health care.

3.2 | Literature Search Strategies

The search terms were organised into four concept groups using a Population Intervention Context and Outcome (PICO) framework (Scells et al. 2020; Kloda et al. 2020), as illustrated in Table 1. Search terms within each concept group were combined using Boolean operators 'OR' and combined with 'AND'. All common variations and truncations were included to ensure comprehensive coverage of relevant literature. CINAHL,

PsychINFO, EMBASE and MEDLINE online databases were searched on the 20th of May 2023 with no time limit.

3.3 | Study Selection Process

The studies were selected following inclusion and exclusion criteria that were structured using the Sample, Phenomenon of Interest, Design/Evaluation and Research type (SPIDER) framework (See Table 2) (Cooke et al. 2012). Studies were included if they focused on carers (family members, friends, or unpaid supporters) of persons with lived experience and mental health services and explored their perspectives on seclusion and/or restraints. We included empirical research of any design (qualitative, quantitative, or mixed methods) published in peer-reviewed journals. Studies were excluded if they focused solely on healthcare providers' or persons with lived experience perspectives, were conducted in non-mental health settings, or were published in languages other than English.

3.4 | Data Evaluation

The Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) diagram (Figure 1) systematically evaluated studies for eligibility in four main stages. Studies were identified using online electronic databases. Duplicated studies were removed. Author 1 screened studies' titles and abstracts within EndNote (Hupe 2019). Authors 1 and 2 reviewed the remaining studies' full text independently. Meetings and discussions were held around the inclusion or exclusion of the studies until there was a consensus. This process identified 10 studies while excluding 12 studies for reasons identified in Table 3. The quality of each study was assessed using the Mixed Methods Appraisal Tool (see Table 4) independently by Authors 1 and 2. A summary of the final studies is presented in Table 5.

3.5 | Data Analysis

The first author used the NVivo program to analyse the findings section of the studies following Whittemore and Knafl's (2005) systematic approach of sorting, coding and summarising primary sources. Initial coding of primary sources was conducted using NVivo 12 software (Edhlund and McDougall 2018), followed by the creation of matrices to identify patterns. The codes were compared and contrasted to find analytical relationships. Codes of similar concepts were grouped and named under a sub-theme. Subthemes of connected relationships were combined under a theme. Data were reduced through coding of the study results. This process resulted in four themes and ten subthemes. The team then identified themes and relationships through regular collaborative analysis sessions. The process was iterative, with ongoing verification of interpretations through team discussions.

3.6 | Rigour

Several strategies were employed to enhance the review's rigour. The systematic search strategies were carefully documented,

TABLE 1 | Search terms.

Search question	What are carers' perceptions toward the use of seclusion and restraint in mental health care?			
PICO framework	Population	Intervention	Context	Outcome
Concepts	Carer	Coercive practices	Mental health care	Perceptions
Search terms:	Carer	Forced medication	Psychiatry	Experience
All searched as keywords	OR	OR	OR	OR
	Caregiver	Compulsory	Mental	View
	OR	Medication		OR
	Family	OR		Impact
	OR	Tranquiliser		OR
	Parent	OR		Influence
	OR	Emergency sedation		OR
	Mother	OR		Effect
	OR	Seclusion		OR
	Father	OR		Belief
	OR	Restraint		OR
	Partner	OR		Attitude
	OR	Coercive		OR
	Sister	OR		Description
	OR	Containment		OR
	Brother	OR		Opinion
	OR	Restrictive		OR
	Siblings	OR		Reflection
	OR	Clinical holding		OR
	Relative	OR		Last resort
	OR	Segregation		OR
	Cousin	OR		Incident
	OR	Confinement		OR
	Husband			Understanding
	OR			OR
	Wife			Story
	OR			OR
Son			Awareness	
OR			OR	
Daughter			Knowledge	
OR			OR	
Children			Definition	
OR			OR	
Neighbour			Meaning	
OR			OR	
Friend			Perception	
			OR	
			Perspective	
			OR	
			Decision-making	
			OR	
			Event	
			OR	
			Report	
			OR	
			Survey	
			OR	
			Narrative	
			OR	
			Feeling	

TABLE 2 | Inclusion and exclusion criteria.

SPIDER framework	Inclusion criteria	Exclusion criteria
Sample	Adult carers of adult with lived experiences of mental health conditions.	Carers of adolescents and children
Phenomenon of Interest	Perceptions of seclusion and restraints (chemical, mechanical and physical)	Perceptions of other restrictive measures such as observations, emotional restraint, involuntary admission and time out. Observable behaviours related to restrictive practices.
Design/Evaluation	Mental health and psychiatric care	General care, intellectual disabilities care, nursing homes, outpatient, intensive care units and residential homes.
Research type	Peer-reviewed journals qualitative, quantitative and mixed-method research.	Conferences abstracts, dissertations, policy documents, letters, editorials, guidelines, books chapters, literature reviews and commentaries.
Article language	English	Other languages

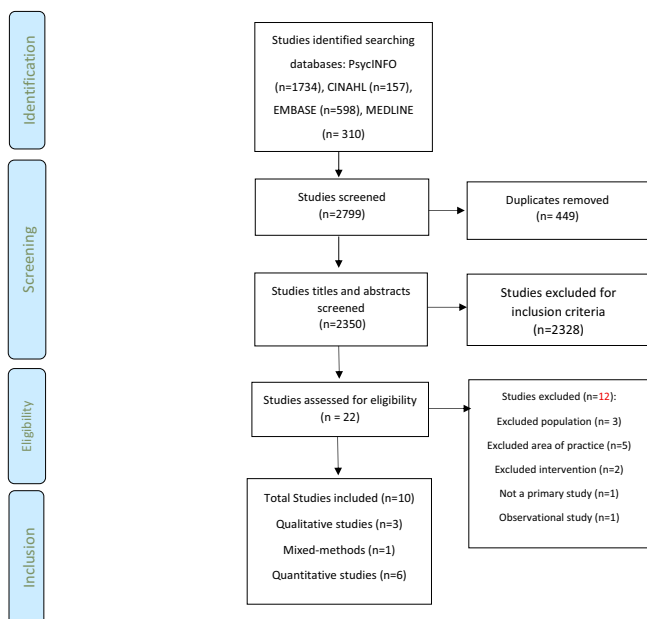


FIGURE 1 | PRISMA flowchart.

and screening and quality assessment processes were conducted independently by two reviewers. An audit trail was maintained throughout the analysis process. Regular team meetings were held throughout the process to discuss emerging themes and ensure interpretative consistency. This structured approach enabled a comprehensive synthesis of the available evidence while maintaining methodological rigour and transparency.

4 | Findings

4.1 | Studies' Descriptions

The systematic search identified 10 studies that met the inclusion criteria, published between 1993 and 2019 (see Table 5). These studies represented diverse geographical locations, including Australia ($n=3$), USA ($n=1$), Sweden ($n=1$), India

($n=1$), Switzerland ($n=1$), Nepal ($n=1$) and Ireland ($n=2$). The studies employed various methodological approaches: qualitative ($n=3$), mixed-methods ($n=1$) and quantitative ($n=6$). The number of carers in each study ranged from 15 to 308 carers, predominantly family members including parents, spouses, partners and adult children, siblings and relatives. Other carers included friends and carers' advocates. In some studies, participants included both those with lived experience as well as carers.

4.2 | Studies' Quality Appraisal

The Mixed Methods Appraisal Tool (MMAT) assessed the quality of the 10 studies evaluating three qualitative studies, a mixed-methods study and six quantitative descriptive studies based on the tool's predefined criteria (see Table 4). Authors 1 and 2 agreed on the scores given in Table 4, which show a detailed description of the studies' qualities. Overall, the methodological quality of the included studies ranged from high to low, reflecting varying degrees of rigour. As such, the findings of this review should be interpreted with caution, particularly when themes incorporate studies with notable methodological limitations.

Qualitative studies (Brophy et al. 2016a, 2016b; Tingleff et al. 2019) were conducted rigorously, demonstrating strong methodological quality. All studies reported clear aims, and appropriate qualitative methods of data collection, analysis and interpretation. However, both authors acknowledged that Brophy et al. (2016b) received a partial rating (C) for data substantiation, indicating that although most findings were supported by the data, certain interpretations may not have been sufficiently grounded in the evidence as reported in the publications.

The only mixed-methods study included was the study by Hoge et al. (1993). While the study presented a clear research question and provided an appropriate rationale for using a mixed-methods approach, it demonstrated limitations in effectively integrating qualitative and quantitative data to produce a cohesive and meaningful conclusion.

TABLE 3 | Reasons for excluded studies.

No	Authors	Reason for exclusion
1	Allen et al. (2006)	Exclude—population (adult carers of children)
2	Asher et al. (2017)	Exclude—context (outpatient setting not inpatient setting)
3	Brown et al. (2013)	Exclude—population (adult carers of children) & phenomenon (vehicle restraints i.e., children's car seats etc.)
4	Bilanakis and Peritogiannis (2008)	Exclude—type of study (this is a letter)
5	Danivas et al. (2016)	Exclude—phenomenon (it was not about the perception only the frequency of aggression)
6	Jöbges et al. (2022)	Exclude population (consumer did not necessarily have a mental health condition, it was about recent ICU admission)
7	Laila et al. (2018)	Exclude—context (outpatient setting not inpatient setting)
8	Ma et al. (2023)	Exclude—context (outpatient/consumer home setting not inpatient setting)
9	Meijer et al. (2017)	Exclude—phenomenon (it was not about the perception but their views of an intervention)
10	Noorthoorn et al. (2008)	Exclude—population (did not include carers)
11	Tay et al. (2017)	Exclude—context (about restraint in the home)
12	Werner et al. (1993)	Exclude—context (Nursing home)

The six quantitative descriptive studies demonstrated varying levels of methodological rigour (Gowda et al. 2019; Kinner et al. 2017; Kjellin et al. 2004; Ranieri et al. 2015; Reisch et al. 2018; Shrestha 2018). Most studies were rated positively (Y) for having clearly defined research questions and employing relevant sampling strategies. Kinner et al. (2017) demonstrated the highest level of methodological robustness, meeting all MMAT quality criteria. In contrast, Gowda et al. (2019), Kjellin et al. (2004), and Ranieri et al. (2015) raised concerns regarding the appropriateness of the measurement instruments. Ranieri et al. (2015) also received a negative rating (N) for nonresponse bias, indicating a significant methodological limitation. Reisch et al. (2018) and Shrestha (2018) received partial ratings (C) for questionable sampling and measurement reliability, reflecting notable methodological weaknesses.

4.3 | Themes and Subthemes

This study found that carers describing seclusion and restraints (chemical, mechanical and physical) as practices were associated with significant adverse effects on both persons with lived experience and themselves. As a result, carers advocated for the elimination of restrictive practices. However, recognition that healthcare providers' negative behaviours and attitudes, as well as an absence of a calming environment, were barriers to achieving this goal. Effective elimination and a reduction in the use of restrictive practices require empathy during de-escalation and the application of restrictive practices only as a last resort, ensuring safety measures are in place during and after containment for persons with lived experience and their carers. Analysis revealed four overarching themes: (1) Adverse experiences of seclusion and restraints, (2) Elimination of seclusion and restraints, (3) De-escalating through empathy and 4. Safe implementation of the last resort. All themes contained a

total of 10 subthemes that illustrated the complexity of carers' perspectives on restrictive practices. Themes and subthemes are illustrated in Table 6.

4.3.1 | Adverse Experiences of Seclusion and Restraints

This theme described carers' narratives of negative consequences of using seclusion and restraints on persons with lived experience and themselves, as illustrated in the two emerged subthemes: (1) Carers' perspectives of persons with lived experience adverse experiences and (2) Carers' adverse experiences.

4.3.1.1 | Carers' Perspectives of Persons With Lived Experience Adverse Experiences.

Carers characterised restrictive practices as inherently traumatic interventions that violate human rights and dignity. They described witnessing their loved ones' distress during these interventions, with particular concern about the potential for re-traumatisation. A parent of an adult child poignantly described this experience: "*It's like watching your child being assaulted, even though you know it's supposed to be therapeutic*" (from Tingleff et al.'s (2019) study, 124).

These practices are considered a violation of human rights, a traumatic experience, a trigger for past trauma, a factor that increases the risk of death and a barrier to future help-seeking behaviours (Tingleff et al. 2019; Brophy et al. 2016a, 2016b; Kinner et al. 2017). Carers consistently identified restrictive practices as coercive and punitive rather than therapeutic. Seclusion and restraints are coercive practices that overpower persons with lived experience forcibly against their will (Kinner et al. 2017; Brophy et al. 2016b). This perception was particularly strong regarding mechanical restraint, which carers viewed as the most distressing form of restriction. The risk of physical harm during

TABLE 4 | Mixed Methods Appraisal Tool (MMAT).

Authors/qualitative studies appraisal questions	S1. Are there clear research questions?		S2. Do the collected data allow to address the research questions?		1.2. Are the qualitative data collection methods adequate to address the research question?		1.3. Are the findings adequately derived from the data?		1.4. Is the interpretation of results sufficiently substantiated by data?		1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?		
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	
Brophy et al. (2016a)	Y		Y		Y		Y		Y		Y		
Brophy et al. (2016b)	Y		Y		Y		Y		C		Y		
Tingleff et al. (2019)	Y		Y		Y		Y		Y		Y		
Authors/Mixed methods studies appraisal questions	S1. Are there clear research questions?		S2. Do the collected data allow to address the research questions?		5.1. Is there an adequate rationale for using a mixed methods design to address the research question?		5.2. Are the different components of the study effectively integrated to answer the research question?		5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?		5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?		5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?
Hoge et al. (1993)	Y		Y		Y		N		Y		C		
Authors/quantitative descriptive appraisal questions	S1. Are there clear research questions?		S2. Do the collected data allow to address the research questions?		4.1. Is the sampling strategy relevant to address the research question?		4.2. Is the sample representative of the target population?		4.3. Are the measurements appropriate?		4.4. Is the risk of nonresponse bias low?		4.5. Is the statistical analysis appropriate to answer the research question?
Gowda et al. (2019)	Y		Y		Y		Y		C		Y		
Kinner et al. (2017)	Y		Y		Y		Y		Y		Y		
Kjellin et al. (2004)	Y		Y		Y		Y		C		Y		
Ranieri et al. (2015)	Y		Y		Y		C		Y		N		
Reisch et al. (2018)	Y		Y		Y		C		Y		Y		
Shrestha (2018)	Y		Y		Y		C		C		Y		

Abbreviations: C, Cannot tell (Mixed Methods Appraisal Tool, 2018); N, No; Y, Yes.

TABLE 5 | Studies description.

Author/year	Country	Study aim	Study design	Type of coercion	Sample & sampling method	Data collection method	Recruitment site	Questions' guide/tool	Data collection			Carers		
									Researcher position/ interviews language	Relationship to persons with lived experience	Persons with lived experience mental health conditions	Researcher position/ interviews language	Relationship to persons with lived experience	Persons with lived experience mental health conditions
Brophy et al. (2016a)	Australia	To examine the perspectives of persons with lived experience and their supporters regarding barriers and enablers to reduce the use of seclusion and restraint in mental health settings	Qualitative focus group	Physical restraint, mechanical restraint, chemical restraint and seclusion	Sixty-six participants were recruited through convenience sampling	Ten focus groups (five persons with lived experience and five carers' focus groups)	Four Australian cities and a rural location	Questions about seclusion and restraints' use, observation, elimination and effects	Two facilitators: (1) an experienced qualitative researcher and mental health practitioner (2) an academic with lived experience of mental health condition	Parents, siblings, marital partners and carers of advocacy roles	In carers' groups: 36 participants: 29 women and 7 men	N/R	General inductive approach	
Brophy et al. (2016b)	Australia	To explore persons with lived experience and their supporters' perspectives on the effects of seclusion and restraint in mental health settings and what contributed to its' use	Qualitative focus group	Physical restraint, mechanical restraint, chemical restraint and seclusion	Sixty-six participants were recruited through convenience sampling	Ten focus groups (five persons with lived experience and five carers' focus groups)	Four Australian cities and a rural location	Questions about seclusion and restraints elimination, reduction, observations and use	Two facilitators: (1) an experienced qualitative researcher and mental health practitioner (2) an academic with lived experience of mental health condition	Parents, siblings, marital partners and carers of advocacy roles	In carers' groups 36 participants: 29 women and 7 men	N/R	General inductive approach	
Gowda et al. (2019)	India	To measure carers' attitudes and perspectives on coercion and restraint practices in psychiatric inpatient units	Descriptive, cross-sectional study	Physical restraint, chemical restraint and seclusion	Random sampling (computer generated)	Semi-structured interviews using a questionnaire	Department of psychiatry	Semi-structured questionnaire to capture experiences of hospitalisation of the patients, and attitudes and perspectives on coercion and restraint practices (questionnaire developed through a pilot).	Not reported	Spouse, son/ daughter, Parents, brother/ sister and friends/other	200 carers: 121 male and 79 female	N/A	McNemar test and descriptive statistics	
Hoge et al. (1993)	USA	To refine the conceptualisation and measurement of coercion	Exploratory mixed methods	Involuntary admission including restraints	Convenience sample, recruitment of persons with lived experience and carers from one acute psychiatric in-patient unit	Semi-structured interviews	Hospital site	Quantitative and qualitative questions about differences and similarities in perceptions about coercion	Two practitioners and four social scientists	Family members and others	18 persons with lived experience with their family members or their party	N/A	Interviews including a 5-point scale about five dimensions of coercion	

(Continues)

TABLE 5 | (Continued)

Author/year	Country	Study aim	Study design	Type of coercion	Sample & sampling method	Data collection method	Data collection			Carers		
							Recruitment site	Questions' guide/tool	Researcher position/ interviews language	Relationship to persons with lived experience	Persons with lived experience mental health conditions	
Kimmer et al. (2017)	Australia	Explore beliefs regarding whether the elimination of seclusion and restraint was desirable and possible	Mixed-methods design (only quantitative data reported)	Physical restraint, mechanical restraint, chemical restraint and seclusion	Email distribution lists, discussion forums, appropriate the media, individual networks, relevant newsletters and stakeholders identified through the project	Quantitative multiple-choice and qualitative open-ended questions	Australia-side community	Questions about demographic characteristics, experiences related to mental illness and restrictive practices and attitudes and beliefs regarding the use of restrictive practices in mental health settings	Not reported	308 carers	N/A	Descriptive and inferential statistics
Kjellin et al. (2004)	Sweden	To explore possible regional differences in the use of coercion in psychiatric care as experienced by persons with lived experience and relatives	Serial interview design	Chemical restraint and seclusion	Recruitment of carers identified by persons with lived experience at 4 acute psychiatric inpatient units	Consecutive and random sampling of persons with lived experience and purposive sampling of carers	Hospital	The coercion ladder, persons with lived experience assessment using the global assessment of functioning scale and the brief psychiatric rating scale	Relatives	162 carers	Substance abuse including psychoses, affective mood disorders and other diagnoses	Descriptive and inferential statistic
Ranieri et al. (2015)	Ireland	To determine carer's perception of the levels of perceived coercion, perceived pressures and procedural justice experienced by their loved ones during their admission to acute psychiatric in-patient units	Quantitative design	Perceived coercion and pressure including physical restraints	Recruitment of carers identified by persons with lived experience at 3 acute psychiatric inpatient units	Purposive sampling	Hospital admission site	The MacArthur Admission Experience Survey	Parents, spouses, partners, siblings, children and other relatives	66 carers	Bipolar affective disorder, paranoid schizophrenia, schizoaffective disorder, major depressive disorder and other mental health disorders	Descriptive and inferential statistic
Reisch et al. (2018)	Switzerland	To compare attitudes of persons with lived experience, healthcare providers and next of kin to coercive measures.	Descriptive cross-sectional study	Chemical restraint, physical restraint, mechanical restraint and seclusion	Recruitment of healthcare providers, persons with lived experience and next of kin from three acute psychiatric inpatient units	Self-reported questionnaire (persons with lived experience provided instruction on how to complete the questionnaire)	Hospital	The Attitudes to Containment Measures Questionnaire	Next of kin	230 carers	N/A	Descriptive and inferential statistic

(Continues)

TABLE 5 | (Continued)

		Data collection							Carers				
Author/year	Country	Study aim	Study design	Type of coercion	Sample & sampling method	Data collection method	Recruitment site	Questions' guide/tool	Researcher position/ interviews language	Relationship to persons with lived experience	Persons with lived experience mental health conditions	Data analysis	
Shrestha (2018)	Nepal	To explore the knowledge and attitude of family members of persons with lived experience	Descriptive cross-sectional study	Physical restraint	Purposive sampling from one acute psychiatric inpatient units	Structured interview	Hospital	An interview schedule was designed to assess the demographic data of participants, their educational level and relation with patient, knowledge regarding restraint and attitude regarding restraint	Not reported	Family members	Schizophrenia, schizotypal and delusional with mood (affective) disorder, neurotic, stress-related and somatoform disorder	Descriptive and inferential statistics	
Tingleff et al. (2019)	Ireland	To investigate the perceptions of mechanical restraint held by relatives of persons with lived experience of forensic mental health including factors impacting its use and duration	Qualitative design utilising symbolic interactionism	Mechanical restraint	15 participants recruited via purposive and snowball sampling	Semi-structured interviews with individual (n = 11) or couple (n = 2)	Support groups (including social media and forensic facility staff)	Questions about parents' perceptions of mechanical restraint use before, after and during the intervention and its reduction	Researcher position not stated. Interviews were conducted in Danish	10 mothers and 5 fathers	10 women 5 men	N/R	Thematic data analysis

TABLE 6 | Findings themes and subthemes.

Themes	Subtheme	Description
<i>Theme 1: Adverse experiences of seclusion and restraints</i>	<i>Subtheme 1: Carers' perspectives of persons with lived experience adverse experiences</i>	Physical and psychological harm experienced by persons with lived experience during acts of forced containment
	<i>Subtheme 2: Carers' adverse experiences</i>	Carers' negative psychological experience of witnessing or knowing about their loved ones' containment
<i>Theme 2: Barriers to the elimination of seclusion and restraints</i>	<i>Subtheme 1: Negative healthcare providers' behaviours and attitudes</i>	Stigmatising, othering and dehumanising attitudes and discriminatory behaviour toward persons with lived experience who have been contained before
	<i>Subtheme 2: Lack of a calming environment</i>	Uncomfortable waiting areas, strong lightning and lack of private beds in unit designs
<i>Theme 3: De-escalating through empathy</i>	<i>Subtheme 1: Using cognitive empathy</i>	Understanding the reasons for persons with lived experience escalated behaviour and individualised strategies to address these reasons
	<i>Subtheme 2: Using emotional and compassionate empathy</i>	Understanding persons with lived experience feelings during a crisis, dealing with them companionably
<i>Theme 4: Safe implementation of the last resort</i>	<i>Subtheme 1: Sharing decision making</i>	Share the decision on seclusion and restraint use by providing carers with comprehensive information about these practices.
	<i>Subtheme 2: Initiating the last resort</i>	The use of seclusion and restraint as a last resort is only initiated when all available alternatives have failed to ensure physical protection and safety
	<i>Subtheme 3: Safety during implementation</i>	Possible physical and psychological safety that might be considered even when the person with lived experience is under the containment of seclusion and restraints
	<i>Subtheme 4: Safety after implementation</i>	The need for after-implementation safety strategies that might reduce or relieve the adverse effects of seclusion and restraints used on persons with lived experience and their carers

prolonged mechanical restraint emerged as a significant concern, with carers reporting instances of pressure sores, muscle weakness and respiratory distress (Tingleff et al. 2019). A prolonged period of restrictive practice use may refer to the time exceeding one hour of containment, during which close monitoring is conducted every 15 min (Ministry of Health 2020). Using these practices to establish behavioural boundaries was perceived as punishment to their loved ones for their unwanted behaviours (Kinner et al. 2017; Tingleff et al. 2019).

Carers perceived that the use of coercion in care violated human rights even when restrictive practices were administered as a last resort (Brophy et al. 2016a, 2016b; Kinner et al. 2017). Seclusion and restraint events were described as traumatic and emotionally damaging experiences (Kinner et al. 2017; Brophy et al. 2016b; Tingleff et al. 2019). Carers expressed concerns that

past seclusion and restraint experiences are potential triggers for long-term trauma, isolation and avoidance of mental health services (Brophy et al. 2016a, 2016b, Kinner et al. 2017).

4.3.1.2 | Carers' Adverse' Experiences. The impact of restrictive practices extended beyond persons with lived experience to affect carers profoundly. Three key aspects emerged: erosion of trust, feelings of powerlessness and vicarious trauma. Carers described feeling helpless when unable to protect their loved ones or influence the decision-making process. As one carer of an adult child in Brophy et al.'s (2016a) study expressed: "You're meant to protect your child, but at that moment, you can't. You're forced to watch them suffer" (p. 601).

The use of restrictive practices often damages carers' trust in mental health services, particularly when they receive

inadequate communication or transparency about the safety of the intervention (Kinner et al. 2017; Tingleff et al. 2019). Distrust due to safety concerns was mainly associated with the use of mechanical restraint (Kinner et al. 2017, Tingleff et al. 2019). Carers feel powerless for not being able to protect their loved ones from being subjected to these practices (Brophy et al. 2016a). Witnessing the coercive implementation of these practices, especially mechanical restraint on their loved ones, exacerbated feelings of concern to experiencing trauma (Tingleff et al. 2019; Kinner et al. 2017; Brophy et al. 2016a). Therefore, the authors proposed an investigation of human rights abuse and poor practices during seclusion and restraints, such as prolonged periods of mechanical restraint and lack of adequate care (Tingleff et al. 2019; Brophy et al. 2016a).

4.3.2 | Barriers to the Elimination of Seclusion and Restraints

The second identified theme describes carers' perceptions of healthcare providers' behaviour and attitudes, and lack of a calming environment as barriers to the elimination of seclusion and restraints from mental healthcare (Brophy et al. 2016a, 2016b; Kinner et al. 2017). Subthemes include: (1) Negative healthcare providers' behaviours and attitudes and (2) Lack of a calming environment.

4.3.2.1 | Negative Healthcare Providers' Behaviours and Attitudes. Carers suggest the elimination of seclusion and restraints is acceptable and achievable through changes to healthcare providers' behaviour and attitude, and adaptation of evidence-based practices. Carers highlighted that some healthcare providers exhibited intolerance to disruptive behaviours that can be de-escalated without using forced containment (Tingleff et al. 2019). Additionally, some healthcare providers displayed stigmatising, othering and dehumanising attitudes toward persons with lived experience subjected to seclusion or restraints (Tingleff et al. 2019; Brophy et al. 2016a, 2016b). Carers concluded that managerial healthcare providers should ensure the implementation of evidence-based, effective de-escalation techniques and healthcare providers' accountability where human rights are breached (Brophy et al. 2016a, 2016b).

4.3.2.2 | Lack of a Calming Environment. Carers reported that the physical place in which persons with lived experience were being treated should facilitate a calming atmosphere. In emergency departments, persons with lived experience in crisis who experienced poor lighting and sat in uncomfortable waiting areas might feel more stressed and distracted from responding therapeutically to healthcare providers' attempts to de-escalate (Brophy et al. 2016a). In in-patient units, persons with lived experience who are being treated in a unit of a fishbowl design might feel segregated and separated from healthcare providers on an interpersonal level (Brophy et al. 2016b). Thus, this design keeps nurses inside the nursing station behind transparent glass while all persons with lived experience are together in a big hall, preventing an opportunity for privacy or seeking refuge in a quiet space (Brophy et al. 2016b).

4.3.3 | De-Escalating Through Empathy

The third theme reports on carers' suggestions for the use of cognitive, emotional and compassionate empathy during de-escalation planning and implementation as an effective alternative to the coercive force used when implementing seclusion and restraints during situations of behaviour disturbance within in-patient units and emergency departments. This theme includes the following subthemes: (1) Using cognitive empathy and (2) Using emotional and compassionate empathy.

4.3.3.1 | Using Cognitive Empathy. Healthcare providers should show cognitive empathy in de-escalation planning by understanding the reasons for persons with lived experience escalated behaviour and which individual strategies can be used to address these reasons. According to carers, reasons for their loved ones' escalated behaviour were often related to their unmet needs (Brophy et al. 2016b; Tingleff et al. 2019). Carers expressed a desire to inform healthcare providers about how to effectively meet their loved ones' needs, which might assist in de-escalating a situation without the need for restrictive practices, particularly mechanical restraint (Tingleff et al. 2019). Therefore, carers urged healthcare providers to address the specific needs of their loved ones that are associated with their mental health vulnerabilities and strengths (Brophy et al. 2016b; Tingleff et al. 2019). Furthermore, carers suggested that healthcare providers should assess the early warning signs such as agitation of persons with lived experience and carefully consider their mental status and risk factors (Tingleff et al. 2019; Brophy et al. 2016b; Kjellin et al. 2004; Gowda et al. 2019). Risk factors include acute conditions posing physical risk to themselves and others, those under involuntary admission, and those affected by recreational drugs (Tingleff et al. 2019; Gowda et al. 2019; Kjellin et al. 2004; Brophy et al. 2016a; Ranieri et al. 2015; Hoge et al. 1993).

4.3.3.2 | Using Emotional and Compassionate Empathy. Healthcare providers should show emotional and compassionate empathy to persons with lived experience by understanding their feelings during a crisis and dealing with them compassionately. Understanding the negative feelings that arise when resorting to coercion instead of compassion in care is important. Some carers noted that healthcare providers should understand and respond professionally and competently to early signs of negative emotions experienced by persons with lived experience rather than allowing these negative feelings to escalate to the point where restrictive practices are necessary (Tingleff et al. 2019). Failure to understand persons with lived experiences' emotional needs may lead to isolation, increased agitation and escalation to behavioural disturbance (Brophy et al. 2016b; Tingleff et al. 2019). Overall, training on de-escalation should involve demonstrating greater empathy toward persons with lived experience in which healthcare providers acknowledge that the use of coercion is a failure in care, not a standard part of it (Kjellin et al. 2004; Tingleff et al. 2019; Gowda et al. 2019).

4.3.4 | Safe Implementation of the Last Resort

This theme describes carers' suggestions for the safe implementation of seclusion and restraints when all alternatives have

failed, and they were used as the last resort through shared decision-making. This theme includes four subthemes: (1) Sharing decision-making, (2) Initiating the last resort, (3) Safety during implementation and (4) Safety after implementation.

4.3.4.1 | Sharing Decision-Making. This subtheme describes that healthcare providers should share the decision on seclusion and restraints use by providing carers with comprehensive information about these practices. Carers should have comprehensive information on seclusion and restraints to make an informed decision on the appropriate type of restrictive practices that might be used with less adverse consequences to them and their loved ones. The use of chemical and physical restraints was more acceptable among carers than other restrictive practices, such as seclusion and mechanical restraint (Gowda et al. 2019; Kinner et al. 2017; Reisch et al. 2018). One study indicated that family members' knowledge about physical restraint was correlated with their attitudes toward its use (Shrestha 2018). Carers reported that receiving more information about restrictive practices improves their trust in healthcare providers and reduces feelings of insecurity, frustration and isolation (Tingleff et al. 2019). This indicates that providing carers with comprehensive information about seclusion and restraints might reduce the adverse psychological distress of witnessing or knowing that their loved ones were secluded or restrained.

4.3.4.2 | Initiating the Last Resort. This subtheme describes the use of seclusion and restraints as a last resort, only initiated when all available alternatives have failed to ensure physical protection and safety. Carers agreed that the main aim for using restrictive practices is to maintain physical protection in situations such as involuntary admission (Brophy et al. 2016a; Hoge et al. 1993; Ranieri et al. 2015). Some carers prioritised the use of restrictive practices to offer a degree of physical protection in some crises over the loss of autonomy and isolation of PLE (Gowda et al. 2019; Kinner et al. 2017; Shrestha 2018; Tingleff et al. 2019). Thus, carers who agreed on involuntary admission that mostly involved coercive restraints perceived this type of admission as justifiable (Ranieri et al. 2015; Hoge et al. 1993).

4.3.4.3 | Safety During Implementation. This subtheme reports on possible physical and psychological safety that might be considered even when the person with lived experience is under the containment of seclusion and restraints. According to carers, while the person with lived experience is under the containment of seclusion or restraints, healthcare providers and carers should still provide them with physical and mental care. During time spent in seclusion and restraints, carers urged healthcare providers to care for persons with lived experiences' essential physical needs, including physical contact, provide environmental calming stimulus and maintain therapeutic communication (Brophy et al. 2016b; Tingleff et al. 2019). Carers reported that healthcare providers should not restrain their loved ones in a room with no physical stimulants, such as a TV or a person, especially when being sedated (Tingleff et al. 2019). Healthcare providers and family members should maintain therapeutic communication at the person's side during time spent in restrictive practices (Brophy et al. 2016b, Tingleff et al. 2019). When physical protection is achieved, restrictive

practices should be terminated immediately. An unnecessarily prolonged stay under containment might escalate further behaviour disturbance (Tingleff et al. 2019).

4.3.4.4 | Safety After Implementation. This subtheme highlighted the need for after-implementation safety strategies that might reduce or relieve the adverse effects of seclusion and restraints used on persons with lived experience and their carers. Safety considerations following the implementation of seclusion and restraints should include follow-up and debriefing strategies (Tingleff et al. 2019; Brophy et al. 2016b). Carers reported that healthcare providers should conduct a follow-up evaluation after persons with lived experience are released from restrictive practices to reassess any unmet needs (Tingleff et al. 2019; Brophy et al. 2016b). Additionally, carers suggested that debriefing should be provided for both persons with lived experience and family members who witnessed the containment of their loved ones (Tingleff et al. 2019). They emphasised the need for healthcare providers to help persons with lived experience process negative emotions associated with being restrained, as well as to support family members in managing the distress they experienced when observing their loved ones in mechanical restraint (Tingleff et al. 2019).

5 | Discussion

This integrative literature review explored carers' perceptions of seclusion and restraints (mechanical, physical and chemical) that are used in adults' mental healthcare. Included studies followed descriptive qualitative and quantitative methodologies. The synthesis of findings from these studies revealed that carers' involvement in decision-making regarding seclusion and restraints can facilitate the use of the least coercive measure, using seclusion or restraints as the last resort, as well as the elimination of these practices. The international purpose for investigating seclusion and restraints is to facilitate their reduction and elimination from practice (World Health Organisation 2019). Efforts to reduce or eliminate these practices might only be effective when involving carers and their loved ones (Havilla et al. 2024).

5.1 | The Use of Restrictive Practices as a Last Resort

Carers urged healthcare providers to use restrictive practices only as a last resort due to these practices' adverse effects on PLE and their carers. Emotional trauma was shared among persons with lived experience and their carers who witnessed these events, as well as the violation of persons with lived experience human rights of autonomy (Brophy et al. 2016a, 2016b; Zugai, Gill, and Ramjan 2024). The psychological and physical consequences of using body force within restrictive practices were found in persons with lived experience, carers and healthcare providers' experiences and reported within quantitative research (Bennetts et al. 2024; Hawsawi et al. 2020; Karroumi et al. 2024; Lawrence et al. 2022). The use of coercion during seclusion and restraints is an international concern for violating the right of autonomy due to the power imbalance between persons with lived experience

and healthcare providers (Zugai, Gill, Hay, and Ramjan 2024; Duffy and Kelly 2023; Bennetts et al. 2024; Butterworth et al. 2022). Persons with lived experience have the right to self-govern, regain control and be empowered to make informed decisions regarding their health (Zugai, Gill, Hay, and Ramjan 2024; Duffy and Kelly 2023). However, being coerced by these practices made them feel powerless, dehumanised and punished (Bennetts et al. 2024; Hawsawi et al. 2020; Butterworth et al. 2022).

Carers are also concerned that the main purpose of using seclusion and restraints might not always be the last resort for physical protection. A recent systematic review on how restrictive practices were conceptualised, used and perceived revealed that healthcare providers use restrictive practices for other intentions than the last resort, including the intention to make persons with lived experience physically safe, behaviour management and reduce the risk of violence (Muluneh et al. 2024). These treatment objectives should be an important part of mental health nursing work in acute care mental health practice rather than reasons for the use of seclusion and restraints (Wyder et al. 2017). Some nurses might resort to seclusion and restraints due to fear, lack of expertise, training, teamwork and leadership among healthcare providers (Lawrence et al. 2022; Wilson et al. 2024). Therefore, carers highlighted the need for healthcare providers' training on de-escalation and empathy.

5.2 | De-Escalating Through Empathy

Carers stated that effective de-escalation through empathy might maintain safety, manage difficult behaviour and facilitate an understanding of the early signs of escalation. Similarly, Goodman et al. (2020) found that effective de-escalation within acute units occurs when nurses build therapeutic relationships based on understanding, regulating and validating persons with lived experience's feelings of trauma that are linked to behaviour disturbance. For persons with lived experience, what makes them feel safe is the compassionate therapeutic relationship with nurses (Cutler 2021). Therefore, emotional and compassionate empathy within nurse-person relationships, as well as cognitive empathy of knowing the history of persons with lived experience very well, was regarded as protective factors for the use of seclusion and restraints (Gerace and Muir-Cochrane 2019). Gerace et al. (2018) explored nurses' use of empathy during conflict, finding that when nurses took persons with lived experience perceptions and felt their emotions, they provided compassionate care even during hard times. Nurses' ability to perform trauma-informed care relies on their ability to show empathy, emotional regulation and self-awareness, which are the core competencies in emotional intelligence (Wilson et al. 2024).

5.3 | Physical Environment

Carers suggested that the physical environment of emergency departments and inpatient units can trigger a person's behaviour disturbance. These include poor lighting, cold seats and the design of an inpatient unit with limited privacy for persons with lived experience. Carefully adjusting

the design of the physical environment for persons with lived experience can reduce the need for seclusion and restraints (Oostermeijer et al. 2021). A recent systematic mapping review of non-pharmacological interventions to reduce restrictive practices found that some interventions included therapeutic environment design and décor that were made based on carers' recommendations (Baker et al. 2021). These designs might include sensory rooms, comfortable and private areas, calm and quiet spaces, gardens and recreational facilities (Oostermeijer et al. 2021). While the evidence regarding the use of sensory rooms as an effective alternative to seclusion and restraints is inconclusive, these rooms might help persons with lived experience in self-management and emotional regulation (Haig and Hallett 2023).

5.4 | Initiating the Decision to Use Restrictive Practices

Carers suggested that the decision to initiate restrictive practices should be shared with them. Thus, in some incidents, carers aided healthcare providers in physically, chemically and mechanically restraining their loved ones in the emergency department (Danivas et al. 2016). Therefore, they should be involved in making decisions regarding the use of restrictive practices. A systematic review by Muluneh et al. (2024) found that the decision to use restrictive practices was not based on obtaining carers' informed consent on behalf of persons with lived experience. Carers were involved in the process of decision-making with the person with lived experience, which resulted in nurses being able to avoid using physical restraint (de Casterlé et al. 2015). Thus, concerns regarding legal claims against the hospital resulted in nurses agreeing to the family's decision to avoid restrictive practice (de Casterlé et al. 2015). Having family members around their loved ones with mental health challenges facilitated more carers supervising with nurses (de Casterlé et al. 2015).

5.5 | The Least Coercive Measure

In our review, carers requested to be involved in choosing the least physically violent coercive measure. Most of them preferred the use of chemical restraint, using medication, as this was more acceptable among carers than seclusion and mechanical restraint, where physical force is the only method to control the persons with lived experience movement. Georgieva et al. (2012) found that persons with lived experience who were secluded and chemically restrained preferred chemical restraint as being the least coercive choice they had experienced. Aligning with carers' and persons with lived experiences' preferences, recent evidence showed that chemical restraint was the most commonly used restrictive practice in adult mental healthcare (Belayneh et al. 2024).

5.6 | Safe Implementation

Previous research found that restrictive practices are non-therapeutic and care was not a part of these events (Hawsawi et al. 2020; Bennetts et al. 2024). Persons with lived experience

who were restrained with severely restricted movement had no access to their body parts and were isolated from communicating with others (Muluneh et al. 2024). Therefore, carers requested that safe implementation should include physical and psychological care of the person with lived experience. De Cuyper et al. (2023) stated that practice recommendations for safe physical restraint implementation should avoid prone positions and protect the head, neck and airway. Moreover, safe psychological implementation recommends communicating and observing the person with lived experience under containment. Regarding the duration of containment, carers suggested that restrictive practices should be terminated as soon as physical protection was achieved. Similarly, providers and persons with lived experience recommended short durations of 15 min for physical and mechanical restraints and an hour for seclusion (De Cuyper et al. 2023).

6 | Strengths and Limitations

This review addressed critical knowledge and methodological gaps regarding carers' perceptions of seclusion and restraints while acknowledging certain limitations. It represents the first literature review to provide a collective understanding of carers' unique perspectives on the adverse effects, elimination and implementation of these practices. Carers' insights underscored the critical importance of empathy as a powerful interpersonal skill. A lack of empathy among carers has been associated with persons with lived experience having symptom relapse (Girón and Gómez-Beneyto 1998), while a lack of empathy among nurses has been linked to increased use of seclusion and restraints (Yang et al. 2014). The findings also highlighted the need for safer implementation of these practices and urged healthcare providers to distinguish between physical protection and psychological safety. The use of Whittemore and Knaf's (2005) analytical framework enabled the integration of data from studies employing diverse methodologies, including both quantitative and qualitative approaches, facilitating a comprehensive exploration of the review's aim. Additionally, the absence of a specified timeframe allowed for the inclusion of a wide range of peer-reviewed studies, providing a thorough representation of existing research.

Despite its strengths, the review has notable limitations. It primarily focused on the perceptions of carers who had witnessed seclusion and restraint events, as well as those who had not. This inclusion of carers with potentially limited understanding of these practices may impact the credibility of the findings in accurately reflecting the lived experiences of participants (Thomas and Magilvy 2011). Additionally, the collective analysis of carers' perceptions of seclusion and restraint as restrictive coercive practices may have hindered a nuanced understanding of the specific effects of each practice. For example, the findings indicated that carers preferred certain interventions, such as chemical restraint, over methods such as mechanical restraint and seclusion. However, these preferences were not explored in depth. Finally, the practical application of some of the study's recommendations may present ethical and logistical challenges. For instance, while carers advocated for involvement in decision-making regarding sensitive health issues such as seclusion and restraint for their adult loved ones, such involvement

could conflict with persons with lived experience privacy and confidentiality, indicating the complexity of implementing these recommendations.

7 | Conclusion

This integrative literature review examined carers' perceptions of seclusion and restraints in mental health care. The findings indicate that both carers and their loved ones with mental health conditions experience significant adverse effects from these restrictive practices, with carers advocating for their elimination by addressing healthcare providers' attitudes, behaviours and environmental triggers. The review also highlights the potential effectiveness of empathy in de-escalation to reduce the need for such practices. Carers called for the safe implementation of seclusion and restraints, only as a last resort, emphasising the importance of involving carers and persons with lived experience in decision-making and ensuring physical and psychological care during these events. While many carers view these practices negatively, others prioritised the use of some restrictive practices, such as seclusion, over other practices, such as mechanical restraint, in cases where all other alternatives have failed to ensure physical safety. Future research should focus on developing safe alternatives and strategies that ensure that seclusion and restraints are truly used as a last resort. Policymakers should involve persons with lived experience and carers in safety planning and emphasise the safe, compassionate and humanised implementation of restrictive practices as a last resort only.

8 | Relevant for Clinical Practice

Carers' perception of seclusion and restraints was mostly negative due to knowing and witnessing the coercion of their loved ones when seclusion and restraints were used (Kinner et al. 2017; Brophy et al. 2016a, 2016b; Tingleff et al. 2019). However, carers' attitudes improved with increased knowledge about restrictive practices, and some considered the use of these practices as justifiable in certain cases, with a few even participating in the containment of their loved ones (Danivas et al. 2016; Ranieri et al. 2015; Hoge et al. 1993; Gowda et al. 2019; Kjellin et al. 2004; Shrestha 2018; Reisch et al. 2018). Despite this, they strongly believe that the use of seclusion and restraints can often be prevented and, when implemented as a last resort, can be made safer, compassionate and humane (Kinner et al. 2017; Brophy et al. 2016a, 2016b; Tingleff et al. 2019; Danivas et al. 2016; Gowda et al. 2019; Kjellin et al. 2004; Shrestha 2018; Reisch et al. 2018). Therefore, they suggested that healthcare providers should first be well trained on de-escalating through empathy to guarantee their use of seclusion and restraints was the last resort (Lakeman 2020; Kinner et al. 2017; Brophy et al. 2016a, 2016b).

Carers recommended that the elimination of seclusion and restraints is achievable when hospital managers make healthcare providers accountable for their decision to use restrictive practices. According to Deveau and Leitch (2020), implementing a strict policy on restrictive practices facilitated managerial investigations into increased usage and reinforced the

expectation that healthcare providers should employ these practices solely as a last resort. Moreover, hospital administration should make proper adjustments to create a calming environment. Access to sensory rooms, comfortable and private areas, calm and quiet spaces, gardens and recreational facilities should be provided within hospital settings to persons with lived experience in inpatient units and emergency departments (Oostermeijer et al. 2021; Haig and Hallett 2023).

Moreover, training on empathy within de-escalation is necessary to minimise the need for coercion and minimise the damage to the therapeutic relationship (Wilson et al. 2024; Gerace and Muir-Cochrane 2019; Gerace et al. 2018). Empathy is an important interpersonal skill within emotional intelligence competencies that supports social success in interpersonal relationships (McNulty and Politis 2023). Improving mental health nurses' emotional intelligence might support nurses' interpersonal ability to regulate their emotions and recognise, empathise and interact with persons with lived experience emotional demands during difficult situations (van Dusseldorp et al. 2011). According to Lakeman (2020), using empathy helps persons with lived experience to co-regulate even under extreme states of extraordinary experiences, such as hearing voices or disturbing beliefs, such as delusional thoughts.

Carers and persons with lived experience should be involved in care, recovery and safety planning in collaboration with healthcare providers. Carers and persons with lived experience should be involved in a comprehensive seclusion and restraints reduction program. Havilla et al. (2024) reported a significant reduction in seclusion and restraints rates following the implementation of a multilevel intervention that actively involved both persons with lived experience and carers. In this intervention, carers and persons with lived experience were involved in the planning, implementation and delivery of training programs, participated in care, recovery and safety plans and served as supporting peers for other carers and persons with lived experience (Havilla et al. 2024).

Author Contributions

All authors substantially contributed to the conceptualisation, design, analysis, editing and interpretation of the manuscript. T.H. and J.A. screened the papers for inclusion. T.H. conducted the data extraction and analysis, with data extraction checking by J.A.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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