RELATIVES AND CARERS' PERSPECTIVES ON RESTRICTIVE PRACTICE IN INPATIENT SETTINGS FOR PEOPLE WITH PSYCHOSIS DIAGNOSES

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ABSTRACT

Background: Restrictive practice is a common occurrence in inpatient mental health settings, despite policy shifts towards less restrictive approaches. Carers play a significant role in acute mental healthcare yet are often left out of both clinical conversations and research. There is emerging but limited qualitative exploration of carers' perspectives on inpatient restrictive practice in the UK context. Further, research in the area typically does not distinguish between acute mental health presentations, despite some evidence suggesting that restrictive practice may be experienced differently by those with psychosis.

Aim: The present study therefore aimed to explore the experiences and perspectives of carers of people with psychosis regarding the use of restrictive practice in inpatient settings.

Methods: Eight semi-structured interviews were conducted with carers of a loved one with a psychosis-related diagnosis. Data was analysed via reflexive thematic analysis.

Results: Five themes were constructed, each with two to three sub-themes. Themes included: 'System-wide impacts'; 'Restrictive practice and psychosis'; 'Negative operations of power'; 'A need for dialogue'; and 'Prospects for system change'.

Implications: The results were discussed in relation to the previous literature on staff, service user, and carer perspectives, showing some agreement between the three groups. Novel findings were discussed, including exploration of the complex relationship between psychosis and restrictive practice, which offered an argument that this may be fundamentally different to those with other mental health difficulties. The findings highlighted the value of carers' insights in shaping care and potentially reducing the need for restrictive interventions, and took a systemic lens to understanding restrictive practice in terms of its impacts not only on those directly involved but throughout wider networks. Implications for research, clinical practice, policy and service development are considered.

CONTENTS

1. INTRODUCTION

1.1 Chapter overview

This chapter begins with a grounding in the landscape and structure of UK inpatient mental healthcare, and how restrictive practice is defined both by policy and by various groups. The links between psychosis and restrictive practice are established, contextualising part of the focus of the present study. Quantitative evidence demonstrating the impacts of restrictive practices is discussed, followed by qualitative experiences of staff and service users. The rationale for involving carers in acute mental healthcare and understanding their perspectives is discussed, providing the foundation for another part of the present study. A literature review of carers' perspectives and experiences of restrictive practice is then discussed with regards to key findings and gaps in the literature, leading to the research question of the current study.

1.2 Inpatient mental health care in the UK

In the 1950s, the UK approach to treating serious mental health difficulties began to shift from institutional care and towards increasing provisions in the community, leading to large-scale closures of inpatient mental health facilities in the 1980s. This trend continued into recent years, with policies such as the NHS 10 Year Plan prioritising resources for community mental health services and early intervention, and psychiatric beds seeing the largest percentage reductions between 1988 and the present day (Kings Fund, 2021). The typical presentation of individuals in psychiatric inpatient settings has therefore changed significantly, as only those with the highest levels of distress and acute risk meet admission thresholds. Individuals can be admitted voluntarily (informally) or involuntarily detained under section, most commonly Section 2 or 3 of the Mental Health Act. It is well known that there are disparities in rates of sectioning mirroring the societal inequalities in the UK, with the most recent statistics still showing that Black and Black British people were over four times more likely than white people to be sectioned. Rates were also 3.5 times higher in the most deprived areas of the country than the least deprived areas (NHS Digital, 2023).

People who experience psychosis on average make up between one third and one half of people admitted to any type of psychiatric ward (WHO, 2022). While depression and anxiety have been found in some studies to be associated with more frequent instances of hospitalisation, people who experience psychosis have been found to have the longest inpatient admissions in comparison to other diagnoses, with almost twice as many occupied bed days as for those diagnosed with depression and anxiety (Thompson et al., 2004). A time-series analysis of trends in psychiatric admission between 1988 and 2020 in England (Degli Esposti et al., 2022) demonstrated that throughout this time period, a diagnosis of schizophrenia was associated with the second highest number of hospital admissions (secondary only to alcohol use disorder) and accounted for almost half of all bed days. Importantly, while overall admission rates had reduced over time, admissions for those with a schizophrenia diagnosis showed the smallest decrease (35.9%), compared to around 70% for depression, dementia, and conduct disorders. This shows a disparity in admission trends for those experiencing psychosis, demonstrating that there are increasingly more people hospitalised in the UK with some form of psychosis in proportion to other presentations.

1.3 What is ‘psychosis’?

In recent years, clinical understandings of unusual experiences such as hallucinations and unusual beliefs have begun to shift from a categorical framework to one acknowledging a spectrum of experiences. This can be seen reflected in the development of At Risk Mental State services within Early Intervention provisions. Unusual experiences have been increasingly linked to trauma and framed as responses to distressing and oppressive social conditions, such as in the Power Threat Meaning Framework (PTMF). Despite this, inpatient settings are largely guided by a biomedical model and are diagnosis-driven; indeed, many community services require a formal diagnosis to receive support. Additionally, within research, perhaps due to a need for operationalised inclusion criteria based on more clearly defined groups, definitions of psychosis are generally guided by a diagnosis of a schizophrenia-spectrum ‘disorder’.

For the purpose of the present study, the definition of psychosis was taken to be any form of diagnosis relating to psychosis, including schizophrenia-spectrum diagnoses as well as First Episode Psychosis and ‘unspecified’ psychosis, to allow for diagnostic uncertainty. While there is overlap in unusual experiences across people with many kinds of mental health difficulties (for example, voice-hearing in those with complex trauma presentations), those who are given the above labels have often experienced more significantly altered experiences of reality, and thus may have very different experiences of inpatient admissions. This definition reflects the realities of how service users are categorised and labelled within inpatient contexts and in research. It also allowed for consideration of potential impacts of the diagnostic labels, and their associated connotations, which could in itself shape the inpatient experience for the carers and their loved ones. This definition of psychosis is therefore utilised throughout this paper, in shaping review of the literature as well as inclusion criteria for the study.

1.4 What is restrictive practice?

As defined by the Mental Health Act (1983), restrictive practices or restrictive interventions are “deliberate acts on the part of other person(s) that restrict a patient’s movement, liberty, and/or freedom to act independently”. It specifies that these practices are intended for use when there is immediate risk of, or currently occurring, harm to the individual or those around them. These situations could include physical assault, deliberate self-harm, threatening or destructive behaviour, extreme or dangerously prolonged over-activity, or attempts to abscond from an inpatient setting (where an individual is under section). Restrictive practices included under the Act are as follows (Mental Health Act Code of Practice (CoP), 2015). Restraint refers to restriction of movement, either through direct physical contact (physical restraint) or the use of devices like handcuffs or belts (mechanical restraint). Rapid tranquilisation is the use of oral medication or intra-muscular injections to “calm or lightly sedate” an individual. Seclusion is defined as supervised isolation and confinement away from others, and long-term segregation refers to preventing an individual from freely mixing in the ward environment. Finally, the Act covers deprivation of access to normal daytime clothing, referring to where an individual is required to wear tear-proof clothing to reduce risks of self-harm or suicide.

The CoP also makes reference to blanket restrictions, albeit in a separate chapter to that describing the above procedures. Blanket restrictions refer to “rules or policies that restrict a patient’s liberty and other rights, which are routinely applied to all patients…without individual risk assessments”. This can include access to outside space, the internet and mobile phones, personal correspondence, money, or activities.

In addition to those acknowledged by the CoP, the Restraint Reduction Network (RRN) identify the following as restrictive practices: surveillance (by staff or cameras); cultural restraint (using cultural norms to restrict behaviour or expression of views and values); and psychological restraint (any communication strategy which implements psychological pressure to influence behaviour) (RRN, n.d.). Taking a human-rights based view informed by those with lived experience, this definition goes beyond the legal guidelines to include practices which could be more embedded in daily practice and harder to challenge or evidence. The concept of “emotional restraint”, such as perceived bullying, manipulation or threats to withdraw privileges, has been endorsed by service users and carers in research (Roper et al., 2015). These disparities between legal and policy definitions and service user and carer perspectives carry the risk of missed opportunities to understand and ameliorate harm, and highlight the importance of listening to the definitions of those with lived experience.

1.5 NHS policy and restrictive practice

National Institute for Health and Care Excellence (NICE; 2015) guidelines on managing violence and aggression in inpatient settings state that restrictive practice

(RP) should be implemented only if preventative strategies such as de-escalation and offering PRN (as needed) medication have been ineffective. In accordance with the Act, NICE states these practices should not be used to punish, inflict harm or humiliation, or establish dominance; they should be used no longer than is absolutely necessary, and should always be the least RP needed to manage the present risk. NICE (2015) also recommends a person-centred approach when these interventions need to be used, following individual care plans based on service users' preferences, as well as taking into account individual factors like physical health and developmental stage when considering and carrying out RP.

Reducing the use of RP in NHS mental health inpatient settings has been a priority for several years, with the 2015 Code of Practice highlighting concerns of overuse or inappropriate implementation of RP. Despite this, in 2017 the CQC reported that some people were still receiving "overly restrictive care". In response, the Mental Health Safety Improvement Programme was established, which ran a Quality Improvement (QI) programme over 18 months, involving 38 inpatient units in reducing RPs (Shah et al., 2022). On a legislative level, in 2018 the Mental Health Units (Use of Force) Act published further regulations aiming to prevent inappropriate use of RPs. The CQC (2019) published further guidance against blanket restrictions on access to phones, money, post and others, specifying these should be limited only based on individual risk assessments, excluding secure units.

Despite the reduction of these practices forming a clear priority for stakeholders, RP remains a concern. In the most recent available statistics, NHS Digital reported 14,130 separate incidents of restrictive interventions (including mechanical, chemical, and physical restraint; seclusion; and segregation) within the month of October 2023 across England. These encompassed 20,515 types of interventions (as multiple RPs may occur within one incident), and were carried out on 2,820 people (NHS Digital, 2023). Within this month, prone (face-down) restraint was used 575 times, despite increasing calls to completely ban prone restraint in healthcare due to its significant risk of death due to asphyxiation (Mind, 2013). The most common recorded reasons for the use of restrictive interventions in October 2023 were the prevention of harm to self and others. This was followed by the facilitation of nasogastric (NG) feeding, likely on eating disorder units. However, the fourth most common reason was ‘unknown’, which was recorded for 1,585 incidents. This raises concerns about the justification of these practices, and questions about the quality of data reporting. Indeed, given that this is a relatively new feature of NHS Digital’s data reporting, and considering potential reluctance to report, it is likely that these statistics represent an under-estimation of the actual rates of restrictive interventions. Rates are also likely to be higher for those from Black or other Minority Ethnic backgrounds (Payne-Gill et al., 2021; Pedersen et al., 2023).

It should be noted that practices like surveillance, cultural, or psychological restraint (RRN, n.d.), and blanket restrictions, are not included in reported statistics. There is a lack of clear methods to objectively report on these forms of RP, which limits our understanding of their prevalence and impact and adds to the importance of lived experience perspectives.

1.6 Psychosis and restrictive practice

While restrictive practice can impact any individual admitted to a ward, there is an argument for focusing on psychosis in particular when exploring RP.

As outlined in Section 1.2, increasingly stringent gatekeeping criteria indicate that those with psychosis may be more likely than those with other difficulties to be admitted to UK inpatient wards, and to be sectioned. Moreover, research has suggested a link between those diagnosed with schizophrenia and increased incidences of seclusion and restraint (Martin et al., 2007; Miodownik et al., 2019). In a systematic review of 49 cross-cultural studies, those with this diagnosis were more likely to be restrained than those with mood or personality disorder diagnoses or substance use difficulties (Beghi et al., 2013). Chieze et al. (2019) argue that psychosis-related diagnoses could act as a moderator or risk factor for long-term RP exposure, due to the chronicity and pattern of recurrent relapses.

Beghi et al. noted that “aggressiveness” was the most common reason for restraint and most commonly associated with schizophrenia diagnoses, suggesting a moderating relationship. There is a higher risk of arbitrary restraint and seclusion when professionals view service users as dangerous, aggressive, or difficult to manage (Alldred et al., 2007). Such attitudes among professionals may be disproportionately associated with psychosis. A systematic review found consistent perceptions of dangerousness, unpredictability, and increased desire for social distance, among medical professionals towards those with psychosis (Le Glaz et al., 2022), which persisted after training. These perceptions are comparable to public attitudes towards those with psychosis, despite professionals' higher levels of training (Stuber et al., 2014). Such attitudes in mental health professionals may be mediated by emotional exhaustion, burnout, and decreased professional quality of life (Koutra et al., 2021), suggesting that staff in pressured, under-resourced inpatient environments may be more susceptible and that these perceptions may impact on the way they treat such service users. Additionally, psychosis is disproportionately diagnosed in those from Black and other Minority Ethnic backgrounds (Qassem et al., 2015; Schwartz and Blankenship, 2014), who are known to be more at risk of being subject to RPs, such as increased risk of seclusion and prone restraint in a 3-year UK study (Payne-Gill et al., 2021). Taken together, this evidence provides an argument for narrowing the focus of research on RP to understand the potential unique interactions and impacts on those with psychosis; and this aim shapes the focus of the present study.

Given that research on the topic often does not specify diagnoses, or groups all inpatient populations or 'severe mental illness (SMI)' together, this paper discusses research in the general area in order to map the landscape and contextualise the present study. Unless otherwise mentioned, research discussed in this chapter is not specific to psychosis. In reviewing the literature, 'psychosis' is taken to mean those given a schizophrenia-spectrum diagnosis. While there are long-documented critiques of the validity of these diagnoses, this reflects how service users are labelled and classified within inpatient settings and in research.

1.7 Quantitative evidence of impacts of restrictive practice on service users

The increasing emphasis on reducing RP in policy and practice is supported by significant evidence of its impacts on those experiencing it. A systematic review

(Chieze et al., 2019) consolidated findings from 35 studies quantitatively comparing the effects of seclusion, restraint, or both, with either another RP or none.

Reported benefits were limited, and were subject to methodological limitations. For example, Soininen et al. (2013) reported higher self-reported quality of life self-ratings at discharge for those who were secluded or restrained, compared to those who were not. However, researchers noted that this was likely due to significant diagnostic differences between the two groups. Positive outcomes were mostly associated with seclusion. Some participants agreed that seclusion had been necessary (Hammill et al., 1989) and reported feeling safe, secure, and benefiting from consistent attention from staff (Mann et al., 1993). However, power imbalances and limited autonomy during admission may limit the expression of negative views and falsely inflate positive ones. Other studies endorsed benefits for “less dangerous” ward environments through secluding the most distressed individuals (Hafner et al.,1989). This raises clear ethical questions regarding benefits for the majority at the expense of restriction and harm for individuals.

Chieze et al. summarised evidence for a broad range of negative impacts. Many studies demonstrated associations between longer admission times and seclusion and restraint (McLauglin et al., 2016; Mattson & Sacks, 1978; Schwab & Lahmeyer, 1979). It is difficult to draw causal conclusions from such studies, as both factors may be mediated by higher levels of distress. Seclusion alone is not effective in reducing agitation as higher doses of medication are still required (Hafner et al., 1989), and does not improve resolution time after incidents (Cashin, 1996).

Rates of PTSD following seclusion or restraint in the reviewed studies ranged from 25-47% (Fugger et al., 2015; Whitecross et al., 2013). There is evidence for a bidirectional association highlighting the increased vulnerability to RP for those with past trauma, and the risk of re-traumatisation as a result (Steinert et al., 2007). Links between restrictive interventions and psychosis were also found, with 31-52% of secluded individuals reporting hallucinations (Palazzolo, 2004; Kennedy et al., 1994). Kennedy et al. specified that 30% of these were not present prior to seclusion, and pre-existing hallucinations increased in intensity during seclusion. Individuals experiencing hallucinations were also secluded for longer than those who were not.

Up to 73% of participants rated seclusion as a punishment, and 62% as overused (Martinez et al., 1999). Physical restraint was widely associated with higher ratings of perceived coercion, and more negative emotions than seclusion (Gowda et al., 2018), perhaps due to its experience as less physically intrusive.

Physical harms are also wide-ranging, most often associated with physical and mechanical restraint. These include deep vein thrombosis, pulmonary embolism, fractures, head injuries, pressure sores, bruises, bent fingers, and "Chinese burns"[1] (Kersting et al., 2019; Ishida et al., 2014; Mind, 2013). Prone, or face-down, restraint has been linked to increased risk of death, often by cardiac arrest and positional asphyxia, as highlighted by high-profile UK cases such as Rocky Bennett and Seni Lewis. Physical harms associated with seclusion were primarily due to self-injury or physical complications due to a lack of observation while secluded (Kersting et al., 2019).

Quantitative evidence clearly demonstrates a range of serious risks to physical and mental health of those subjected to RP. It should be noted that quantitative research often does not feature more 'informal' RPs as they are harder to operationalise and may arise more in qualitative explorations.

1.8 Staff and service users' perspectives on restrictive practice

As the two parties most directly involved in and impacted by RP, there is a relatively established research base exploring perspectives and experiences of both staff and service users. In order to contextualise carers' perspectives, qualitative research focusing on staff, service user, or both perspectives, is first summarised here.

1.8.1 Experiences and impacts

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[1] "Chinese burns" is a phrasing taken from a service user quote in Mind, 2013; this is an outdated term which carries potentially offensive connotations, and the injury is now more commonly referred to as a snakebite. However, the phrase is used here as a direct quote from the 2013 source.

Psychological distress in both staff and service users associated with RP is well documented. Butterworth et al. (2022) noted in a review of 21 qualitative studies across both groups that distress is long-lasting after the event, suggesting long-term psychological impacts for both staff and service users. Staff often report anxiety, fear, and feelings of guilt and blame (Fereidooni et al., 2014). Attributions of blame and failure are reported by some staff to negatively impact relationships within the staff team, as well as staff-patient relationships (Mooney & Kanyeredzi, 2021). Staff distress is often attributed to a moral dilemma of having to balance conflicting paradigms of risk aversion and safety versus trauma-informed or recovery-focused approaches often advocated for by higher-level policy, as well as contradicting their values and reasons for working in a caring role (Muir-Cochrane et al., 2018; Moran et al., 2009; Bigwood & Crowe, 2008). This is echoed by UK inpatient staff (primarily healthcare assistants and support workers), who reflected that this conflict between expectations of the role and personal values led to a shift from initially questioning RP to accepting it as an inevitable, necessary burden (Mooney & Kanyeredzi, 2021). Almost all staff in this study had utilised informal support to manage the difficult emotions linked to this, for example reflecting with colleagues, while some had accessed structured support.

In service users, the characterisation of RP as punitive is a common finding (Hui, 2017; Tully and Berry, 2022), with both physical and psychological impacts being overwhelmingly negative. These experiences are often associated with intense anxiety, and loss of dignity (Hui, 2017), as well as fearing death or physical injury (Butterworth et al., 2022). In an integrative review into the available evidence regarding these impacts, Cusack et al. (2018) found themes of trauma and retraumatisation; distress and fear; and feeling ignored, powerless, and dehumanised. Powerlessness is an overarching theme in other research, and may be particularly amplified for those service users with already marginalised identities, such as women (Tully and Berry, 2022). Perceived removal of human rights, such as feeling imprisoned, dehumanised, experiences of being laughed at, and having basic needs neglected, are documented (Butterworth et al., 2022). Both staff and service users have shown support for ideas to reduce distress caused by RP, such as the provision of psychological support like debriefing or therapies for both parties following an incident (Butterworth et al., 2022).

Some benefits of RP have been endorsed by some subsets of service users. For example, it has been suggested that some female service users felt a sense of calm from being physically restrained and may engage in behaviours to elicit restraint in order to regain perceived control; seclusion can also reportedly have a calming effect (Sequeira and Halstead, 2002; Haw et al., 2011). However, these beneficial effects do not appear to apply to the majority of service users, and in any case, it is clear that the wide-ranging harms outweigh these benefits, which could be achieved through less intrusive and dangerous means. Some service users have acknowledged the need for some rules and restrictions in providing structure and routine (Tully and Berry, 2022), echoing the perspectives of staff in some studies, though in the same study service users warned that overly relying on these measures can lead to institutionalisation.

Other research has utilised less traditional avenues to elicit service user perspectives, such as Jina-Pettersen (2022) which analysed posts and comments on a Reddit community ‘r/PsychWardChronicles’. Inpatient settings were described as worsening psychological distress through restrictive and coercive practices, with one poster writing, “they don’t realise it makes us more psychotic”. Many described “complying” while in inpatient settings in order to be discharged more quickly, which could increase the risk of relapse in the community. Authors argued that RP on inpatient wards may therefore be contributing to a public health crisis, as the associated trauma may be leading to disengagement from mental health services, leaving individuals more vulnerable in future and less likely to access support.

1.8.2 Differing perspectives

There are differing perceptions of RP both between different individuals, and between staff and service users as groups. In a scoping review of staff perspectives on RP in Australia, Chavulak et al. (2023) reviewed nine papers encompassing 1429 participants’ views. All papers included nurses, with four including other staff (one with peer support workers, one with allied healthcare professionals, and two where the other staff roles were unclear). They noted that while the concept of ‘safety’ arose across the studies, pertaining to both service users and staff, professionals’ conceptualisations of safety could affect the implementation of RP. For example, RPs could be framed as a safety measure against physical and verbal assault for staff, while other staff frame it as a risk to safety in itself that causes distress for both staff and service users.

In studies exploring views on why RP occurs, service users primarily highlight factors relating to staff, such as a lack of reflection or need to control and dominate service users (Price et al., 2018), or inadequate communication and support from staff during times of distress leading to further escalation (Bonner et al., 2002). Communication is also seen by service users to affect how distressing the intervention is, citing factors like being given explanations for what is happening and having their questions answered before, during, and afterwards (Kontio et al., 2012). Staff have also reflected on the role of communication in therapeutic rapport and building knowledge of service users' presentations, therefore helping to recognise when and how to intervene prior to escalation (Gerace & Muir-Cochrane, 2019). Butterworth et al. (2022) highlighted that service users tend to perceive the lack of emotional support or communication from staff following a restrictive intervention as being ignored (Cusack et al., 2016), leading to increased tension and disconnect, while staff attribute this to staffing and time pressures. This paper reported some service users' views that if they had understood why a restraint happened, they could take responsibility for their actions and prevent re-occurring RP. This reflects the expressed need for clearer communication from staff, but could also reflect a tendency to place responsibility for change on the individual receiving care, rather than staff or systemic factors. Further, staff widely believe there are limited alternatives as effective in maintaining safety (Butterworth et al., 2022), which implies that regardless of service users' attempts to adjust their behaviours, they may still be subject to these interventions in the name of harm reduction.

Staff frequently highlight the role of organisational and environmental factors in impacting their ability to build relationships and increasing the use of RPs, such as high turnover of staff and service users, staff shortage and burnout, unsettled ward environments and organisational demands (Meehan et al., 2022; Perkins et al., 2012). Fear has also been highlighted as a key motivator for staff in implementing RP, as reducing such interventions may leave staff vulnerable to assaults (Chavulak et al., 2023). Staff have also more frequently attributed the use of RP to service users' behaviour, for example being violent, aggressive, or out of control (Perkins et al., 2012). While less common, there is some acknowledgement of these factors by service users; for example, participants in Price et al. (2018) identified behaviours in themselves like quick escalation, aggression associated with psychosis, and experiences of command hallucinations, as particularly difficult for staff to manage with verbal de-escalation and acknowledged that restrictive interventions may be needed.

Not only do service users and staff differ in their narratives of why RP happens, but also in what they consider to be restrictive. Bendall et al. (2022) highlighted that staff see “negotiation” as a positive alternative to restraining or secluding, but that service users experience the “negotiation” in itself as coercive. This could easily explain why “directing a service user to modify their behaviour”, while a common feature of de-escalation attempts, is recognised as an often unhelpful approach which can escalate conflict (Cusack et al., 2016). This disconnect and difference in conceptualisation perhaps reflects the poor communication described in many studies.

1.9 The importance of carers' involvement and perspectives

A carer is any adult who provides care for another adult due to physical or mental disability or illness (Care Act, 2014). In the UK, up to 10.6 million people are unpaid carers (Carers UK, 2022), with approximately 13% supporting people with mental health difficulties (Carers Trust, 2024).

Developments in NHS and government policy over recent years have highlighted the importance of involving, supporting, and recognising carers. The Care Act (2014) made it a local authority requirement to provide support and safeguard the wellbeing of carers through providing a Carers Assessment and local authority support for identified needs. The NHS Long Term Plan (2019) also outlined goals relating to better recognition of and support for carers, such as the development of carer passports and plans to support carers with contingency-planning. However, the provision of such support has been constrained by the resources of local authorities, and a lack of increased funding to adult social care (Carter, 2021; Carers UK, 2019). Further, these policies reflect a focus on general health services, with a lack of specific support for carers of people with mental health needs and particularly those who require inpatient admissions, despite this translating to specific challenges and burdens on carers.

Within mental health services, the Triangle of Care, a Quality Improvement (QI) programme promoting partnership between carers, service users, and staff aiming to improve care and clinical outcomes, has now been adopted by 45 Trusts (Carers Trust, 2023). Its initial development for acute mental health settings (The Princess Royal Trust for Carers, 2010) perhaps reflects the particular importance of carer involvement during times of mental health crisis. It encourages commitment at all organisational levels to six key standards, including identifying carers at first contact, providing a range of carer support services, and having a defined role in the service responsible for carers. This demonstrates a shift towards carer involvement in mental health care.

The importance of carer involvement for those with more serious mental difficulties is well-established in the literature. In those experiencing psychosis, support from families and social networks has been associated with reduced positive symptoms, fewer readmissions, longer time spent in remission, and improved medication adherence (Norman et al., 2005; Tempier et al., 2013; Glick et al., 2011). Involvement during inpatient admissions can lead to increased utilisation of aftercare or community services post-discharge, as well as improved compliance with medications (Haselden et al., 2019). This study emphasised the importance of communication between carers and staff throughout admission, including exchanging information about the individual's mental health, discharge planning, and signposting to support services.

The importance of involving networks is underscored by the recommendations of Family Interventions (FI) as best practice for presentations such as psychosis (NICE, 2014), though this is typically accessible only in community services. Some models of family involvement have been applied to acute inpatient settings, such as Open

Dialogue, the Somerset Model, and the Family Systems Approach, which have common themes of communication, language use, and shared decision-making (Dirik et al., 2017). However, widespread implementation of any model is historically poor (Eassom et al., 2014). Some research has shown it is feasible to introduce structured protocols for carer involvement in inpatient settings (Kaselionyte et al. 2019), although further large-scale research is needed. Clinicians, service users, and carers have suggested carer involvement in acute inpatient settings should happen as soon as possible after admission, and ward staff should be actively engaged in this (Giacco et al., 2017). In reality, carers are most likely to be involved in discharge planning, if at all, and report feeling excluded from care and encountering barriers in communication with ward staff (Wood et al., 2021). Similarly, while carers have expressed a need for emotional support during inpatient admissions, they largely do not feel adequately supported with their own mental health needs (Stuart et al., 2020).

Systems theory (Minuchin, 1974) understands behaviours, or perceived ‘problems’, as a function of interactions and relationships between different elements of a system, rather than locating them within individuals. A system is any network of interdependent, interacting elements, for example a family, or a mental health service or ward. Hospitalised individuals exist within the system of the ward environment, containing both peer and staff relationships, but also within their support networks outside of the ward. Within the ward, RP could be conceptualised as an ineffective attempt by staff to ‘solve’ a ‘problem’ such as medication refusal or perceived high-risk behaviour, or maintain homeostasis in the form of stability on the ward (Dallos & Draper, 2010). The potentially escalated behaviour and increased distress resulting from RP can then be perceived as difficult or threatening, thus maintaining the cycle. An individual’s experiences of RP may shape their interactions with carers and loved ones, maintaining distress and perpetuating harm throughout the wider system. Therefore, despite often not being directly exposed, carers may experience indirect distress and harm as a result of RP. Further, as in Bronfenbrenner’s (1979) mesosystem and exosystems, this could feed back into carers’ interactions with their loved one as well as permeating through carers’ own support networks, friendship groups, or work settings. This may then have top-down impacts on the individual service user at the centre. RP can also be framed as an operation of embodied, coercive, ideological and legal power, which, as acknowledged by the Power Threat Meaning Framework (PTMF; Johnson and Boyle, 2018), can extend beyond individuals to families and communities. Carers may then develop their own meanings and responses to the indirect threat posed by RP, which are as important to understand as those of the individuals and staff directly experiencing RP.

Therefore, carers are potentially negatively impacted by RPs despite not being inpatients themselves, and their involvement carries benefits for improvements to care and clinical outcomes. Insights from theory, literature, as well as the direction of policy, all indicate the value of better understanding and amplifying carers' perspectives.

1.10 Literature review: Carers' perspectives on restrictive practice

Given the importance of involving and understanding the perspectives and experiences of carers, a literature search was undertaken to explore carers' perspectives on RP. Initially, due to the interest in understanding the experiences of those caring for people with psychosis in particular, the search included terms pertaining to psychosis. However, this procured a very limited number of records across multiple databases. While three of these upon review were relevant to carers' perspectives on RP, none appeared to focus on psychosis specifically, and the inclusion of these terms was thought to be limiting the pool of records. Considering that much of the literature may not specify the diagnoses or presentation of those being cared for, or may utilise heterogenous inpatient populations, the decision was made to broaden the search to understand the perspectives of carers of those experiencing inpatient RP in general, as this often includes those experiencing psychosis. The aim of the review was therefore to map the literature on the topic, summarise the experiences and opinions of carers, and understand how diagnostic groups and presentations are documented, if at all, within the literature.

Three databases, Academic Search Ultimate, CINAHL Complete, and APA Psycinfo, were searched using the following terms:

> ("restrictive practice*" or "restrictive intervention*" or "restrain*" or "seclusion" or "seclud*" or "physical intervention*" or "forced medication" or "coercive") AND ("carers" or "informal carers" or "relatives" or "family members" or "caregivers") AND ("perspectives" or "views" or "perceptions" or "attitudes" or "opinion" or "understanding" or "experience")

The search was limited to studies available in English and published from 1980 onwards, given the significant changes in the landscape of inpatient mental healthcare and use of RPs in recent decades.

The initial search produced 738 results. The inclusion criteria for the review were:

- Contains sufficient information on the experiences, attitudes, or perspectives of carers (including family, friends, or any other kind of informal carers); this could include studies solely recruiting carers, or carers alongside service users and/or professionals.
- Focuses on any form of RP on inpatient wards.
- Includes the experiences of those caring for people experiencing psychosis, or with diagnoses of psychotic disorders. Papers where diagnoses of those being cared for were not specified, or where they were of a mixed or general inpatient population, were also included, as these populations often include those with psychosis.
- Qualitative, quantitative, or mixed-methods studies, given that they address attitudes or experiences.

Exclusion criteria were:

- Papers relating to carers of specialist populations which may have particular considerations for RPs, such as dementia or eating disorders, or carers of those with clearly different diagnoses to psychosis, such as personality disorder diagnoses.
- Reviews of the literature, due to potential bias in selecting and summarising studies and the risk of duplication.

- Quantitative studies which do not address attitudes or perceptions, for example those measuring frequency of RP usage.

In Figure 1., a PRISMA diagram summarises the stages and reasons for exclusion.

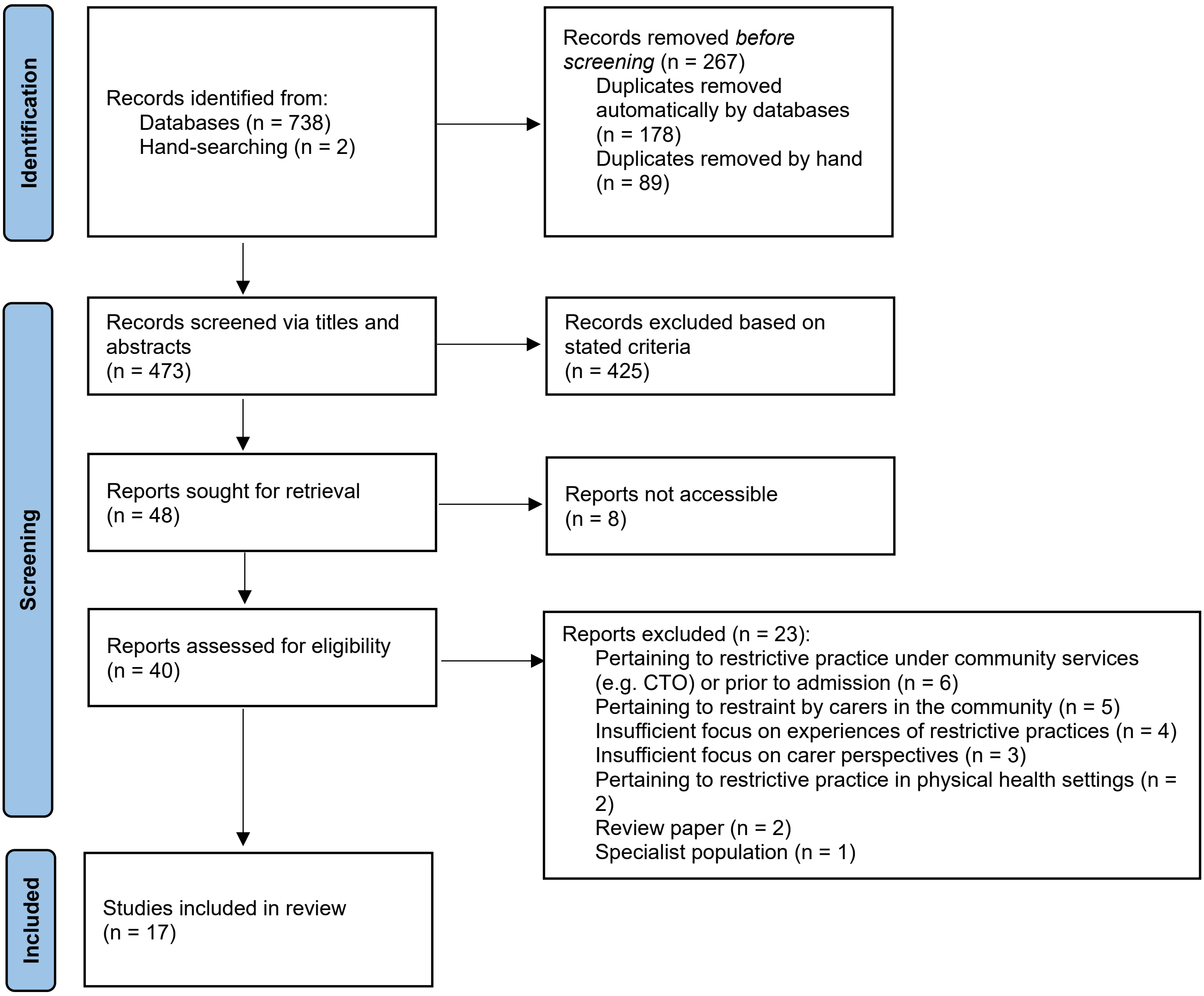

Figure 1: PRISMA diagram

17 papers were included: 7 quantitative studies, 9 qualitative studies, and 1 mixed-methods study, ranging across 10 countries. A table summarising the results is located in Appendix A. The majority (n = 13) did not specify the diagnoses or mental health presentations of the loved ones of the carers involved. Though two reported a

majority of psychosis-related diagnoses in loved ones, none specifically recruited service users, or carers of service users, who experience psychosis as a separate group. Given the range of countries represented, findings are likely to reflect differing legislation, policy, healthcare systems and sociocultural attitudes towards RP. Key findings, as well as limitations and gaps in the literature, are discussed presently.

1.10.1 Findings from quantitative studies

Given the relative novelty of the research area and limited number of in-depth qualitative explorations of carers' perspectives on the topic, quantitative measures of attitudes or opinion ratings can offer an initial outline. However, some quantitative papers sourced were lacking detail about their methodology, raising concerns about the rigour of the research. For example, Shrestha (2016) reported positive attitudes in Nepalese carers towards the use of RP, but that they were ill-informed about some of the risks of physical harm. Bilanakis et al. (2008) reported descriptive differences in attitudes between carers and service users, with 80% of service users rating seclusion and restraint as unjustified and traumatic, and 89% of relatives rating them as justified. Both of these papers lacked detail of the study procedures and measures used, as well as information about the samples; therefore conclusions drawn from these are limited.

An Indian study utilised the Staff Attitude to Coercion Scale (SACS) to compare attitudes between carers and psychiatrists (Raveesh et al., 2016); some areas of agreement were found, including the role of scarce resources and security concerns in maintaining coercive practices, and that this could be necessary in dangerous situations. However, the carer responses were notably inconsistent, and the SACS had a Cronbach's alpha of 0.07 for carers compared to 0.58 in staff. The items in this measure were designed around professionals' opinions and were not necessarily understood in the same way by carers. In response, Gowda et al. (2019) developed a tailored measure to explore carers' attitudes. They found that carers rated some RPs such as chemical and physical restraint high in acceptability, and that the majority of carers denied that RP affects autonomy, interpersonal contact, or isolation. However, the questionnaire developed for this study limited participants to ‘yes’, ‘no’, or ‘don’t know’ responses, leaving no room to account for nuanced opinions.

A more standardised measure, the Attitudes to Containment Measures Questionnaire (ACMQ) was used in two Swiss studies (Reisch et al., 2018; Hotzy et al., 2019), which describes and visually depicts 11 forms of RP and asks participants to use a Likert scale of 0-5 to rate their acceptability, with higher scores corresponding to higher rejection. It also measures if participants have experienced each practice. It includes some forms of restriction which are not applicable to all countries and settings, for example the ‘net bed’ which is not used in Switzerland, which may affect how acceptable participants find them. In general, Reisch et al. (2018) showed that carers’ ratings fell ‘in the middle’ of staff and service users on the majority of items, although their scores were closer to those of service users, indicating more agreement than with professionals. Hotzy et al. (2019) also demonstrated this pattern. This study also showed that carers’ and service users’ level of approval was not affected by whether they had experienced the intervention or not, or by study site. Whereas, professional attitudes appeared to vary depending on their hospital policy and practices.

An Irish study (Ranieri et al., 2015) adapted the MacArthur Admission Experience Survey (AES) to measure carers’ perspectives, from its original use to measure inpatient perspectives. They administered the AES to 66 carers, who were mostly parents, finding that perceived coercion at discharge was rated significantly lower among carers than service users, and that carers perceived the admission as more procedurally just than service users. Both findings were consistent at later follow-up. Ranieri et al. suggested that the disparity could be due to difficulties in communication between carers and service users, and with professionals, about what happened during admission and how this impacted the individual; opportunities such as pre-discharge meetings where all parties could share their perception of the admission and events of coercion were suggested. In this study, only 50% of service users approached gave consent for their carers to be contacted; it is possible that this could lead to those with better relationships being included in the study, and therefore the disparity could be underestimated.

1.10.2 Findings from qualitative and mixed-methods studies

Brophy and colleagues have conducted several large-scale studies into this area in Australia. A mixed-methods national online survey (Kinner et al., 2017) explored perspectives on the benefits and harms of seclusion and restraint, and the feasibility and desirability of eliminating these practices. 1,150 responses were analysed from service users (46%), carers (27%), and professionals (27%). While the majority of participants agreed that restraint and seclusion cause harm, infringe on human rights, and damage therapeutic trust, this was most endorsed by service users and least by professionals. Professionals were also most likely to perceive benefits in these practices relating to safety and boundary-keeping, while service users were least likely. Echoing the above quantitative findings, this suggests that carers' perspectives tend to fall 'between' these two groups of stakeholders, perhaps indicating complexity of opinion or greater ambivalence. Carers were however more in line with service users in their views that eliminating chemical restraint and seclusion is desirable and feasible, in contrast with professionals. The qualitative data in this study indicated a shared recognition of the harms caused by restraint and seclusion, and importantly an agreement across the groups of the significance of emotional restraint.

Two papers were published from a study involving five focus groups with service users and five with carers (Brophy et al., 2016a and 2016b). This research represented an important addition to the sparse literature on carers' perspectives on RP. Though the study aimed to focus on seclusion and restraint, participants identified a range of examples of poor and coercive practice, including lack of empathy and communication in staff, use of excessive force and RP as a first resort. These practices intersected with experiences of marginalisation, for example, an Indigenous carer who did not speak English reported that staff "refused" to inform her about incidents of RP or to consult her about how to care for her loved one. Both carers and service users considered RP a breach of human rights, which evoked a powerlessness in service users but also in their carers due to poor communication from staff, and restricted access to and knowledge about their loved ones. This supports the idea that the negative impacts of RP spread further than the individuals directly involved. Other themes included trauma, which had ongoing impacts on recovery; RP as a mechanism for staff to maintain control and routine; isolation; dehumanisation; and anti-recovery, where the use of RP on wards was contrasted with recovery-focused approaches adopted by community services.

In discussing barriers to reducing RP, carers and service users highlighted physical environment factors, the potential influence of substance use, and implicit barriers including ongoing trauma and its impact on recovery and the impact of stigma on how service users are perceived. Both groups showed strong support for peer support workers and advocates whose understanding and lived experience may help to change organisational cultures. Carers felt that increased involvement in care would reduce the need for RP, supporting a more individualised understanding of their loved ones and how to support them. They also suggested staff training, and using less technical language around seclusion and restraint, as this was thought to protect staff from acknowledging the harms and legitimise RP as the norm. Focus groups were small due to resource constraints, however they were held over a breadth of geographical areas including urban and rural settings, increasing the representativeness of the sample.

In a fourth Australian study involving focus groups with carers, staff, and service users, Fletcher et al. (2019) echoed calls for peer support workers and improving the knowledge and continuity of staff. All groups emphasised the importance of organisational culture shifts and resources in achieving meaningful change to RP. Carers rated reducing boredom and increasing meaningful activity as the highest priority for reducing RP, as it was seen as an underpinning factor to many escalating situations. In agreement with service users, carers felt that more supportive staff contact was needed, whereas staff felt that this was already part of their everyday practice. Both Fletcher et al., (2019) and Brophy et al. (2016a; 2016b) benefited from the inclusion of lived experience researchers in co-facilitating focus groups, allowing for increased safety and validation of shared experiences, as well as involvement in data interpretation to enable ongoing contextualisation of the themes.

Two published articles, and one piece of grey literature, were found representing UK carer perspectives. The two papers (Goodman et al., 2020; Rippon et al., 2018) explored views in the context of particular inpatient settings in England, namely high-secure forensic and child and adolescent wards respectively. Their findings may therefore reflect particular challenges of these settings and may not generalise to experiences on all inpatient wards. In forensic high-secure settings, dominant views across focus groups of staff, service users and carers were that MDT collaboration and therapeutic relationships between staff and service users were key; participants felt that de-escalation was most effective as an embedded, ongoing practice. Carers emphasised staff factors such as skills mix, beliefs that some staff may enjoy exerting power through RP, and that staff must reframe perceived aggression as a survival mechanism or trigger. Rippon et al. (2018) demonstrated the view of RP as necessary at times for preserving safety was present in carers, service users, and professionals relating to adolescent wards. Carers in this study acknowledged the potential of both physical and psychological harm of RP, and emphasised the features of the inpatient environment itself which can trigger behaviours in service users which can elicit RP, and that these behaviours were worse on wards than in other settings. Similarly to previously outlined studies, carers described being uninformed about the types of RP used on wards until after it happened; insufficient information led to some carers searching online for more details, which could be misinforming and distressing for them. Focus groups and interviews in this study were conducted by different facilitators, which could have impacted on the data collected through variations in engagement and style. However, the use of vignettes in data collection may have prompted reflection or discussion which may not have otherwise arisen.

Finally, research by Carers Trust Scotland (2022) also explored the lived and living experiences of RP from the perspective of carers and service users as part of the Scottish Patient Safety Programme for Mental Health, a national QI programme aiming to improve safety and reduce harm on Scottish adult mental health. While this research lacks some rigour and detail on research procedures, it adds contributions from Scotland’s NHS context which differs in structure and provisions to NHS England services. A significant, largely unmet need was transparent and clear communication at several levels, from making ward rules and expectations clear to all parties at the outset to communicating information about incidents of RP. Participants shared that many expectations and plans were implicit, suggesting that this could lead to service users acting in ways which could unknowingly provoke RP.

Participants also emphasised increasing access to activities as a primary strategy to reduce RP, as well as increasing access to advocacy. Carers expressed that they wanted staff to proactively engage with them, taking time to elicit and document their insights into their loved one's triggers and what works for them earlier in admission. Minimal examples of good practice relating to RP for carers involved constant empathetic communication, explanation of the RP, and reassurance regarding safe usage.

A Danish study explored parents' perceptions of the use of mechanical restraint (MR) in adult forensic settings, distinguishing between a sense of trust versus distrust in the parents (Tingleff et al., 2020). Trust was characterised by positive sentiments about care and protection associated with MR, which lessened their need to assert themselves to advocate for more inclusion and involvement in care. Distrust was characterised by negative sentiments and a need for more involvement in response to this; this was the dominant experience, with a sense of needing to "fight the system" by repeatedly, often unsuccessfully, seeking dialogue and information. While positive experiences were a minority, some reported that MR had a calming effect on their child and that staff responded well to their physical needs during MR; MR was seen by some as protection from harm, as well as from additional sentencing which could result from aggressive behaviour. This study mostly included mothers; different carers such as children, siblings or friends would likely have differing views and needs which should be understood.

Martinsen et al. (2019) demonstrated similar themes in young carers aged 14-22. This research did not explicitly focus on RP, but coercion was a primary theme arising from their exploration of young carers' experiences of mental healthcare in Norway. All but one participant were never informed by staff about incidents of RP, instead finding out through their family member, demonstrating a similar unmet need for clear communication. This may be particularly relevant for young carers, who may be negatively impacted by staff's desire to 'protect' them from distressing information. They described feelings of ambivalence and guilt, as they had often been instrumental in having their loved one admitted, and therefore felt responsible for their experiences of RP; this damaged relationships in some cases.

Finally, Valimaki et al. (2022), though focusing on attitudes towards aggression, was considered relevant to the review as RP is often discussed, and utilised, in the context of behaviour perceived as ‘aggressive’. Carers thought that staff need to better understand service users, provide more support, and explore the reasons for their apparent aggression, rather than relying on medication and restraint. All groups in this study endorsed the view of RP as necessary in some instances, and restraint was viewed by all groups as a normal procedure in response to aggression. Despite this, all agreed that the restrictive ward environment could increase ‘aggression’, thereby increasing tensions between staff and service users and leading to unnecessary RP. Carers highlighted the lack of activity on the ward as a significant factor leading to aggressive behaviour and subsequent RP, whereas staff thought that the primary factor was a lack of sufficient safety measures and advocated for increased security guards or police presence. In these focus groups, professionals were present due to safety concerns, which could have limited what carers and service users felt safe to share; views of RP as necessary could also represent an appeasement of the staff present for the discussion.

1.10.3 Critiques and gaps in the literature

Perspectives of carers on this topic in the literature, while emerging, are lacking in nuance and specificity. While offering some measurement of attitudes and comparisons between stakeholders, quantitative studies lack the opportunity for deeper exploration and understanding of perspectives required for a complex, sensitive topic. They are often subject to methodological issues such as using invalid or unreliable measures (Raveesh et al., 2016), or poor description of their procedures (Shrestha, 2018; Bilanakis et al., 2008) which limits replication and understanding of the implications.

While qualitative studies have offered some valuable understandings of the complexities and nuances of carers’ views, in particular the large-scale Australian studies (e.g. Brophy et al., 2016a and 2016b), these are also subject to limitations. Broadly, many studies include carers alongside other stakeholder groups (namely service users and various professionals), and while this can shed light on areas of similarity and difference, some studies summarise themes across all groups, making it more difficult to understand the particular perspectives of carers and leading to a loss of richness of carers' accounts. Adding to this, carers can be less represented in the overall sample in the research due to difficulties recruiting them (e.g. Goodman et al., 2020), which further weakens their voices in the overall findings. As is perhaps to be expected, many studies focus on seclusion and physical restraint; this is understandable given the significant potential for physical and psychological harm associated with these practices, but means that the more subtle forms of RP such as emotional coercion or blanket restrictions can be ignored.

Furthermore, as is outlined above, there are minimal studies conducted using UK samples, and while settings like Australia can be compared to an extent due to some similarities in their healthcare system and wider culture, the NHS is itself a specific context influenced by socioeconomic and political contexts particular to the UK, which will interact with the use of RP and perspectives on it. It is therefore important to widen the UK literature. Of those studies in the UK, and indeed across countries, there are no studies which specifically focus on the perspectives of carers of those experiencing psychosis. Most group all inpatient populations, or 'SMI', together, or do not specify the presentation of the people being cared for. Some studies which do report diagnostic information have a majority or significant proportion of people with schizophrenia spectrum diagnoses, however these are still grouped with other presentations. This is despite the fact that, for reasons outlined in Section 1.6, those experiencing psychosis could present with unique challenges in inpatient settings which could influence their experiences of RP.

1.11 Summary and research question

RP is a pertinent issue within inpatient mental healthcare and can present itself directly through practices like seclusion and restraint, and indirectly through informal or emotional coercion, restrictive physical environments, and blanket rules. These practices can affect some demographics and populations more than others, for example those from Black and Minority Ethnic backgrounds in the UK, and all forms of RP can lead to a range of psychological and physical harms affecting not only the individuals directly involved but those in the wider system around them. Studies into RP, both quantitative and qualitative, often group all ‘SMI’ presentations together, with a minority focusing solely on psychosis, despite the fact that such individuals may have differing experiences of inpatient care to those with diagnoses such as depression or personality disorder, meaning that particular experiences may be lost in the research. Those experiencing psychosis may be at elevated risk of RP, which could be explained by higher rates of psychosis diagnoses in people of colour (who are already at higher risk of being subject to RPs), higher rates of sectioning and the probability of presenting in more acute stages of crisis, or stigmatised perceptions of psychosis within mental health professionals.

Furthermore, carers play a significant role in mental healthcare, particularly in times or crisis, yet are often left out of clinical conversations and research. Carers’ perspectives in the literature were emerging but limited, and sometimes overshadowed by service user or professional perspectives even when included in studies. It is imperative to understand how carers experience and view RP as important stakeholders and advocates, in order to incorporate these voices into debates around RP and shape services and policy. Moreover, carers of those who experience psychosis could provide valuable insights as their loved ones may have difficulty recalling the details of their admission or may be less willing to speak about their distressing experiences. In this way, speaking to carers of those experiencing psychosis about their perspectives on RP could deepen our understanding of whether this population experiences RP differently and what their needs are, as well as understanding the experiences of carers in these situations.

To the author’s knowledge, no research exists exploring carers’ perspectives on the topic of RP pertaining to the particular population of individuals with psychosis, within the context of the UK healthcare system. Therefore, the present study explored the research question: **What are the experiences and perspectives of carers of people with psychosis, regarding restrictive practice in inpatient settings?**

2. METHOD

2.1 Chapter overview

This chapter introduces the epistemological stance of the research and outlines the study design and procedure. Ethical considerations and steps taken to respond to these are discussed. The analytic approach is justified and described, and the chapter concludes with the researcher's consideration of personal reflexivity in relation to the research design, process, and analysis.

2.2 Epistemological stance

This research was predicated upon a critical realist epistemology, which can be seen as ontologically realist and epistemologically relativist (Pilgrim, 2020). Ontological realism assumes a material reality independent of our minds; our thoughts, constructions, and discourses are considered part of this reality, but emerge from an external, material world. Epistemological relativism acknowledges that the ways in which we understand reality, for example via research, are constructed by our own perspectives and experiences (Pilgrim, 2020). Therefore, although a material world exists, each person, community, or culture will perceive it through the lens of various assumptions or narratives. This can be likened to "moderate" social constructionism, in that there are historical, political, sociocultural contexts which construct our versions of reality.

When applied to research, a critical realist position assumes that data can tell us about reality, but are not direct, full representations (Harper, 2011). When interviewing carers about their perspectives on the restrictive practices their loved ones have experienced, we could expect that they conveyed their subjective experience of these events, but may not have awareness of factors influencing both the events and their perspectives on them (for example, cultural or familial beliefs, economic and political contexts). It is therefore recommended to draw upon other sources to understand these contextual factors which might contribute to participants' experiences (Harper, 2011).

From this perspective, the researcher inferred from interviews concrete information about events which have occurred on inpatient wards in terms of restrictive practices, while acknowledging that these accounts were influenced by the social and cultural contexts of each participant. This position also allowed for subjective interpretations of what constituted restrictive practice; in designing this research, it was important for this definition to be broad, as we continue to recognise more everyday practices on wards as inherently restrictive. Therefore, a critical realist perspective allowed for discussion of events or policies which were perceived as restrictive or coercive by the individual or their carer, validating the impact of these alongside more traditionally recognised forms of restrictive practice such as restraint.

2.3 Research design

The study employed an exploratory, qualitative approach. Qualitative methods are recommended for understanding subjective experiences (Barker et al., 2002), which corresponded with the present research question. Semi-structured interviews were utilised to reflect an exploratory position, in which broad topics identified by the researcher were balanced with topics brought by participants, providing the opportunity to gain novel, unexpected insights from participants' unique experiences (Wilkinson et al., 2004). Moreover, the richness of in-depth qualitative data had the potential to capture nuances which may have been previously missed in the literature, both by quantitative studies and qualitative studies focusing on broader groups. This design therefore provided the opportunity to bring forth experiences or perspectives that may be specific to carers of those with psychosis.

2.4 Participants

2.4.1 Recruitment

2.4.1.1 Initial consultation

During initial planning stages, the researcher consulted with a member of the University of East London People's Committee, who was a relative of a person with psychosis who has experienced inpatient restrictive practice. Frameworks such as the ladder of participation (based on Arnstein, 1969) position consultation within a 'doing for' bracket, asserting that incorporating input and experiences of those directly affected into a project is valuable, but that this can also be tokenistic and does not by itself constitute a 'doing with' form of true co-production. The researcher was therefore mindful not to conflate this consultation with co-production at any time, and, in order to reduce the risk of tokenism, endeavoured to put the consultee's suggestions into practice as much and as concretely as possible.

Learnings were incorporated into strategies for recruitment: for example, the consultee advised approaching smaller or localised carer support groups. They also highlighted potential barriers to recruitment, such as that carers are often not informed of instances of restrictive practice during an admission, or alternatively may not think their loved one's experiences constitute restrictive practice. This reflection informed the researcher's approach to defining and exploring what constitutes restrictive practice in conversations with potential participants, and enabled the researcher to raise these potential barriers during screenings and interviews in a curious way.

2.4.1.2 Recruitment strategies

The majority of participants were recruited through volunteer sampling via online advertisement on various platforms: dedicated Instagram and Twitter accounts; online communities specific to mental health, caring, or psychosis; third sector carers' support groups; and websites and newsletters advertising research involvement opportunities. One participant was recruited through the researcher's personal networks. This is discussed in Section 2.6.1.

2.4.1.3 Managing fraudulent contacts

During early stages of recruitment, several emails and messages were received appearing to represent bot or scam contacts. “Imposter participants” are a newly emerging challenge in qualitative research, particularly in studies conducted online and offering compensation. In an effort to maintain a trusting relationship with the target community, while preserving research integrity (Drysdale et al., 2023), these contacts led to the introduction of a screening stage prior to consent (Section 2.5.1). This was seen as a valuable opportunity to establish rapport and comfortability, as well as filtering “imposter” participants through questions intended to confirm eligibility and authenticity (Jones et al., 2021).

2.4.2 Inclusion criteria

The study adopted broad definitions of restrictive practice, as well as who constitutes a carer, to maximise recruitment and capture a range of experiences. The inclusion criteria were anyone:

- over 18 years old;
- who is a relative or other carer (including friends) of someone with any diagnosis relating to psychosis;
- who can speak English fluently enough to participate in an interview;
- whose loved one with psychosis has experienced at least one instance of restrictive practice on a UK inpatient ward (for example: restraint, seclusion, enforced medication, as well as deprivations of liberty such as blanket restrictions, restricted access to phones or outside space, having belongings removed, etc).

There were no explicit criteria relating to the length or amount of time passed since the most recent admission. Instead, during the screening stage mentioned above, potential topics were discussed and participants were asked if they felt they could both remember sufficient detail, and were sufficiently involved at the time, to participate in an interview on the subject. Those that confirmed both of these were considered eligible for participation.

2.4.3 Sample demographics

8 participants were recruited; none withdrew after the point of consent. The demographics of the sample are summarised below in Table 1.

To further protect anonymity, data regarding ethnicity and loved ones' diagnoses will be instead summarised across the sample. Participants were White British (n = 6), White Irish (n = 1) and Other – Mixed (n = 1). Participants described their loved ones' primary diagnoses as: paranoid schizophrenia (n = 4), psychotic disorder not otherwise specified (n = 2), schizophrenia (n = 1), and depression with psychotic symptoms (n = 1). Three loved ones reportedly had one or more secondary diagnoses, which included PTSD, depression, bipolar affective disorder, autism and ADHD, OCD, EUPD, and anxiety disorder.

Pseudonym	**Age**	**Gender**	**Relationship to loved one**	**Restraint**	**Seclusion**	**Forced medication**	**Deprivation of liberty**	**Other (specify)**
Alfie	25-29	Male	Sibling	Y	Y	Y	Y	Y – force feeding via nasogastric tubes
Anna	50-54	Female	Cousin	N	Y	N	Y	Y – restricted access to the internet; witnessing restraint
Christine	55-59	Female	Parent	Y	Y	Y	Y	N
Hugh	65-69	Male	Parent	Y	Unsure	Y	Y	N
Laura	55-59	Female	Parent	N	N	Y	Y	Y – restrictions on belongings allowed to take in
Rachel	50-54	Female	Parent	N	N	N	Y	N
Susan	60-64	Female	Parent	Y	Unsure	Y	Y	N
Zoe	35-39	Female	Sibling	Y	Y	Y	Unsure	N

Table 1: Sample demographics

While this data was not formally collected, interviews suggested that the majority of loved ones had had more than one admission, and that the majority had been under section at least once. Interviews also suggested that most admissions being discussed were within the last five years, although this data was not explicitly collected.

2.5 Procedure

2.5.1 Initial contacts and screening

Potential participants expressed interest via email or direct message on a social media platform. All interested parties were sent a Participant Information Sheet (PIS, Appendix B) and given time to read and consider the information. In the event that they did not respond, the researcher contacted them once more after one week. Those interested in proceeding were offered a brief screening call by phone or Teams, to confirm eligibility, establish familiarity with the researcher, and provide an opportunity to voice any questions or concerns about taking part. Eligible and consenting participants were then sent an electronic Consent Form (Appendix C) by email, and the interview was scheduled. Consent Forms were returned by email, either signed electronically or by hand and scanned.

Two optional boxes on the form were clearly marked and flagged during screening. All participants consented to an optional box to receive a summary of findings after the research had concluded. All participants also consented to an optional box to be contacted for potential member-checking during analysis, where participants would have the opportunity to validate themes against their experiences (Birt et al., 2016); however, this was not possible due to time constraints at the analysis stage.

2.5.2 Semi-structured interviews

Consent was verbally re-confirmed with each participant prior to commencing the interviews, and participants were given the opportunity again to ask questions. They were reminded of potential topics of conversation, and that they could pause or withdraw at any time.

Interviews were conducted on Microsoft Teams and lasted approximately one hour. A semi-structured interview schedule was developed in agreement with the researcher's supervisor, informed by professional experience and knowledge of the topic as well as review of the literature. The schedule began with direct questions regarding the nature of the restrictive practice, then provided prompts for broad areas of potential interest such as the impact, understanding of the rationale, and views on different approaches (Appendix D). An exploratory approach meant that conversations were led both by the schedule and by the points brought by the participant.

Due to the sensitive nature of the topic, the researcher utilised their skills as a trainee clinical psychologist to respond empathically to distress and strong emotions arising during the interview, taking care to validate the perspectives of the participants. The power imbalance between researcher and participant in this case was further emphasised by the researcher being employed within the NHS, thus representing the system which had perpetuated harm. A deliberate decision was made to name this dual role and normalise feelings of potential distrust towards the researcher, and to respond non-judgmentally and non-defensively when participants expressed negative views towards the system or psychology. Processes for debriefing and compensation following conclusion of the interviews are described in Sections 2.6.2 and 2.6.3.

2.5.3 Data management

Interviews were recorded and auto-transcribed within Microsoft Teams. In accordance with GDPR and the Data Protection Act (2018), recordings and transcripts were stored securely on UEL OneDrive, a secure cloud-based storage, accessed through a password-protected account. Transcripts produced by Microsoft Teams were anonymised by the researcher: all names of people and places such as hospitals or wards were removed, and participant names were replaced by a pseudonym.

Personally identifying data, including participants' names and contact details, was stored separately and kept only for the duration necessary to contact participants to provide a summary of the research findings, or identify their data in the case of withdrawal, which was not required. Anonymised demographic information, anonymised transcripts, and other files pertaining to data analysis and interpretation will be retained for a maximum of five years after conclusion of the project and stored on a UEL OneDrive account, to allow for amendments and potential dissemination.

2.5.4 Transcription

Automatic transcripts were obtained from Microsoft Teams, but contained varying degrees of inaccuracy depending on audio quality. The transcription process therefore entailed listening to interviews in full and correcting or re-writing transcripts to present an accurate account. Transcription was carried out by the researcher, and treated as a key phase of data analysis in supporting initial immersion in the data (Bird, 2005). As Point and Baruch (2023) highlight, transcription is an interpretative act biased by the judgements the researcher makes during the process. As such, the researcher was mindful of their preconceived ideas and experiences relating to the topic area. A primarily denaturalistic approach to transcription was taken (Oliver et al., 2005), meaning that idiosyncrasies like pauses or stutters were mostly removed, and tone and non-verbal gestures were not described. This was in line with the critical realist stance, and the focus on analysing content rather than form in this study (analysing what was said, rather than how it was said).

2.6 Ethical considerations

Ethical approval was sought from (see Appendix E) and granted by the University of East London (UEL) Ethics Committee, subject to a minor amendment querying the handling of already-collected data if an insufficient number of participants were recruited for thematic analysis (see Appendix F). It was resolved that if needed, a mixed-methods approach would integrate existing interview data with supplementary data from sources such as blog posts and personal accounts, ensuring the contributions of participants already interviewed were not wasted. However, the minimum number of participants was reached and this strategy was not necessary. The study was designed in line with the UEL Ethics Committee guidance and the British Psychological Society (BPS, 2014) Code of Human Research Ethics, and prioritised protecting the rights of all participants in accordance with the Human Rights Act (1998). Particular considerations are outlined below.

2.6.1 Recruitment through a personal network

As mentioned in Section 2.4.1.2, one participant was known to the researcher as an ex-colleague prior to their participation. This raised considerations such as whether they felt pressured to consent, or potential conflicts of a dual relationship. To address the former concern, the researcher did not approach this participant, rather they volunteered via a social media advertisement. Addressing the second point, conversations were had prior to consent informing them of the nature of the interview, and discussing transparently the implications of sharing information that the researcher may not otherwise have known. The participant had the opportunity to choose what to disclose. During the interview, the researcher was mindful of separating prior knowledge from the questioning. No concerns were raised at any stage.

There is a possibility that this participant's data could be influenced by response bias, in potentially giving answers intended to conform to the researcher's expectations or desired responses based on our prior working relationship. To manage this, the researcher ensured questions were as open as possible and made efforts to balance empathetic responses (to build rapport and comfort during the interview) with being mindful not to lead or sway their responses.

2.6.2 Informed consent

To ensure that consent was fully informed, all potential participants were sent a PIS via email in response to their initial contact. They were encouraged to take time to read this in full and consider the details of the study. The PIS contained information on the rationale and background of the research, a detailed outline of the procedure, benefits and risks (including potential distress), information on data management, and specific processes of withdrawal from the research. It explicitly outlined probable areas the interview might cover, in consideration that the subject matter is emotive and that prior preparation may help to manage potential distress.

The initial screening call outlined in Section 2.5.1 also provided an opportunity to confirm participants' understanding of these areas to ensure their decision was fully informed, as well as allowing them to raise questions or concerns. Once participants agreed to take part, written consent was documented via a completed Consent Form, returned by email. Informed consent is an ongoing and dynamic process within research which does not stop at signing a form (Gupta, 2012). In light of this, consent was verbally re-confirmed prior to the interview beginning, and participants were reminded of their right to withdraw at any time.

2.6.3 Potential distress

The interviews centred on the inherently sensitive subject matter of loved ones' experiences of restrictive practices, requiring participants to recall times of acute crisis. The potential for psychological distress for participants was acknowledged both within the PIS and the screening call. This was managed by ensuring participants knew they could take breaks at any time, as well as to inform the researcher if they did not want to answer a question or go further into a topic. The semi-structured approach supported a more conversational interview style, to allow participants to feel as comfortable as possible. Where participants expressed difficult emotions during the interview, the researcher was able to use their skills as a trainee clinical psychologist to respond to this sensitively and empathically, as well as confirming their consent to continue.

All participants were given an immediate debrief after the interview, where they could reflect on the experience and feedback any concerns. A further debrief by phone was also available within two weeks of the interview date, in the case of participants becoming distressed or concerned about the conversation after leaving the call. No participants required this. The researcher enquired about personal support networks, and a debrief sheet was supplied with details of organisations which could provide further support if needed (Appendix G).

2.6.4 Compensation

Participants were not only contributing their time, but being asked to recount often painful personal experiences which could be upsetting. In return for their contributions, a £5 voucher was offered to each participant, which required the completion of a form. Some participants elected not to accept this; most due to not wanting to be compensated, but some due to concerns around supplying personal details in order to claim the voucher. This posed an ethical dilemma; as this process was unavoidable, the researcher ensured all participants were aware of the requirements to claim a voucher before consenting, allowing them to make an informed decision.

2.6.5 Language used in research materials

Study materials such as the PIS, Debrief Sheet, and graphics used to advertise the study, contained the term “loved one” to refer to the person being cared for by the participants (alongside terms like “relative”). This was intended as an inclusive term as the research was open to carers of all kinds, not only family members (for example, friends or partners who are in a caring role). It was also considered preferential over terms such as “service user”, which is used in more clinical contexts and may be alienating and impersonal to a carer audience. The use of this term both in research materials and within this paper, and the potential limitations of this, is discussed reflectively in Section 4.4.1.

2.7 Analytic approach

2.7.1 Justification of thematic analysis

Guided by the research question and epistemological considerations, a thematic analysis (TA) approach was considered the most appropriate to interpret the data.

TA is a qualitative method for identifying and analysing patterns of meaning within a dataset (Braun & Clarke, 2006), best suited to “elucidating the specific nature of a given group’s conceptualisation of the phenomenon under study” (Joffe, 2012). It is often employed to explore subjective experiences and perspectives of a particular group of people; in this case, carers’ perspectives of inpatient restrictive practices applied to people with psychosis. Similarly, TA can be applied within different epistemological frameworks. In this case, applied with a critical realist stance, it acknowledges the meaning-making and broader contexts within individual accounts, while maintaining a focus on ‘real’ material events (Braun & Clarke, 2006).

Themes can stem from manifest content, which is explicitly spoken, and often require researcher interpretation to tease out latent content, or more implicit underlying meanings (Joffe, 2012). This process was important for a topic such as experiences of restrictive practice, as there may have been many implicit meanings beyond that which was shared explicitly. Participants may not be consciously aware of some underlying factors, or for many reasons may be unable or unwilling to speak them aloud, for example being directly critical of NHS mental health services when interviewed by an NHS mental health professional. This was in line with the critical realist and moderate social constructionist ideas that perceptions and experiences of the world are inevitable shaped by higher contexts, and these will not always be explicitly accessible.

The analysis utilised a combined inductive/deductive approach, which is recommended for high-quality qualitative work (Joffe, 2012). From a bottom-up interpretation of the raw data, the researcher sought to understand participants’ experiences and perspectives, and remained open and curious to themes being driven by new or unexpected concepts. However, the researcher also held some expectations derived from psychological and social theories, professional experience, and pre-existing literature. Demarcation of themes was grounded in Braun & Clarke (2006)’s guidance emphasising whether a theme captures something important in relation to the research question, rather than necessarily its prevalence within the dataset.

A further strength of TA is its systematic and transparent nature with regards to specific processes of analysis, which this paper represents by detailing the analysis stages below.

2.7.2 Stages of analysis

Data familiarisation: This stage began with conducting and transcribing the interviews. Following transcription, each individual transcript was re-read multiple times. During these readings, the researcher established an understanding of the breadth and depth of the content and began noticing potentially meaningful patterns. Note-taking was used to gather initial ideas for potential codes, and reflections throughout.

Generation of initial codes: Transcripts were imported into NVivo 14, which was used throughout analysis. Coding involved identifying the most basic segments of raw data that could be interpreted in a meaningful way according to the research question (Boyatzis, 1998). Coding was carried out electronically, following Braun & Clarke (2006)'s guidance to code inclusive of surrounding context to preserve meaning. An example of a coded transcript extract can be found in Appendix H.

Searching for themes: Themes were identified and constructed with relevance to the research question and prevalence across the dataset in mind. Handwritten notes were used to support reflection and flexible thinking around ways in which codes could be organised and how they related to each other. NVivo was then utilised to formally organise codes into initial themes and sub-themes.

Reviewing themes: Initial themes (see Appendix I) were discussed reflectively with the research supervisor, and the framework was reviewed to identify areas where clarity was needed or coherence could be enhanced. This led to further refining and the development of the final thematic framework.

Defining themes: Once themes and sub-themes were finalised, each was given a name which represented the 'story' it was telling, situating this within the broader narrative.

Report-writing: In reporting the results of the analysis, themes and sub-themes were summarised in a way which described the themes and explicit content of the data and also built a coherent narrative. Extracts were selected from anonymised transcripts across the dataset to evidence the themes, as well as to bring life and voice to the narrative.

2.7.3 Reflexivity

Reflexivity is an essential component of both the qualitative research process and of a critical realist approach. Willig (2008) defines personal reflexivity as the ways in which the researcher's values, experiences, beliefs, and social identities directly shape the research, and in turn the personal and professional impacts of the research on the researcher. The latter, along with epistemological reflexivity, will be returned to within the discussion, while the former is discussed here.

During data collection, transcription and stages of analysis, the researcher engaged in reflective journaling to intentionally and consciously consider aspects of their identity and experiences which were relevant to the research process. The researcher held previous professional experience of working as an Assistant Psychologist within acute inpatient settings, and had witnessed multiple forms of restrictive practice. These experiences evoked strong emotional responses and formed a foundation of strongly-held beliefs around person-centred care, fairness, and human-rights approaches to crisis. The researcher was also aware of their own lived experience of mental health difficulties allowing a deeper level of empathy, while acknowledging their privilege in not having required hospital admission, and therefore being mindful not to assume they can automatically 'understand' the experiences discussed. Clinical psychology training at the University of East London had enhanced pre-existing critical ideas held by the researcher towards 'traditional' mental health services and the biomedical model, and contributed towards the researcher's questioning of the popular disease-based definition of 'psychosis'. The researcher was aware of how this could unconsciously steer both the direction of interviews and the interpretation of data, and yet also valued the ability to genuinely empathise with participants having witnessed similar incidents or who hold similar critical views.

Informed by Social GRACES (Burnham, 2012), the researcher considered the intersection and opposition of their various identities with potential participants. As a white female from a lower-middle class background, there were disparities between the researcher’s identities and those of the people most often diagnosed with psychosis, and most affected by restrictive practice and hospitalisation (notably Black men). Thought was given to this during the planning and execution of recruitment, and considering how to navigate differences during interviews. As shown in Table 1, the sample actually had a prevalence of White British voices, in contrast to these statistics; the researcher reflects on this within the discussion.

2.8 Quality appraisal

There are debates about the appropriateness of applying standardised quality criteria to a qualitative approach (Smith, 1990). Therefore, three guiding principles of quality (Spencer & Ritchie, 2011) were used to appraise the current study: contribution, credibility, and rigour. This is discussed in the critical review (Section 4.3).

3. RESULTS

3.1 Chapter overview

This chapter presents the findings of the reflexive thematic analysis exploring the research question, “What are the experiences and perspectives of carers of people with psychosis, regarding restrictive practice in inpatient settings?”.

Five themes were constructed from the data, each with two to three sub-themes. The final thematic map is shown in Figure 1, while earlier themes can be found in

Appendix I. Transcript extracts are included to support the researcher's interpretations of the data. Some quotes have been edited for clarity and brevity; ellipses have been inserted where words have been removed. Interviewer interjections are italicised. Square brackets are used where identifying information has been redacted, or clarifying information added. Some smaller quotes are used within paragraphs or theme titles; text within quotation marks should be noted to be taken from transcripts.

It is important to note that the majority of participants expressed difficulty in fitting their experiences of RP into the categories used within the closed questions at the start of the interview, reflected in the columns of Table 1. In addition to practices identified at this stage, many identified further examples throughout the interview: these included the application of blanket rules, the physical environment itself being restrictive, and many accounts of emotional coercion, such as threats of restraint or psychological manipulation. Where carers are referring to a particular practice, this has been noted, however the themes presented capture carers' experiences across the spectrum of RP, rather than relating to specific practices.

Within each theme, experiences are discussed which are distressing and can evoke strong emotional responses. The practices in Table 1 and mentioned above may be labelled in different ways by different audiences; for example, for some, such experiences would be seen as in line with abuse. This is referenced at times throughout this chapter where relevant to participants' descriptions. However, the researcher's approach to analysis aimed to faithfully conceptualise the experiences and perspectives conveyed by the carers, rather than describing or categorising events on the ward. The majority of participants did not use this language, so the researcher chose not to broadly label their experiences as abusive in the thematic framework when they may not identify with this. However, considering that many readers may relate the findings to abuse, this is discussed further in Section 4.3.3, in line with the remit of the Discussion chapter to make links and place findings in context of wider concepts beyond the interpretation of the data presented in this chapter.

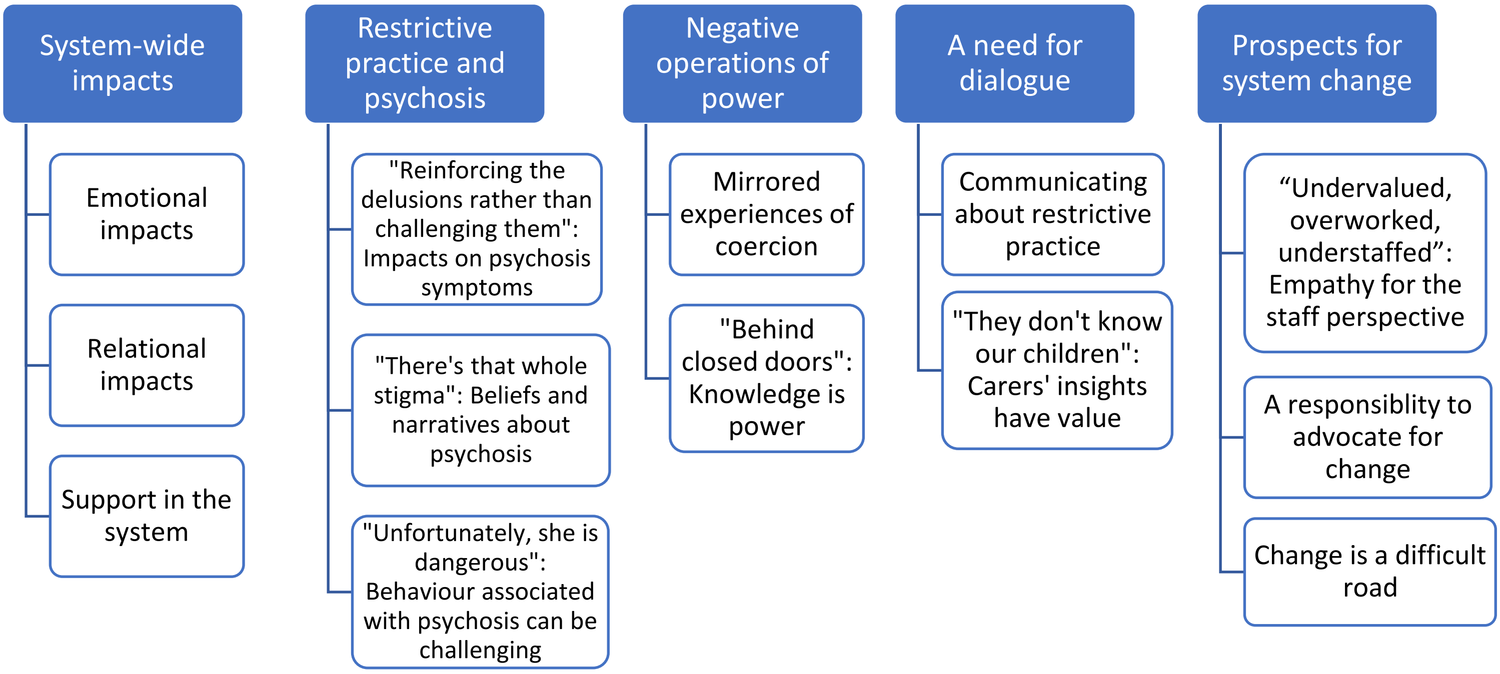

Figure 1: Thematic map

3.2 Theme 1: System-wide impacts

This theme encapsulates the impacts of RP on carers, their loved ones, and throughout the wider system around them. It includes three sub-themes, capturing emotional impacts, relational impacts, and support within the system.

3.2.1 Emotional impacts

The first sub-theme relates to the wide-ranging emotional impacts associated with RP, endorsed by all eight participants. Many described anger in response to RP, such as Hugh after hearing about incidents of restraint:

> Me? Oh God, I I sort of get sick with anger. Takes me two three days to wind down and, and if not longer. – Hugh

References to “agitation” to conceptualise the distress for both parties implied a sense of restlessness in response to RP, but simultaneously appeared to make it difficult to share or talk about the distress with others:

> The day after [a restraint], I could see [my son] came in shaking, I go what, what’s up? And he was just sort of mumbling really to himself, quite agitated. And, um, that’s quite horrible. – Hugh

> [While my sister was hospitalised] I was proper aggressive, agitated all the time, erm, it’s like erm, I didn’t know how to talk about certain things. – Alfie

Carers spoke about the particular emotional impact on loved ones of having personal belongings or access to outside restricted, as this could limit their access to coping mechanisms which could otherwise alleviate distress. Laura gave the example of being unable to smoke due to not being allowed outside of the grounds:

> the cigarette thing is a massive thing because that's a big part of his life, sadly. And yeah having limited access to that is very difficult. – Laura

> I think [seclusion] was a bad thing because again she didn’t have access to her things, nice things, you know which would help her to distract her. – Anna

Worry, anxiety, and fear were present for both carers and their loved ones. Carers felt their loved one had become more anxious as a result of repeated exposure to RP, and that these fears went beyond the confines of the ward to being “terrified of the world” (Hugh). Rachel’s son’s experience of having his belongings removed upon admission had led to intense fear, which framed his initial experience of entering hospital:

> I just remember us seeing [Son] on his chair, um, and shaking like it just his whole body was shaking and it was just from fear of the situation he's in right now. – Rachel

Anna described her worry for her cousin’s safety in response to the removal of her phone by staff, as this impacted their ability to keep in touch:

> it makes me worry how she is, it makes me worried that she's suffering needlessly. – Anna

For some, knowledge of the risks of serious physical harms associated with practices like restraint led to a genuine fear that their loved one could die. Susan described her experience of witnessing her son’s restraint, knowing that a friend’s son had died as a result of restraint prior.

> [My friend’s son was] held down and unfortunately he he died in hospital a couple of days later. *[It’s awful.]* So. Which is such a worry you know, because we, we know this can happen. … there's no need for that because you know they can inject them without like all jumping on top of them so they can't breathe. *[Yeah, yeah.]* Yeah it was really, really frightening. *[Yeah.]* He was saying, my son was saying I can't breathe I can't breathe. – Susan

Witnessing RP was experienced as traumatic for carers, from restraints to, in Rachel’s case, the removal of belongings:

> And for us as parents, it was incredibly traumatic and I think I just, soon as I saw where we were going, it was, I was mouthing to my his my coparent, [Son]’s father, I think we should go, this isn’t right, this isn’t where we, he should be. – Rachel

Considering the traumatic effects of RP on their loved ones, some reflected on past traumas potentially being re-activated by restraints and injections, such as “sexual violence” (Zoe). Alfie described his sister’s flashbacks and dissociation when triggered or reminded of RP, years after the incidents:

> [Previous restraint] still does [affect her] now, like you turn around and you sort of speak about certain things and you, oh, she'll flashback. Like she'll literally sit there in a daze, and you’re like, ‘[sister’s name].’ Like ‘what's going

> on mate?' And it's like this completely like, it's, it's, she's sitting there thinking about certain things. – Alfie

Carers' stress and emotional distress was described as long-term, with Laura sharing that she had since been "diagnosed with PTSD" relating to her memories of her first visit to her son on the ward. These impacts were so profound that they shaped carers' outlook on their lives, such as Zoe's decision not to have children:

> And it's even influenced things like I've decided not to have children, because although it's, you know, in the scheme of things relatively unlikely that they would have that particular condition … I just can't tolerate the idea that I might create a human being who has to suffer like that. *[Mmm.]* That is how strongly I feel about it. – Zoe

Carers experienced emotional pain in response to observing how their loved ones were being treated, or their loved ones' distress caused by RP. This was linked to a sense of injustice that their loved one deserves compassionate treatment, and disappointment that a setting which was supposed to provide care was causing harm:

> especially when, you know, he's such a kind loving person. And to see people treating him when he's unwell, the way that they do, it really does. Yeah, really, really hurts me. – Susan

Zoe described a sense of dread prior to calling her brother on the ward, due to the intense emotional distress of hearing about his experiences of RP:

> I would dread it. It would be the the worst parts of my week and I'd almost have to kind of go through this psychological trick with myself of saying, you know, if there's no answer after five rings, I'm allowed to hang up. – Zoe

Many carers endorsed feelings of guilt, or having betrayed their loved one, associated with RP. This was often linked with being instrumental in having their loved one admitted; in Hugh's case, having sought a particular referral in the belief that this hospital would provide better care. Carers therefore felt responsible to an extent for their loved ones' harmful experiences during admission:

> I thought oh this isn't going to go very well, and they sort of hinted they're going to force [restraint] on straight away, and I thought oh shit, I wish I hadn't, we tried to refer him. – Hugh

> Devastating. Because you kind of feel you, you feel bet- you know that you've betrayed them as well, because obviously you know, you you do call someone because eventually you think I just don't know what to do because I was, I had no experience of mental health. – Christine

Others felt a general sense of guilt at being unable to "do more" to help or comfort their loved one, given what they were experiencing:

> I felt very guilty because, I just felt a sort of vague sense that I could be doing more, even if it was something as simple as just phoning more often or, finding ways to visit even if it was the other side of the country – Zoe

Several carers spoke about suppressing or bottling up their own emotional distress for the sake of protecting or supporting their loved one. Coupled with their feelings of guilt or responsibility for RP, this could relate to their perception of their roles as carers, which might translate to placing their loved ones' needs ahead of their own:

> You know, because I used to be able to hold it together when I was with [my son]. But as soon as I left the hospital, the frustration and the upset and the hurt and the anger and everything, and as I say I used to just cry ever such a lot. – Susan

> So you know, I learnt over time to be able to say, I'm I'm really, really sorry, how did that make you feel, that sounds terrible, and just empathise [with my brother]. But on the inside I'd be in a lot of pain myself and trying to hold back tears over the phone. – Zoe

3.2.2 Relational Impacts

This sub-theme refers to the perceived relational impacts of RP between carers and their loved ones, throughout wider family networks, and relationships with services. This was endorsed by seven participants.

Many carers reflected that RP had negatively affected their relationship with their loved one. Anger and blame appeared to be directed from loved one to carer and vice versa, where each party at times held the other responsible for what was happening and the ensuing emotional distress:

> there was a stage where I did nothing but blame [my sister] for everything that had gone on. – Alfie

> Yeah, because I, it was, [to my son] it was my fault a lot of the time. – Christine

Carers' attempts to manage their own distress could be perceived by their loved one as a lack of support, which harmed their relationship:

> I can't really deal with it, so I'm just gonna sort of shut down and become like a tortoise. Um, which just made it worse because [Brother] then felt I wasn't taking his feelings seriously and wasn't being there to support him. – Zoe

However, some carers spoke about the enduring nature of their relationship with their loved one. Several referred to preserving the dynamics of their relationships, weathering the harmful experiences of RP as a team, and even that these experiences had brought them closer:

> we have a very good relationship now, it's quite funny we have that typical brother sister relationship of, if people see it on the outside I'll take the piss out of her and I'll play pranks on her, and she'll do exactly the same to me – Alfie

> We can still make the best out of the worst situation sort of thing … He will always tell me the truth as well. Even if he says mum, you're gonna be angry. So I was like, well, you know, we've been through worse. – Susan

> I'm very grateful that she trusts me and confides in me about anything. So in fact, if anything, it’s strengthened our relationship because she knows I'm there. – Anna

Several carers described rippling impacts of RP throughout their wider family. For some, relational difficulties arose from feelings of anger and blame relating to RP; for others, from disagreements about whether inpatient care was doing more harm or good for their loved one:

> You end up disagreeing, you know about what’s the best thing for your child. And then when that’s in between the family, the hopelessness just um, the despair can be huge. – Hugh

> Well you’re very angry, and [his] brothers are angry, you're all angry, you're frustrated, you. It’s, it’s. It’s a very destructive period. – Christine

Further, carers spoke about how their loved one’s relationships with inpatient and community services were damaged by their experiences of RP. This often led to their loved one being unwilling to seek help in times of crisis or engage with services to maintain their wellbeing, which was distressing for carers:

> he's terrified of services in any way shape or form now, he's got no, no team behind him. He's not taking medication and he's unwell. And it's sort of very, very difficult. Yeah. – Laura

These testimonies suggest that the enactment of RP on one individual significantly affects not only their relationship with the people and services around them, but also relationships between others in the system.

3.2.3 Support in the system

This sub-theme, relating to four participants, captures carers' experiences of seeking support to manage these impacts, and of providing support to others.

Some carers spoke about the value of professional support for mental health difficulties in light of their experiences of RP. Laura shared that she was waiting to receive "EMDR" (Eye Movement Desensitisation and Reprocessing) relating to traumatic memories of her son's admission. Alfie shared that he and another sibling had been "under CAMHS, having counselling sessions" to process his sister's experiences, as well as "support groups and stuff that my mum went to" which were experienced as beneficial. Alfie reflected on the positive impact of having accessed timely support:

> [Without support] I'd probably have a lot more questions … and I probably wouldn't have the understanding of, what has actually happened to her. I probably wouldn't even be able to talk about this. I'd probably shut, try and block it as people do – Alfie

Hugh spoke about the importance of finding and building community, benefiting from connecting with like-minded carers with similar experiences:

> what I found solace in is just meeting other families who agree with me. So that's, my networking, why I do little things like that [Name of Organisation] idea. – Hugh

Some carers also spoke about harnessing their difficult experiences of RP to help others, either professionally through their careers, or through communities.

> I can only use that and what I've been through as a better opportunity to support family members when they're going through experiences. – Alfie

> I kind of do an online family support, but you know, we just kind of. We did try to explain what's normal, what the real risks are, and you know, 'cause, it's just people just haven't got a clue what goes on. – Hugh

> It's influenced the work that I do, that I’ve gone into public service to, I don't know, can't save [my brother] so maybe I can save someone else, I don't know. – Zoe

3.3 Theme 2: Restrictive practice and psychosis

This theme pertains to carers’ perspectives of how RP interacted with their loved ones’ unusual experiences associated with psychosis. It captures a bidirectional relationship described by carers, wherein they felt that experiences of RP worsened or increased their loved ones’ symptoms, as well as aspects of their behaviour and ways in which they were perceived by staff making them more vulnerable to RP.

3.3.1 “Reinforcing the delusions rather than challenging them”: Impacts on psychosis symptoms

Firstly, many carers perceived RP as exacerbating the delusional beliefs their loved one was distressed by during admission. This sub-theme was endorsed by seven participants. For example, experiences of restraint and forced injections were thought to confirm existing paranoia and fears relating to staff:

> And he believed that he was being injected with a range of different things, microchips, you know, all kinds of things, things that were going into his cells and things to control him. Um and fed into his feelings of fear about what staff in different care settings were doing to him, or who was in charge of them. – Zoe

> [my son] did say to them you’re poisoning me … and [staff] said he was being delusional and it’s like, well actually he’s not, you’re delusional ‘cause that’s exactly what you’re doing. – Christine

More everyday environmental restrictions, such as cameras in bedrooms and locked doors, were also felt to increase loved ones' feelings of fear and paranoia in the context of psychosis:

> I'd feel quite panicked if someone locked the door and wouldn't let me out. And and especially when you're suffering the, the terrors what my son does. And then you're locked in with those terrors. You can't, you can't get away from them. – Susan

There was a sense in some interviews that this negative impact was worsened by the fact that their loved one, while unwell, had an impaired understanding of what was happening and why. This confusion may have made RP even more distressing, such as in Alfie's sister's experience of restraint and injection, and Rachel's son's experience of having belongings removed:

> When you're in a very vulnerable state, you don't understand something, and then all of a sudden you've got people piling on top of you or you got things being taken away from you, things being shoved in your nose and all of that, it just becomes like, what on Earth is going on? – Alfie

> he didn't know what how strict they were gonna be. He was just too out of it to know whether they were just taking it away completely. – Rachel

Being deprived of familiar items or meaningful activity was also felt to have a detrimental impact on their loved ones' psychosis, as it left them without distraction from their unusual experiences:

> chances are it can accentuate paranoia. And and obviously it's, if you, if you're in a kind of barren environment with little to do, you're more vulnerable to, to, it's harder to distract from the psychosis, um, and you know, you know, do and manage it, because there's nothing else to fill your mind or fill your time. – Anna

> there’s nothing reassuring or safe or um, comforting that he can turn to, he’s just in a room that’s completely void of any personal belongings. And I think it would have definitely increased his psychosis symptoms for sure, and his anxiety level. – Rachel

Some carers also acknowledged that, as loved ones’ experiences of psychosis could be traumatic and damaging in themselves, separating the additional impacts of RP could be difficult:

> I think in some ways it's quite difficult to try and kind of turn around and say what was because of what she'd experienced, but also because of what was going on in her mind. – Alfie

3.3.2 “There’s that whole stigma”: Beliefs and narratives about psychosis

In this sub-theme, various beliefs about psychosis were named by carers, some relating to theoretical understandings of psychosis and some to societal assumptions or narratives about people with psychosis. Several carers felt that these ideas may have been either explicitly or implicitly present in staff or in ward culture, and may have led to RP being used for their loved one. This sub-theme relates to seven participants.

Some carers acknowledged that the label of psychosis could be associated with ideas of being aggressive or dangerous. The perceived negative connotations attached to such diagnoses were felt to be detrimental to their loved ones’ treatment.

> you don't want to be like, it's just everything that's associated with it. It's, you know, it's got such stigma and negative connotations. – Laura

Alfie shared his perspective that staff would “assume the worst” about his sister, which could lead to unnecessary RP being used. He related this to their potential associations of psychosis with aggression:

> you've been labelled with psychotic symptoms or psychotic disorder at a young age. People just literally think they're a murderer. They're, they're gonna kill people. They're going to be aggressive and stuff. – Alfie

Some spoke about commonly-held medical explanations of psychosis amongst inpatient staff, framing psychosis as an illness or disease. Some felt that these ideas belied a reliance on medication as the necessary treatment, therefore increasing the likelihood of forced or over-medication of their loved one.

> [staff] see it as an illness that needs medication and then, get them in or get them out on it – Hugh

Others highlighted that biomedical ideas of psychosis allowed staff to minimise the impact of the restrictive physical environment of the ward on their loved ones' mental state, in contrast to carers' opinions that the environment was "feeding into" their distress:

> they just think that the patient's ill and it's the illness. That was, you know, said to us quite often, it's just the illness, when we were saying well, this isn't a great environment for him – Rachel

Other explanations of psychosis, such as that it may be related to parenting, were highlighted. Zoe explained how she perceived ward staff to at times place the blame on her parents for her brother's behaviour on the ward, which then was seen to provide a justification for their use of RP to manage such behaviour. Zoe observed this through her parents' responses to staff, explaining that they felt responsible and apologetic for his expressions of distress:

> a member of staff would say oh you know [Brother] can't come to the phone because, well, you know, there's been an incident because you know, it's, it's [Brother]. [My parents] would be the ones saying oh god I'm so sorry I'm, you know of course of course of course, we understand completely, I'm terribly sorry, you know, sorry that you're having to put up with him. – Zoe

Furthermore, some carers spoke about infantilising ideas held by professionals about people with psychosis, where professionals appeared to hold low expectations for what someone with psychosis could do or achieve. This was thought to perhaps reinforce a lack of motivation in staff to engage meaningfully with their loved ones due to a lack of belief in recovery, which could lead to RPs being used.

> there's no ambition … It's just totally absent, and so you end up in this revolving door of care where people become institutionalised and that model of care then embeds, that low ambition for patients sort of embeds an idea that it's just about churn, you know, just just kind of get them through, it doesn’t really matter – Zoe

Not only were loved ones felt to be vulnerable to RP because of these narratives and conceptualisations of psychosis, carers also reflected that they are less likely to be believed or taken seriously when raising concerns about RPs, due to being viewed as unreliable:

> I know it sounds really kind of not true and ‘delusional’, which is another thing. Is that if anyone does report any kind of abuse, verbal whatever, they just wash, put it aside. – Christine

3.3.3 “Unfortunately, she is dangerous”: Behaviour associated with psychosis can be challenging

Carers also reflected that the ways in which loved ones could express their distress or respond to what they were experiencing, could result in unpredictable or chaotic behaviour that could be challenging for staff to manage. This sub-theme was endorsed by five participants. They acknowledged that at times, the use of RP could be understandable in response to such situations.

> I mean obviously with the psychosis, it's more erratic, so I can understand the staff being, um finding that more challenging. – Susan

> he's suffering with ill health that will lead to unpredictable and sometimes very challenging behaviour. – Zoe

Some also acknowledged that the perception of their loved one as dangerous or aggressive could, at times, be accurate; whether this was due to their psychosis generally, or evoked by situational triggers:

> because when she's unwell, she's very high risk. She's, unfortunately, she is dangerous. – Alfie

> [the seclusion] probably was because he was being aggressive towards [the staff], because they're pretty aggressive anyway. – Christine

Overall, there was a sense that staff were ill-equipped to manage the behaviours associated with psychosis, which was seen to lead to a reliance on RPs such as over-medication:

> They’re just unskilled with those things, they’re unskilled with psychosis, unskilled with bipolar. You know, whatever it is, they just throw loads of medication at it. – Hugh

3.4 Theme 3: Negative operations of power

While the thread of power runs implicitly throughout all discussion of RP, and indeed is present across the other themes presented here, this theme captures carers’ explicit and direct experiences of power enacted by staff and the inpatient system in general. The two sub-themes respectively explore carers experiencing coercion themselves in similar ways to their loved ones; and how the structures and systems of the wards were seen to maintain power imbalances. Taken together, they portray a cycle of harm perpetuated against both carers and loved ones through oppressive power structures, and capture their responses to this.

3.4.1 Mirrored experiences of coercion

This sub-theme was endorsed by five participants and captures their experiences of coercion and powerlessness that mirror those of their loved ones.
Carers’ accounts of loved ones’ experiences of RP frequently included threats, emotional coercion, and manipulation. Carers emphasised that these more subtle practices should be discussed, considering them just as prominent and harmful as physical interventions like restraint, forced medication and seclusion:

> then they do the psychological coercion, don't they? Well, you've got no freedom unless you take medication. – Christine

Many carers used the concept of “compliance” to describe how their loved one had adapted to the environment, implying that they either became passive in adhering to staff expectations or learned to “play the game” in order to leave hospital:

> He, my son will be quite compliant, um. To, he’s bright and he knows that the sooner he complies, the sooner he'll be released. – Susan

Examples such as Susan’s quote above may be compared to abusive relational dynamics, suggesting that loved ones were acting so as to survive and escape the situation as soon as possible.

Such themes of emotional coercion were also present in carers’ own experiences of interactions with professionals during their loved ones’ admission, displaying the permeation of power imbalances and harm not just enacted on the individual but throughout their support system. They described feelings of helplessness in the face of perceived authority, and an understanding of how their loved one experienced this:

> In fact, I think I remember when I really felt, or [Son] must have felt or at least had a taste of it, when the doctor said to me, we’re gonna put him on Clozapine anyway whether you like it or not.” – Christine

> I think, you know you are coming up across a, an authority that you don't feel you're very, you have much power. – Rachel

Through their positions of authority and perceived expertise, professionals were seen by some to use medicalised language in order to justify RPs. This was seen in relation to concepts like "capacity" and "insight". For example, Hugh described this as a repeated excuse for forced medication and restraint used on his son, as professionals framed him as lacking insight into his condition and therefore unable to make decisions about his care.

> this thing about capacity, he's unaware of what he's doing, so he needs his meds, he's unaware that the drugs help him. And I go, well fuck that, you know, he doesn't like your fucking drugs, and you're not listening to him. – Hugh

As a result of these experiences, carers described feeling "bullied" (Hugh), belittled, and hurt by professionals:

> you feel really small and outnumbered, and unsupported. – Rachel

> they even did it to me, you know, it was totally, they just take your power away from you. You have no power. You have no, or control or whatever the word is, you have no control over your own life. – Christine

In these ways, their experiences are comparable to those of their loved ones, despite their distanced position from the inpatient environment itself. These mirrored experiences of the negative impacts of power associated with inpatient care suggest wide-reaching oppressive effects throughout families and wider systems.

3.4.2 "Behind closed doors": Knowledge is power

This sub-theme, endorsed by all eight participants, captures carers' experiences of inadequate information and knowledge relating to RP and inpatient care, which compounded their feelings of powerlessness and left them more vulnerable to perceived manipulation or coercion from staff. Carers spoke about a lack of understanding of how the wards work or what to expect, particularly during early admissions.

> I was very new to severe mental ill health then, you know, it was his first admission and…I didn't, I didn't know what on Earth was going on, you know. – Laura

> So it's totally unknown just how much you're allowed to do, how much, what the rules are really, if they're going to get worse. We didn't really know anything about sectioning or, um, we were quite surprised to find out that even though we'd gone in as an informal they could still section him – Rachel

This places carers in a position of needing to place trust in what professionals are doing and saying, and being less able to question practices they might be uncomfortable with. This was further compounded by what many described as a 'closed-door' culture. The majority of loved ones' admissions were not on secure wards; this instead referred to a perceived lack of transparency from the ward about rules and expectations, and repeated barriers to gaining information about what was happening to their loved one.

Carers spoke about their efforts to gain information on their loved ones' progress on the ward or incidents of RP as frustrating and often unsuccessful, with many perceived barriers:

> sometimes when you ring [the ward] you can't get, there's no one to answer the phone or they say the right person to answer the query isn't there, they don't get back to you. Um, I have sent emails, so sometimes I've got the reply, oh this, we will look into this, but nothing happens, nothing happens. – Anna

When it came to RP, carers largely described gaining information from their loved one about what they had experienced and why. They actively sought information from sources like other family members, or carrying out their own research into subjects like medications due to the lack of information provided by the ward:

> And we haven’t, we've had to do all the research ourselves. You know, you just kind of just afterwards [following a ward round], then you might go and research all about, um, clonazepam and what's that how’s that similar or different to lorazepam – Rachel

Alfie demonstrated that even in some instances where RP is directly witnessed, carers can be physically ‘shut out’ which can contribute to feelings of powerlessness. He explained that his sister was pulled away from him and restrained immediately upon her arrival at hospital, leaving him shut on the other side of a door:

> And they just went they was like, alright, [restrained her] straight to the floor. Um and that was, that was that, door closed behind me and it was like, you're not allowed in here – Alfie

The multiple barriers described above, from being unable to contact the ward to being physically shut out of it, acted to perpetuate the already imbalanced power dynamic between the carers and the inpatient system.

Generally, there was a sense of needing to fight to be involved in care, or have their opinions listened to regarding RP. As a result, even when views were taken on board, carers often felt they were being a nuisance, causing problems, or were made to feel overbearing by attempting to understand and be involved in decisions:

> once you kick up enough of a stink, people tend to listen a little bit more, but you shouldn't have to get to a position where you're causing problems for, or like, feel that you're causing problems for you to get, erm, get your opinions heard on on, what's happening. – Alfie

> I definitely was listened to. So I think I did use the word arguing, but I, it was it was a discussion and I put, but I felt like a pushy neurotic mother. – Laura

For some, pushing back against this power imbalance led to arguments and confrontations with the ward staff:

> I was banned from the hospital ‘cause I just, I hope you all rot in fucking hell for what you’re gonna do to my son. They banned me and d’you know why they banned me? ‘Cause they knew they they were wrong and they wanted me out of the way. – Christine

Overall, these barriers were seen to prevent carers from gaining the information they may need to understand and more effectively stand up against RP. In this way, the negative operations of power on service users and on carers are perpetuated by the rigid structures and inaccessibility of inpatient care, therefore allowing a cycle of harm and oppression to continue.

3.5 Theme 4: A need for dialogue

This theme captures carers’ perspectives on the importance of communication between staff, their loved one, and themselves. By emphasising the importance of communicating about RP between all parties, as well as the valuable insights carers could offer into their loved ones’ care and management, dialogue is framed as essential for moving towards less restrictive care.

3.5.1 Communicating about restrictive practice

The first sub-theme captures carers’ perspectives of what and how information was communicated regarding incidents of RP, and views on how this could improve. This sub-theme relates to all eight participants.

Some described their dissatisfaction about communication between staff and their loved one during and after incidents, feeling that they were not given effective debriefs or allowed the opportunity to understand what was happening to them:

> I don't think [debriefs] happened enough for her. I don't think she had enough opportunity to understand and ask the questions that she needed to have answered, probably because she's too scared to as well. – Alfie

> *Are you aware of any kind of debriefs or any any sort of follow up that that people get after they've witnessed those things on the ward?*
> No, I've never heard of it. – Anna

Many carers felt that giving an explanation before or during an incident would help their loved one understand why it was happening and reduce their distress; some felt there may be less need for RP if communication was attempted first, for example relating to explaining the reasons to take medication prior to administering it without consent:

> unless he's had some sort of long-term psychological rationale and reasonings, he’s got no reason to take it and um. And so, because he doesn't like the side effects, you know? And if he, if he understood more. – Laura

> explaining to a patient why it's happening and then the kind of what tone of voice is being used in that explanation. Is it like a sort of judicial setting where you're saying, right well we’re gonna have to restrain you now because you've done this. Or is it, okay, so we’re going to use restraint now because this is what's occurred, and the reason I've made a decision to use restrictive practice or restraint whatever is because of this, and you know we'll talk about it later. You know, is it respectful? Is it adult to adult? – Zoe

In general, carers supported the idea of dismantling the hierarchy on the ward and placing service users on an equal footing with staff, which could further support communication:

> Um, a less hierarchical approach would maybe be good, and I think that is happening a bit. You know have, have the um, the patients involved, why not everyone discussing it? – Laura

Carers conveyed a strong view that building relationships with their loved one and meaningfully engaging with them would reduce the need for RPs, as this would enhance staff’s understanding of their needs as well as encourage their loved ones to listen and engage positively with staff. This was presented as a clear alternative approach to restriction and coercion:

> You know, ask him what helps when he's under distress, you know, and whatever he's going through – Hugh

> the staff are very task focused, they they seem to move from one task to another, um, they don’t spend time with the patients … there seems to be a lack of will amongst the staff to actually interact with with the patients. – Anna

The experience of inadequate communication extended to carers too, with carers largely reporting that they were not well-informed about incidents occurring, nor given explanations of rationale or offered debriefs. Carers described finding out from their loved one at a later date if they chose to share this with them, or at times finding out from other service users:

> *So at the time nothing was communicated to you about, about.*
> “Well no I rang the ward and I couldn’t get through to her and another patient told me where she was [in seclusion] and why.” – Anna

> And then yeah, as far as we're, as far as it was for us a lot of like debriefs and communication, hardly anything. Hardly anything. – Alfie

For many this contributed to a lack of understanding of these aspects of their loved ones’ care, and there was a sense that more transparency and open communication about RP occurring would engender more positive relations between families and the ward. The majority of carers expressed a desire for more active effort from the ward in informing them of incidents:

> I would have liked, you know, the ward, they have my number, to have told me. – Anna

> communication is the most important thing. And I think if erm, services were more open with their communication of certain aspects of what is going on, I think they'd actually get more support from the family. – Alfie

Some participants acknowledged the potential barriers to information-sharing. Carers were aware that at times, particularly when experiencing high levels of paranoia or delusions relating to the family, the lack of information shared with them about RP was due to their loved ones declining consent for this:

> Almost never was there an explanation. Um. [Brother]'s preference was that details of his care were not shared with his family, and so they they weren't. – Zoe

In addition, some families might prefer not to hear about RP:

> If they wanted to, but I find that with, with that, a lot of people either don't want family involved or the family don't want to be involved for various things, and I think sometimes that's because they want to protect themselves – Alfie

3.5.2 "They don't know our children": Carers' insights have value

This sub-theme, endorsed by seven participants, captures carers' desire for involvement and offers of valuable insight and understanding.

During our conversations, many carers emphasised their expertise and knowledge relating to their loved one, framing themselves as experts in a different sense than professionals, with different valuable knowledge to offer.

> You don't even know my son. So, and the staff as I say you know they follow the doctors, and actually they have little knowledge if I'm honest. I have more knowledge than them. – Christine

Carers strongly felt that listening to their insights about their loved one would help staff to know how best to engage and communicate with them therefore reducing the need to use RP:

> take more input from the carers, find out actually, and and then, yeah, okay 'cause the patients are often in there long term. So the the more information you have on that person the more they will engage if you talk to them in the right way – Susan

Some had attempted to help staff de-escalate as an incident unfolded, or to share their knowledge of what is effective and ineffective for their loved ones, to try to prevent RP being used:

> when someone is trying to explain calmly that actually this isn't necessary, and you're making the situation worse, more distressing and you know um unfortunately it doesn't, they don't tend to listen shall we say. – Susan

> And once he's in hospitals, I just um, I I let you know, I let it known to nurses and staff that restraint hasn't helped in the past, and I'm going to, you know, I'm not agreeing to it. – Hugh

Through the interviews, carers often spoke about their loved one's personalities, interests, and aspects of their lives over and above their experiences of psychosis. It seemed important to carers for staff to understand and appreciate their loved ones' personality, which might also reduce RP through challenging dehumanisation and enabling more person-centred care planning:

> talk to him about history, politics. Um monarchy, anything that's really interesting. He's bright. And then they'll come and say, oh, my God, he's so clever, and he talks to us now. And I was like, yeah, 'cause you're not asking him how he's feeling. You're asking about things he cares about – Susan

> maximise people's autonomy, freedom to be themselves and engage in, you know, things which are meaningful and helpful to them as individuals. I think

> that would make people weller quicker, reduce burden on staff, reduce the need for, for, or or or perceptions of risk and uncertainty – Anna

This also extended to potential staff perceptions of loved ones as aggressive, with carers often taking a different perspective on this:

> I mean, they said he was violent, my son's not got a violent streak in him. – Christine

> And as I say, even when my son is completely psychotic, you know, he's he's not confrontation. You know there there is nothing. – Susan

In the context of their desire for their perspectives and insights to be more valued and routinely involved in care, some carers pointed to particular models of family involvement that they had heard about or seen utilised in other settings, such as Open Dialogue. Though there was frustration and disappointment that they are not more widely used, and were not available for their loved one, some participants saw utility in these and expressed hope about the future wider adoption of such approaches:

> I think they're talking about Open Dialogue now, that's gonna be really good. – Christine

> I mean I know they're practicing [Open Dialogue] in [UK County] or something. Um, which was actually where we were, but we were obviously not in the right place in [UK County], um. But you know, that, I don't know why that's not being picked up on all, um, why the teaching of psychiatry isn't broadening out. – Rachel

3.6 Theme 5: Prospects for system change

This theme captures carers' complex perspectives on the prospect of change to the current status quo of RP in inpatient services, taken from their discussions of affecting change in specific situations involving their loved one, to involvement in wider systemic shifts in policy and culture.

3.6.1 “Undervalued, overworked, understaffed”: Empathy for the staff perspective

Despite widespread difficult and distressing experiences, carers expressed a sense of empathy and understanding for the position of ward staff and other professionals involved in RP. This sub-theme was endorsed by all eight participants. Respect and appreciation for ward nurses and healthcare assistants in particular was prominent:

> Staff are like parents in some way. They're there and seeing it on the floor every day, day in, day out and seeing what works and what doesn't work. They must have so much insight. – Laura

Alongside this was a universal acknowledgement of the systemic challenges within inpatient care. Carers were acutely aware of the impacts of under-staffing and under-resourcing of the NHS, and how these could influence the use of RP:

> I know they're understaffed, so obviously there's more restrictions because there aren't enough staff. *[Mm.]* Which then does stop them from being allowed out and having anything because there aren't enough staff there to go around. – Susan

In the context of these challenges, staff were framed by some carers as having little control over the approaches used, for example by those who described them as passively following rules rather than acting on their own agency:

> Um but you know the staff were nice and um I think they were in a difficult situation as well and um, um I just think you know, it's just, I don't know, following orders and that's what's going on in that hospital at that time. – Laura

Alfie reflected that, while his sibling would have benefited from more compassionate and physical comfort like hugging when distressed, rather than being restrained or injected, he understood that staff could not offer this kind of care without crossing professional boundaries:

> there's lots of boundaries and it's, and a lot of it I know is safeguarding. … I think that if that was more understood of what she was there for, and what she kind of wanted in a way, and what she needed, I think maybe there would have been less incidents. But I do understand why that wasn't the case and why she couldn't have that. – Alfie

Carers reflected on the emotional toll on staff of being engaged in RPs, recognising that they harmed the staff involved as well as their loved ones. Similarly, the emotional impact of generally working under such difficult conditions was by some acknowledged as a potential contributor to RP in the form of burnout or compassion fatigue:

> I think [restricting time outside] was as demoralising for the staff as it was for … the people that were in there, the service users. – Laura

> I suppose they get compassion fatigue, um I can understand that, but you know. Um and everyone has off days – Susan

Carers' ability to understand and empathise with the perspective of ward staff allowed the majority to acknowledge an inevitability of RP within the current NHS inpatient context. Often linking this to a need to ensure safety and manage risks, many accepted this as a reality, despite holding strongly negative feelings towards it.

> I understand they need to keep everyone safe and [restrictions are] there because of safety issues obviously, and and that I understand and I know it's not, I know how hard the job must be. – Susan

Some carers reflected on some value of RP being implemented, though this was limited. While Anna largely viewed seclusion as unhelpful for her cousin, at the time she was more worried "that she was reportedly suicidal … I just hoped they would do their best to keep her safe." Alfie viewed his sibling being locked out of their room as a restriction which was beneficial, as it pushed them to attend ward activities and instilled more routine:

> Restrictive practice is, is really important for people that don't have, they may not have much grounding, they don't know boundaries, and they may not have a routine. – Alfie

However, despite accepting RP as an uncomfortable necessity, all participants endorsed the need for change in some form, whether this entailed reducing RPs, abolishing them altogether, or changing the way they are carried out or approached:

> I suppose in a way, you know if you have to give the medication, you can't do it any other way, you've gotta do it that way, haven't you? So. But I mean, you know, five to six huge strong men onto one person is a bit fucking extreme, isn't it? – Christine

3.6.2 A responsibility to advocate for change

This sub-theme, including seven participants, captures how in many ways, participants saw themselves as a “representative” (Rachel) for their loved one during admission, with a sense of responsibility to stand up against RP. They related this to their loved ones’ reduced capacity to advocate for themselves when unwell, and a perceived lack of support from other sources:

> when you’re like that you can’t advocate for yourself so who is going to advocate for you? – Rachel

> Nobody seems to stick up for my son, and I get really fed up with it. – Hugh

Some carers felt a responsibility to “call out” (Hugh) coercive practice through conversations with staff, demonstrating a motivation to affect change in direct relation to their loved ones’ treatment. This could be an isolating, frustrating, and confrontational experience, but one that several carers felt a duty to engage in:

> I was talking to the three male doctors that I was sat in, in a room on my own, no advocate, nothing, no one. Um, and they're gonna forced medicate my son with one of the most dangerous psychiatric drugs on this earth. – Christine

This was a stressful experience in itself, as some worried that their actions could negatively affect their loved ones' treatment:

> "I always used to think, well, I'm not gonna, you know, make it worse for him by um. Unless they was particularly rude and I witnessed it, then I would call them out on it." – Susan

For Susan, this even involved physically intervening during an incident of restraint in order to minimise the harm to her son:

> I've sort of had to get involved myself sort of thing when [the staff] won't listen, grab hold of [my son] so that you know they can't then attack me, so. – Susan

By extension, some spoke about feeling driven to affect wider systemic and political change, over and above their loved ones' direct experiences. Anna spoke about "a long-standing battle" to change a blanket policy banning access to the internet and electronic devices. Others reflected on their engagement in complaints processes, activism and wider campaigning:

> I think that doctors should be accountable for the damage that they do. This is why I'm doing it, I'm in the process of [making a complaint]." – Christine

> So I I did march up to Number 10 with with the, we demonstrated. – Susan [after a friend's son died as a result of restraint]

While many felt it was their duty as carers to be champions for wider changes, a conflict arose between this and the already significant burdens associated with caring for someone with psychosis. During admissions, stress for carers is particularly high, presenting a dilemma as this was also felt to be the time where their loved one most needed an advocate. As well as this, carers spoke about their exhaustion generally, and the limits this posed on their ability to fight for change:

> the trouble is that all us carers are exhausted and we're the ones that should probably be initiating change. And you’re just so worn out by it all. – Laura

> you’ve gotta kind of find some extra, um, energy and um, self-belief and kind of like having to, you know, um. Confront an authority and, and try and stand up for your rights on top of everything else, because you’re actually also dealing with the emotional fallout of maybe having lost your son forever to an ill, illness where they don’t really come back, so there’s a lot of grief and there’s a lot of sorrow and there’s a lot of loss. Um, and this is like an extra thing, it’s an extra battle. – Rachel

3.6.3 Change is a difficult road

The final sub-theme, relating to seven participants, captures the uncertainty amongst carers about the future and whether meaningful change was possible, grounded in conflicting perspectives on change between carers and within individuals. A sense of helplessness in some was rooted in feeling unable to change or stop RP during admissions:

> every time I left the hospital, I would literally break down because you know, there wasn't anything I could do about it. You know, I couldn't, you know, change anything. – Susan

> And there’s nothing we can do anyway [when our son is placed in seclusion], I mean. – Christine

For some this was linked to beliefs that RP is a deeply embedded part of the culture of psychiatric hospitals. Carers expressed their perception of RP as an accepted norm and ‘business as usual’:

> And yeah, so it felt just like, BAU. Restrictive practice didn't seem exceptional at all. – Zoe

Hugh saw RP as part of a wider vicious cycle of institutional harm or abuse, which would be difficult to break. In his words, he and his son were stuck in a system which both perpetuated harm and limited their ability to remove themselves from it, for example through legal powers like Community Treatment Orders which could recall his son to hospital. This led to a sense of hopelessness relating to the possibility of change:

> That despair that you know, he, he he will be stuck in a system which will every time there's a crisis, he will be recalled and then locked up, and likely to be restrained again. That sort of realisation is, is, was just really depressing for me. – Hugh

Other reasons that RP would be difficult to change included the sense that it served a function for the institution of inpatient care and its focus on ward management. This is reflected in carers’ accounts of practices like over-sedation being used to control or more easily manage their loved ones while they were unwell.

> I don’t see any change happening. There, there’s clear motivation within in the system not to change it. – Anna

> [Over-sedation], that’s nearly as bad as a physical restraint, really. Er, they just, they just want them sedated as quiet as possible. – Hugh

As a result of this perceived limited potential for change, some carers expressed a loss of faith in inpatient services, or mental health services generally.

> I couldn't really see the point in him going to hospital again now, I don't think I would be actively seeking him going into hospital, I would think what's the point? He's going to go in, be either given an injection or given tablets. – Laura

> I mean, if I knew what I knew now, I would never, ever, ever seek those services ever. – Christine

For some, this led to exploration of alternatives to mainstream NHS care. Models such as the Trieste Model (Mezzina, 2014) and crisis houses, based on community, peer support, and family involvement were discussed as more appealing and effective crisis interventions for loved ones based on less restriction and more compassionate understandings of psychosis:

> looking for alternatives, I mean sort of you know, there are these, ideal houses … or therapeutic communities which you know, don't really rely on coercion. Um so I thought, well, let's try and get my son into some – Hugh

> there's even one country where somebody will come and be in your house with you in that first bit where it's so difficult, you know. And if you had peers coming to your house and speaking then and, and, you know never en- never going to hospital. *[Yeah.]* You know, or having somewhere that wasn't a hospital that is a specialist centre that is just set up more like a home environment. – Laura

Amongst these feelings of helplessness and in some cases disconnect from inpatient care, some tentative hope for eventual shifts towards less RP could be found:

> But you know, everything moves forward whether we want it to or not. And you know they've got to start forward thinking that actually this is not working very well. So let's see, put things in place and. Yeah. – Susan

4. DISCUSSION

4.1 Chapter overview

This chapter compares the themes with staff, service user, and carer perspectives in the literature, and details novel findings. Strengths and limitations of the research are considered. Reflexivity is revisited, and implications for research, practice, and policy are discussed.

4.2 Summary of results

Five themes were presented in response to the research question: "What are the experiences and perspectives of carers of people with psychosis, regarding restrictive practice in inpatient settings?". These included: 'System-wide impacts; 'Restrictive practice and psychosis'; 'Negative operations of power'; 'A need for dialogue'; and 'Prospects for system change'.

4.3 Situating the findings in the literature

4.3.1 Comparisons with staff and service user perspectives

In some ways, carers' perspectives in the current study were in common with staff perspectives in the literature. For example, the moral conflict and guilt endorsed by staff involved in RP (Chavulak et al., 2024) was similar to accounts of guilt in the present findings. For carers, this often linked to a feeling of responsibility for RP due to their role in seeking inpatient care for their loved one; this suggests that carers may take on responsibility in a similar way, and to similar emotional detriment, to staff directly involved in incidents, despite not enacting the RP themselves. The framing of RP as an unavoidable burden by staff (Mooney and Kanyeredzi, 2021) is similar to the perspective offered by carers in this study in acknowledging the necessity of such practices in some situations to ensure safety and manage risk.

The themes also echo service user experiences and perspectives on RP. As discussed previously, service users often discuss these experiences in terms of dehumanisation, violations of human rights, and coercion (Hui, 2017; Tully and Berry, 2022; Cusack et al., 2018). The theme ‘Negative operations of power’ explores how these experiences are mirrored for carers; observing these power imbalances on their loved ones, and experiencing these effects themselves and feeling powerless as a result. Carers’ subjective experience of feeling shut out and excluded from the internal operations of wards added to this, introducing a nuance to their particular experience of these themes differs to the service user experience. Interestingly, powerlessness has also been endorsed by staff (Mooney and Kanyeredzi, 2021). Carers in the current study empathised with this staff perspective; by pointing out the systemic challenges staff face in inpatient settings, and by framing RP as a deeply-embedded part of the culture of inpatient care, some carers appeared to position staff as having little choice or agency in enacting RP. The current study and previous literature therefore suggest a shared experience of powerlessness across all three parties. Kinner et al. (2017) spoke about a shared acknowledgement between these three stakeholders of harm caused to service users by RP; the the present study supports this but extends to recognition of the harm caused to the wider network surrounding the individual, taking a more systemic lens.

In considering wider systemic impacts of RP in the present findings, support was also found for Jina-Pettersen’s (2022) findings linking experiences of RP in inpatient settings with subsequent disengagement from services. This was evident in carers’ discussion of loved ones distancing from or feeling unable to engage with inpatient and community services following RP, and carers’ own loss of faith in mental health services motivating them to seek alternatives to NHS support for their loved one. The public health and economic implications of this are discussed further in Section 4.6.3.

4.3.2 Comparisons with prior research on carers’ perspectives

Some themes from previous research were consistent, which holds value in strengthening the evidence base for these ideas as well as replicating them in a context specific to the UK, and specific to carers of psychosis.

The current findings can be compared to prior qualitative and quantitative studies suggesting that carers' attitudes towards RP lie between those of staff and those of service users, on a spectrum from more positive to more negative. Ambivalence can be seen throughout the themes, for example some carers endorsed their loved ones' behaviours as catalysts for RP while others (or indeed, the same participants) understood RP as a product of ward culture or poor communication. Perhaps most strongly, the theme 'A need for dialogue' captures the dialectics of carers simultaneously empathising with the predicaments of inpatient staff and understanding where RP may be unavoidable, while also fiercely defending their loved ones against perceived injustice, and feeling a strong responsibility to advocate for change. Staff have previously endorsed practical factors as important in reducing RP, like staffing, resourcing, or environmental changes, whereas service users have spoken about improving communication from staff and the role of power and control; both of these positions are reflected in the present themes, for example in carers' desire for dialogue and their acknowledgement of systemic challenges.

Other findings in the present study in line with previous literature include the emphasis carers placed on what they described as emotional coercion and broad definitions of RP, which spanned beyond the initial categories directly asked about at the beginning of the interviews, much like in Brophy et al. (2016a, 2016b). This supports the idea that carers hold wide-ranging conceptualisations of what they consider to be RP, which is more in line with how service users tend to perceive this and in contrast with staff perspectives (for example, Bendall et al.'s (2022) findings about the differing perception of "negotiation" between staff versus service users).

4.3.3 Novel findings

The present study offers several contributions which, to the author's knowledge, are unique to the existing literature. The study explored the views of carers of those who experience psychosis specifically. The theme 'Restrictive practice and psychosis' represents the finding that loved ones' and carers' experiences of RP were uniquely shaped by their loved ones' diagnoses of psychosis, in ways which differ from those with other acute mental health presentations. One sub-theme, '"Unfortunately, she is dangerous"', represents carers' acknowledgement of their loved ones' behaviours during acute psychosis as erratic, difficult to manage and at times presenting physical risk. Service users have acknowledged this in prior literature (Price et al., 2017) but this has not arisen in carers' studies, perhaps due to the range of experiences included and the fact that this was not directly asked about. Furthermore, the other two sub-themes ('"There's that whole stigma"' and '"Reinforcing the delusions rather than challenging them"') extend beyond the consideration of 'difficult' behaviour to explore the effects of narratives around psychosis on the use of RP, and the particular impact RP may have on experiences like paranoia, delusions, and hallucinations. While this is in line with some quantitative research correlating hallucinations with seclusion, these links have not been explored in depth (Chieze et al., 2019). Carers' perspectives in the current study therefore suggest a relationship which could be further explored. Taken together, the theme suggests a circular pattern wherein people labelled with and experiencing psychosis on inpatient wards may be viewed in such a way that evokes and justifies the use of RP by ward staff; these practices in turn can increase distress, intensify their unusual experiences and may lead to increased behaviour perceived as 'difficult' to manage; which could lead professionals to maintain or increase their use of RP.

This is particularly pertinent when considering the relationship between psychosis and trauma. Adverse childhood experiences (ACEs) are common predictors of later development of psychosis (Zhang et al., 2023), and adverse life events in adulthood can contribute to relapses or trigger episodes (Beards et al., 2013). RPs are not only distressing in themselves but can also re-traumatise individuals who have experienced previous trauma, such as sexual assault or physical abuse (Cusack et al., 2018). Indeed, re-traumatisation was discussed by participants in the present study, showing an awareness of these ideas amongst carers. The findings therefore lend credence to these ideas and suggest a nuanced, complex interaction between the ways in which people with psychosis express their distress, how they are perceived by staff (and how this is influenced by external societal ideas), and how use of RP could increase this distress in unique ways.

The third theme, ‘Negative operations of power’, also represents an important addition to the research. Further to the shared experience of powerlessness across service users, carers, and staff referenced in the above section, it offers a lesser-spoken perspective on RP. By highlighting the role of power, and the ways in which the processes of inpatient wards uphold and maintain the power structure, RP can be framed through the lens of a wider systematic oppression, rather than as a lower-level issue. Indeed, some experiences relayed by participants in the present study are reminiscent of hallmarks of abuse; for example, the reported “emotional coercion” and use of manipulation can be compared to gaslighting and other forms of emotional abuse which, in other contexts, may be more readily recognised as such. As well as this, the complex power interplays and impacts of these captured by this theme could be argued to represent a pattern of institutional abuse, defined as “the mistreatment of people brought about by poor or inadequate care or support, or systematic poor practice that affects the whole care setting” (Buckinghamshire Safeguarding Adults Board, 2024). In laying out the varying examples of how this has presented itself in inpatient contexts for people with psychosis, and making explicit the ways in which the system itself maintains its power, this theme opens up the potential for deeper examination and critique of abusive and oppressive practices.

Many prior studies have focused on more practical topics, like perceived reasons for RP and suggestions for improvements (e.g. Fletcher et al., 2019). These are of course important as they can directly inform service and policy development, including the voices of carers in shaping practice. However, they lack the depth needed to explore themes like power and abuse as above, and it is hoped that these findings could contribute to a shift in the literature towards acknowledging more entrenched, systematic and systemic factors in maintaining RP, and labelling this in a more critical way. Across all themes, the current study builds more on how carers have experienced RP through their loved ones, and how they perceive these events. In this way, the findings help to build an understanding of the carer experience, which can often be neglected in practice. The focus on harm caused to the carer by these practices, not only on their perspective of the harm caused to loved ones, lends more weight to the importance of reducing and limiting RP due to its wide-ranging harms.

The theme ‘Prospects for system change’, encapsulating carers’ complex feelings on change to the current status quo of RP, raises an important debate about the role of carers in affecting this change. They often position themselves as advocates and representatives, and feel a responsibility to bring about change. We know that carer burden in those caring for loved ones with psychosis is high in comparison to other mental health difficulties, and carer stress can increase during admissions (Cham et al., 2022). However, the current findings emphasise the increased stress not only of having a loved one unwell, at risk, and in hospital, but specifically having a loved one experience RPs. Carrying with it the significant emotional and relational impacts felt throughout the system, carers may therefore feel a greater need to actively contribute to both individual-level and systemic change.

Lastly, throughout the themes, there is a focus on carers’ strengths and resources. This can be seen, for example, in the sub-theme ‘Support in the network’, demonstrating carers’ use of their own experiences to support others as well as resilience in seeking support for themselves. Similarly, their empathy for staff despite their own challenging experiences, and their many examples of defending their loved one. This brings a strengths-based narrative to the literature within a topic area which is often, understandably, focused on negative experiences. Some participants spoke about seeking out alternatives to inpatient care, such as community initiatives or peer-supported organisations outside of the NHS. This presents a novel perspective as previous studies primarily concern themselves with changes to the current system of inpatient care, whereas the carers in this study offered a somewhat more radical view which may be shared by others.

4.4 Critical review

In this section, limitations of the study are first considered. Then, Spencer & Ritchie's (2011) three guiding principles of quality are utilised to appraise the current study. Contribution, credibility, and rigour are considered in turn.

4.4.1 Limitations

Despite the valuable insights offered, it is important to note the limitations of this research to provide a balanced understanding of the findings. A significant limitation was that the primarily White British sample was not representative of those most affected by the issues at hand. People from Black and other ethnic minority backgrounds are disproportionately affected by RP, as well as being more likely to be diagnosed with psychosis. The themes therefore cannot be said to represent the priorities and perspectives of Black carers or carers of Black loved ones, and nuances relating to intersectionality may not be present. For example, two participants alluded briefly to the role of race or culture in the use of RP, relating to their loved one or their awareness of general trends. This topic was not prevalent enough within this sample to constitute a theme or sub-theme, which may be different with more non-White participants. Participants were also majority female and parents. Overall, a purposive sampling method to better ensure diversity across ethnicity, gender, and relationships could have provided a more comprehensive and nuanced account.

During analysis, it became evident that a majority of the participants held prominent anti-psychiatry or critical beliefs relating to the medical model or inpatient care, which is reflected in the themes. It was unclear from the interviews whether these views represented pre-existing moral or political beliefs, or if they had been borne out of participants' harmful experiences of the inpatient system; on reflection, this could have been explored in more detail. It is possible that the significant representation of these viewpoints in the sample may have resulted from advertising via social media and internet forums, where people with more critical views might be more likely to gather. The response bias inherent in volunteer sampling also means that those with more negative experiences may be more likely to volunteer to air critiques. Additionally, those with less critical views may not recognise practices like indirect emotional coercion or blanket policies as RP, and therefore would not have volunteered for the study. This would suggest that these language choices and advertising methods could have led to a thematic framework that does not represent less critical carer viewpoints. However, another possibility is that these beliefs are simply more common than we may assume in carers of those who have experienced RP, and could be seen as an understandable response to direct exposure to a harmful and oppressive system. The researcher's potential bias in interpreting how representative these views may be of a larger carer population is reflected upon further in Section 4.5.1.1.

The term "loved one" used in study materials may have additionally influenced the type of participants who volunteered for the study. While the rationale for this term is given in Section 2.6.5, it is possible that people with closer or more positive relationships with the person being cared for would be more likely to respond to materials using this term. Those with more difficult or less "loving" relationships may have felt less inclined to take part based on this. Due to this, the resulting analysis may be lacking in representation of the experiences of those with more conflicting relationships and therefore perhaps differing connections to the caring role; for example, these carers may feel less of a desire and responsibility to advocate in comparison to the present sample.

Furthermore, due to time pressures, the researcher was unable to incorporate member-checking into the analysis, so participants did not have the opportunity to validate the thematic framework. Some themes and sub-themes were more interpretive than others, for example those discussing power and coercion which were not necessarily explicitly named, and member-checking can be less useful in these instances (Birt et al., 2016). However, this process would have still held value and would be recommended for future research on the topic.

4.4.2 Contribution

This principle concerns itself with the value and relevance of the study in enhancing existing understanding and contributing meaningfully to theory, policy, practice, or the lives of individuals. Firstly, the study addressed gaps in the literature as the first to explore the perspectives of carers of those with psychosis on the use of RP in the UK. Section 4.3.3 outlines novel findings.

This principle also relates to transferability of the findings to other contexts. Some themes and sub-themes, for example ‘Negative operations of power’ and ‘Beliefs and narratives about psychosis’, contain discussion of broader societal narratives and systemic factors which transcend the idiosyncratic experiences of the participants. This supports the potential generalisability of these perspectives beyond the sample. The idea of generalising qualitative findings is itself contested, due to the focus of qualitative research on exploring and understanding often subjective and individual experiences. Despite this, the present study has replicated key findings of previous studies on the topic as outlined in Sections 4.3.1 and 4.3.2, which supports its generalisability and contributes to strengthening the research base in this area.

Spencer and Ritchie (2011) also encourage researchers to consider the experience of taking part in the study itself when appraising its contribution to individual lives and experiences. While the interviews were not intended as an emancipatory or therapeutic experience, most participants commented during debriefs on their gratitude for being heard in the context of the research, reporting that participation had engendered some hope for change and that it felt meaningful to ‘give something back’. The process of taking part could therefore be seen as empowering or beneficial for some participants. Wider contributions in the form of potential implications for clinical practice, policy and service development are discussed below in Section 4.6.

4.4.3 Credibility

This principle relates to the defensibility and plausibility of the research findings. This can primarily be appraised by reflecting on the use and quality of evidence to support the claims, and how the findings have been validated.

The researcher has made efforts to use verbatim data extracts to support the themes and sub-themes in Chapter 3. Care was taken to include quotes across all participants as much as possible, though this was balanced with compliance with university prescriptions on word count, as well as some participants at times being more articulate or precise in their wording than others. Through research supervision throughout the stages of theme development, the supervisor’s outsider perspective was drawn upon to assess how well the selected quotes evidenced the theme or sub-theme, acknowledging that at times the researcher’s submersion in the data and surrounding context from the interview could influence their judgement of this. There were also attempts made to share variations in perspectives between participants within the sub-themes, as well as to arrange themes in a plausible narrative for readers to follow.

Multiple forms of validation can be employed as credibility checks. While member-checking was not possible, review of initial themes with the research supervisor was utilised to strengthen themes and introduce a different perspective to the interpretation. For example, this process allowed some conceptual overlap in the initial framework to be highlighted, as well as the thread of power throughout some initial themes which later became a prominent theme of its own. This form of validation led to more refined themes in the final framework.

4.4.4 Rigour

Rigour within Spencer and Ritchie’s guidance is taken to encompass the thoroughness and transparency of the research process and extent to which identified methods were followed, safe and ethical conduct, and the dependability or reliability of evidence.

Auditability is key to ensuring rigour of qualitative research. Section 2.6.2 outlines the steps taken in analysis, as well as activities carried out by the researcher alone versus input from their supervisor. Section 2.4 outlines the procedure of data collection in detail, offering transparency of method. Furthermore, Appendices H and I show an example of line-by-line coding of a transcript, and an initial thematic framework respectively; this illustrates the process of analysis and evidences how the researcher arrived at final themes.

Effort was made to employ a clear rationale for decisions made in the design of the study, for example, the choice of a qualitative approach and the use of semi-structured individual interviews (Section 2.2). Some prior studies into the topic have used focus groups, which were considered in initial planning stages; however, interviews were preferable due to the increased safety and anonymity offered by a confidential 1:1 space, as well as the opportunity to build rapport and trust with each individual, which proved beneficial in practice when carrying out the interviews. However, focus groups would add their own value in terms of drawing out experiences or topics which an individual might not have touched on by themselves, and offering solidarity and validation of similar experiences; these could be a beneficial avenue for future research.

Ethical considerations were integral to the research prior to any participant contact, and these are detailed in Section 2.6. As discussed in Section 2.6.1, one participant was known to the researcher professionally prior to their participation. The steps taken to minimise potential bias and discomfort were adequate as no concerns were raised by this participant, boundaries were held appropriately, and responses did not always conform to the researcher's expectations. However, it is always possible that this relationship could have influenced their responses.

Participants reported feeling comfortable during interviews and all received an immediate post-interview debrief, in which no issues arose. Some participants became understandably emotional during the interviews, but distress was minimal and no participants required a longer debrief or later follow-up. One ethical query which was not anticipated during the planning stage concerned a participant whose loved one had died while admitted to a ward. To ensure participation was a safe and informed choice for them, the researcher carried out extra checks regarding their current support system, held more detailed screening conversations about the topics which may be covered, and any which they were not comfortable speaking about. Additionally, steps were taken to separate the researcher's role as interviewer from their dual position as a clinician, and to minimise the power imbalance inherent in an interviewer-participant dynamic; however, this can be challenging in practice. Reflections on this dilemma are included as part of reflexivity in Section 4.5.

Reflexivity is an important facet of rigour in qualitative research, particularly as the researcher’s own values and experiences cannot be separated from their interaction with the research process. In Section 2.6.3, reflexivity was considered in the context of the researcher’s positionality in designing the study, and approaching data collection and analysis; it is revisited in Section 4.5.

4.5 Reflexivity and reflections on the research process

Both personal and epistemological reflexivity (Willig, 2013) will be considered from the perspective of having completed the study, reflecting retrospectively on the research process. To support a reflective position, first-person language will be used within this section.

4.5.1 Personal reflexivity

4.5.1.1 How have my values, identities and experiences influenced the research?

As is discussed in Section 2.6.2, measures were taken to bring aspects of my own identity, values, and life experiences into conscious awareness during the design of the research. During interviews, efforts were made to phrase questions in non-leading ways; however, given my own strong convictions relating to the topic, and prior powerful experiences of witnessing RP professionally, I could have implicitly encouraged viewpoints which were for example more critical with non-verbal cues. At times, I noticed that my internal and external reactions to perspectives which resonated with me personally differed from those which resonated less, and might be more likely to ask follow-up questions in the former case. I was aware of my own constructions of what ‘psychosis’ is, and how this was reflected in my use of non-medicalised language emphasising unusual experiences over diagnoses; this was at times in line with how carers conceptualised psychosis, and at times was not. On reflection, I wonder how this could have impacted their engagement with me and how we spoke about psychosis, though there were also considerable efforts to mirror the language used by carers.

During this process, I occupied a dual role as a researcher and a clinician. Those taking part were aware of the context of the thesis project, and that I was employed by the NHS as a Trainee Clinical Psychologist. I did not routinely disclose my prior professional experience of working in inpatient settings, as I worried that this may, in their eyes, further align me with the professionals and wider system which had perpetuated harm on them and their loved ones. I shared my prior inpatient experience if participants directly queried my background or interest in the topic; this did not appear to damage the relationship in any observable way, but it is difficult to know if this affected what was shared or made some stories untellable in the space. In constructing themes, this also led me to reflect on whether the respect for ward staff expressed by participants was a function of the power imbalance between us. Although I believe steps taken prior to and during the interview did allow us to establish 'safe enough' spaces, supported by participants' transparency and forthrightness with critical views, there is potential that this sub-theme could have been an attempt to appease me as an NHS clinician in a position of greater power.

Another way in which my professional identity may have interacted with the research process is in interpreting and discussing the themes. As discussed in Section 4.4.1, I considered that the largely critical, anti-psychiatry perspectives conveyed in the interviews might be a result of volunteer bias, and representative of a more radical subset of carers. However, on reflection, it is not surprising that carers who have interfaced with a system which causes harm directly to them and their loved ones, and hold more knowledge than the general public or other kinds of carers about the reality of inpatient wards, would naturally hold more critical views. In the later stages of the research process, I have reflected on my position as not only an NHS clinician but one with considerable professional experience in inpatient settings, who has therefore perpetuated and been complicit in some of these practices. Although this led to the development of my own critiques of our current model of inpatient care, it is likely that there remains some blind spots which may have shown in my assumptions that such critiques were controversial or rare. In fact, internationally, many in both public and professional spheres are increasingly speaking out on the infringements of human rights carried out under legislation in inpatient settings, which many rightly label as examples of torture, abuse and neglect (Lehmann, 2024). Lehmann demonstrates how the departure from mainstream services in favour of approaches like Soteria, Open Dialogue, and Crisis Hostels are perhaps more widespread than I or other mainstream mental health professionals might assume. As a result of this, I have continued to enquire as to my own biases and to learn more about these alternatives and the anti-psychiatry movement.

I am compelled to reflect on how other aspects of my identity, especially Whiteness, have shaped the research. It is regrettable that the experiences of Black and other minority ethnic carers and loved ones were not represented in this study, given the relevance of these issues to racialised groups. This has led me to reflect on my potential role in this; for example, there may have been blind spots in how I advertised the study, perhaps guided by where I might seek support or information online, and neglecting the fact that those with other intersecting identities may gather elsewhere. My identity as a white woman was not obvious from the study advertisements, but perhaps a general advertisement was in itself alienating to marginalised groups who may have understandably less trust in services and researchers. If, for example, it was clear that a study was specifically seeking only Black carers, or was using purposive sampling to hear a range of voices, perhaps this may be perceived as more trustworthy as it reflects a greater effort and consideration to reach these groups.

4.5.1.2 How has the research influenced me?

Despite the fact that my pre-existing strong beliefs about RP and our current inpatient care system led me to this research topic in the first instance, I was surprised by the depth and force of emotions evoked in me from listening to carers' accounts. It was important to process and reflect on the emotional impacts of the conversations outside of the interviews, for example in supervision or through reflective journaling. These responses re-awoke convictions in myself to champion carer support and involvement initiatives in my work as a psychologist. Listening to carers endorse the idea that it is 'up to them' to create change made me question why this is, and where this idea has come from. This led to reflections on the role we play as an institution and as individual professionals in placing this burden on carers; we have a direct role in enacting harm and perpetuating the systems which uphold these practices, and hold far more power than carers, yet the feeling of duty (despite their high levels of burden) was common amongst participants.

I was also struck by carers' level of empathy and understanding towards staff. Of course, this was contrasted with critiques of staff, but their grace and respect re-aligned my assumptions that perhaps carers would be, understandably, less able to empathise with ward staff who have been seen to cause harm. I challenged my own biases here in learning that carers are very aware of and sympathetic towards the challenges faced by professionals in the NHS; though this does not minimise their desire for change.

4.5.2 Epistemological reflexivity

Willig (2013) encourages us to think about how the research questions or design has constructed the data and the findings we have located in it. Part of the motivation to carry out this study, and the rationale for the inclusion criteria, was guided by my curiosity about whether some aspects of RP experiences uniquely interact with the experiences of psychosis, and those of the carers of such individuals. This is based in my professional experience and interest in working with and understanding people with unusual experiences which are often labelled as psychosis. A researcher with differing experiences and interests may have chosen a broader research question, asked different questions and interpreted the data differently.

Taking a critical realist approach, I understood the participants' quotes to reflect their real experiences and perspectives, but that these could be shaped by their and my own social and cultural contexts. This is evident in the themes constructed from the data, with reference to the operation of power and narratives which relate to wider phenomena than what participants have explicitly reported. Had I adopted a social constructionist epistemology, I may have chosen to analyse and construct the findings differently; for example, analysing the discourse and how language was used within the interviews would have shaped the findings around what carers do with their talk relating to RP.

4.6 Implications

4.6.1 Further research

Given the limitations of the present sample with respect to diversity of ethnicity, it is strongly recommended that research explores the experiences of RP and psychosis from the perspective of carers from Black or other racialised backgrounds. Future research should also consider embedding carer involvement into its design, procedures and analysis, as this can ensure findings are triangulated by those they represent and test that the right questions are being asked in the most useful ways.

The interview schedule in this study was intentionally broad; as a result, conversations were varied and the resulting themes were conceptually broad. Any one of these themes could be explored in more depth as the focus of a study, in order to garner richer and more nuanced understandings which could not be explored presently. As the ‘Restrictive practice and psychosis’ theme represented a novel finding in the area of carers’ perspectives on RP, further research could explore this in more detail. For example, the circular pattern suggested by the relationship between these sub-themes could be investigated from the perspective of service users and staff, to explore whether this resonates for other stakeholders. Other avenues for exploration by future research could be to further investigate the motivations and experiences of carers who have sought alternative support for their loved ones, outside of traditional or mainstream services. Understanding their reasons for this and the value they find in alternative support could contribute towards tailoring existing services and perhaps support community links, as well as potentially introduce novel narratives to understanding ‘disengagement’ from services.

4.6.2 Clinical practice

The clear emotional and wide-reaching relational impacts highlighted in this study, as well as an acknowledgement of higher-level challenges within the culture and institution of the wards, suggest a need for a more systemic understanding of RP. This can translate into a number of implications, the first relating to the importance of supporting carers and better meeting their needs. Given the clear harms evidenced not just to those directly involved in RP but also those indirectly supporting them and further still, concepts such as debriefs should perhaps be offered not only to service users and staff but to carers and family members following an incident, whether they witnessed it directly or not. This also taps into carers' clear requests in this study to be informed about RP when it happens, and why it was used, as well as for loved ones to be given explanations. In general, these findings strongly support the increased provision of support for carers during inpatient admissions, which although recommended by frameworks like the Triangle of Care, in practice seem to be lacking. Given the high levels of burden reflected in the findings, it may be beneficial for inpatient services to proactively offer support to carers (both in-house and via links with external services, anticipating varying levels of trust in engaging in NHS services given their potentially harmful experiences), instead of placing responsibility on carers to seek their own support.

A further clear implication of the present findings is that increased and more meaningful carer involvement during inpatient admissions may reduce the need to use RP, and mitigate harm when RP is used. Currently, a primary framework applied in the UK for reducing RP on wards is the Safewards model (Bowers, 2014). Within the model, carer and relative involvement is endorsed as a potential modifying intervention for staff to apply to promote greater safety and reduce the need for RP. However the model only encourages carer involvement in the context of specific potential triggers, such as arguments and tensions in the family, or the service user receiving bad news. Safewards also prioritises largely individualised strategies based on staff-service user interactions on the wards. In contrast to this, the present findings call for carer involvement throughout admissions, from beginning to end.

Moreover, the current findings suggest that this involvement should not only be more frequent but also far more meaningfully embedded into the care provided, in a way that makes use of carers' extensive knowledge of their loved one. Carers in this study and others describe an often superficial level of involvement if at all, often being unable to contribute to discussions around care decisions and primarily being involved around discharge planning, for example. It is clear from the results presented here that, instead, many carers want their insights and perspectives routinely included throughout their loved ones' admission, in a way that influences their care directly. There was a strong sense within the data, for example within the sub-theme "They don't know our children", that carers hold more or better knowledge of what will constitute effective care and intervention for their loved one than the ward staff. This lends support to changes to practice to incorporate carers' insights; for example, allowing carers to contribute towards initial care planning in early stages of admission could support staff to build more trusting and genuine relationships through enhancing their understanding of the individual and their needs and interests. This could therefore support more effective de-escalation, reducing the need for RP. As well as this, allowing carers to inform staff of their loved ones' preferences for if RP needs to be used could mitigate the harm and distress caused by RP. Several of the carers named formal models of family involvement, such as Open Dialogue, as ways to support their increased involvement. This along with their expressed empathy for staff perspectives in this study supports the idea of building a true dialogue between carers, staff, and loved ones.

In terms of practical changes to how RP is carried out, the findings strongly support the role of effective communication before, during, and after an incident of RP, with both the individual as well as their carers. This is not a new suggestion, but one that unfortunately seems lacking in practice, as carers' experiences of inadequate or non-existent communication around RP in this study echoed previous literature. As well as this, the finding that carers often feel the need to become an advocate for their loved one is reflective of the apparent lack of professional advocacy provided during inpatient admissions, despite the fact that this should be offered to all those detained under the Mental Health Act as a legal requirement (CQC, 2023). It is clear that this role, while perhaps forming part of their identity as a carer, can also greatly increase carer burden at an already distressing time. Reforming the ways in which advocacy is offered to service users, and increasing awareness of this right amongst families, could reduce this impact. This also supports increased promotion of the use of Advanced Statements, as carers' burden to advocate could be reduced by ensuring individuals' preferences for care are recorded prior to acute crisis.

In addition, the findings suggest that prejudiced narratives about psychosis could lead to unnecessary restrictions and coercion. There may be a role for increased education and training within staff teams aimed at increasing their understanding of psychosis; for example, introducing more trauma-informed understandings such as the PTMF (Johnstone & Boyle, 2018) to counteract medicalised conceptualisations which could more easily justify RP. As these narratives within professionals are likely influenced by societal norms, there is also a place for wider community education, in order to challenge dominant narratives.

4.6.3 Policy and service development

Under-funding and under-resourcing of inpatient services was recognised by all participants. Over and above the implications already discussed, systemic change on governmental and policy levels is essential to meaningful change to the use of RP. Most, if not all, of the suggestions above cannot be achieved without support of local authorities, large-scale service restructuring, and allocation of resources. The present study demonstrates that carers - despite their subjective experience of exhaustion, frustration, and disempowerment - are motivated to be involved in campaigning for change at all levels. The findings therefore support the importance of involving carers' voices in ongoing debates and government- and service-level consultations, to ensure that changes are catering to the needs of families and that the experiences of service users who may not be able to articulate for themselves can be heard. In this way, carers' expertise and knowledge can be incorporated in higher-level contexts like service planning, in order to begin to re-shape services and change organisational cultures from the top-down.

Carers' insights, as outlined in this study, are unique and nuanced; they are aligned with the service user perspective and the experience of being harmed and oppressed themselves, as well as understanding the motivations and challenges of the staff position. In this way, their viewpoints can offer a valuable bridge between two often-opposing perspectives. In addition, through amplifying carer voices in such consultations and campaigns, the present findings and their relation to power and abuse suggests that future policy should shift its focus to re-examining the systemic processes of the inpatient system, acknowledging both the harms it causes and how the system itself upholds long-standing power structures through various barriers. This study shows that carers are well-positioned to highlight and question these structures, and perhaps this may lead to more meaningful change in how RP is viewed and perpetuated in inpatient wards.

4.7 Conclusions

This study explored the perspectives and experiences of carers of people with psychosis, relating to the use of RPs in inpatient settings. Five themes were identified through reflexive thematic analysis: ‘System-wide impacts’, ‘Restrictive practice and psychosis’, ‘Negative operations of power’, ‘A need for dialogue’, and ‘Prospects for system change’.

Some aspects of the findings were in line with previous research, demonstrating that these are applicable to UK contexts. Novel contributions included exploration of the complex relationship between ‘psychosis’ and the experience of RP, offering a perspective that this experience is fundamentally different to those experiencing other acute mental health difficulties. The findings suggest a circular pattern involving unhelpful narratives about psychosis, the behaviours associated with acute psychosis, and the detrimental impact of RP on ‘symptoms’ of psychosis such as increasing paranoia and reinforcing delusions. The findings highlight the value of carers’ expertise in shaping the care provided to their loved ones, and how this could reduce the need for RP to manage distress. This study therefore has implications for clinical practice and policy and service development, and strongly emphasises the need for carers to be involved in attempts at reform to inpatient services. Similarly, the study itself represents an important statement of the significance of amplifying carers’ voices in the literature, where they are under-represented compared to service users and professionals.

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Appendix A: Table Summary of Reviewed Papers

Author and year	**Country**	**Population**	**Diagnoses or presentation of loved ones (if specified)**	**Research methods**	**Aims**	**Key findings**	**Key critiques**
Gowda et al., 2019	India	Carers only	Mixed: 48% schizophrenia and other psychotic disorder, 43.5% mood disorder	Quantitative: questionnaire	To measure carers' attitudes towards coercion and restraint practices.	Carers rated some practices high in acceptability (chemical restraint 82.5%; physical restraint 71%; ECT 56.5%) Majority denied that coercion affects autonomy (69%), interpersonal contact(72%), or isolation (73.5%)	Strengths: developed own measure after previous studies on carers had used inappropriate measure designed for professionals Limitations: questionnaire used had limited non-nuanced response options: 'yes, it is acceptable in an emergency', 'no, it is a crude way of treating' or 'don't know'; also limited cultural generalisability

Shrestha, 2018	Nepal	Carers only	Mixed: majority mood disorder, followed by somatoform disorder, then schizophrenia	Quantitative: questionnaire	To measure family members' knowledge of and attitude towards the use of restraint	Family members show good knowledge about restraint methods but less aware of potential risks and consequences. E.g. only 20% and 6.7% aware of the risk of postural asphyxia and strangulation respectively. Carers report restraint is used to manage violence and aggression but only some believe it helps to reduce this behaviour. Largely positive attitude score, which was moderately positively correlated with knowledge scores.	Limitations: lack of detail of sample size. Lack of detail about the measures used and how questions were asked, and what the scores on the measures mean.
Ranieri et al., 2015	Ireland	Carers only	Mixed: majority schizophrenia or schizoaffective disorder	Quantitative: questionnaire	To determine carers' perception of the levels of perceived coercion, perceived pressures and procedural injustice experienced by service users during admission to acute	Researchers adapted the MacArthur Admission Experience Survey (AES) to measure carers' perspectives Perceived coercion significantly higher among service users than carers at discharge, and carers perceived admission as more procedurally just than service users. Findings consistent at follow-up. Discussed in context of communication difficulties between carers, service users, and professionals Implications for potential negative	Strengths: generalisability - covered range of urban/rural areas, large sample size, included both involuntary and voluntary admissions and range of different carers. Limitations: carers contacted one year plus after discharge, so recall bias could explain disparity; low consent rate among service users for their carers to be contacted to take part (50%), those consenting may have better family

					inpatient units; to compare these perspectives to those of their related service users	impact on care from lack of carer understanding; suggestion of forum meetings prior to discharge to promote understandings of each others' perspectives of the admission	relations so disparity could be underestimated in this sample

Goodman et al., 2020	England	Carers, service users, professionals	Mixed: psychotic disorders, personality disorders, mixed presentations	Qualitative: semi-structured interviews and focus groups	To investigate staff, service user and carer perspectives on the barriers and facilitators to using de-escalation for conflict behaviours in high-secure settings	Carers highlighted: importance of skills mix to help with individualised de-escalation; value of staff understanding and reframing aggression as survival/response to triggers; role of power/control over patients; idea that staff may be projecting their own emotional responses onto service users; staff can be too reactive to escalating situations and would be better to gently enquire. Dominant views across all groups that collaboration across MDT is key, staff-patient relationships being genuine and therapeutic, and that de-escalation needs to be an embedded, daily ongoing process not just a skill.	Strengths: first study in UK high secure settings to look at barriers and facilitators. Asked about specific conflict behaviours/domains which could have helped elicit points that wouldn't have been recalled otherwise. Limitations: poor recruitment of carers (n = 4), no direct comparison between the groups, some unique challenges to high secure units which may not be generalisable to other inpatient settings

Kinner et al., 2017	Australia	Carers, service users, professionals	Not specified	Mixed-methods: online survey with quantitative multiple-choice questions and open-ended qualitative questions	To explore perspectives of carers, service users, and professionals on the benefits and harms of seclusion and restraint, and desirability and feasibility of eliminating seclusion and restraint	Shared recognition of harms across all groups, though professionals were least likely to endorse this and service users most likely. Professionals most likely to perceive benefits re: safety and boundaries, whereas service users the least likely. Carers fall in the middle. Carers showed agreement with service users that eliminating chemical restraint and seclusion is both desirable and feasible, in contrast with professionals. Professionals least likely to think elimination is feasible, particularly re: physical and chemical restraint. Agreement across all groups of harms of 'emotional restraint' - majority were aware of this as a concept, regarded it as harmful, saw it as desirable and feasible to eliminate.	Strengths: large sample, first national survey, asked same questions of all three groups which allows for comparison, accounts for less-explored types of restraint e.g. emotional restraint. Some generalisability to UK due to similar sociocultural context and healthcare systems Limitations: online convenience sample subject to volunteer bias, may attract those with stronger opinions

Brophy et al., 2016a	Australia	Carers, service users	Not specified	Qualitative: focus groups (for carers and SUs separately)	To explore carer and service user perspectives on the use of seclusion and restraint	Themes: RP are a breach of human rights, consumers are powerless and sense that carers share this powerlessness; trauma and ongoing impacts on recovery; belief that staff use RP to gain control and make people "behave accordingly to the routine"; isolation; dehumanisation (as a maintaining factor, and an impact); and anti-recovery. Despite focus on seclusion and restraint, carers and SUs discussed wide range of poor practice, e.g. excessive force, lack of empathy, lack of communication/interaction with both SU and carers (particularly relating to restraint). Groups felt poor practice was due to physical environments, under-resourcing, and fear/stigma amongst staff	Strength: lived experience researcher involved in the research process and facilitating focus groups, allowing safety/validation of experiences, as well as lived experience advisory group involvement. Study gives thought to experiences of indigenous or culturally/linguistically diverse backgrounds and how this intersects. Equal representation of carers and SUs and breadth of geographical areas. Some generalisability to UK due to similar sociocultural context and healthcare systems Limitations: small focus groups due to financial constraints, not purposive sampling so subject to volunteer bias, themes presented across groups so may miss some nuance/difference in views

Fletcher et al., 2019	Australia	Carers, service users, professionals	Not specified	Qualitative: focus groups (for carers, SU, and professionals separately)	To gain understanding of perspectives on recommendations for least restrictive practices in the context of a recent policy enacted in Queensland requiring all acute wards to be locked	Across all groups reducing boredom and increasing meaningful activity seen as priority. 2nd most important is increasing peer-support workers, and 3rd continuity of staff/experience of staff. All groups discussed importance of organisational culture change and increased resources for any meaningful shift. More than other groups, carers endorsed a reception/welcome service, decrease of custodial features and increase of privacy and safety. Carers also emphasised importance of recovery-oriented culture. In agreement with SU, carers felt more supportive staff contact was needed - whereas staff felt this was already part of their everyday practice.	Strengths: inclusion of lived experience co-facilitators in focus groups and in data analysis. Focus groups were separate so participants may have been able to share more freely. Limitations: short recruitment period, researchers noted sample was not as diverse participants as intended. More staff (17) than carers or service users (9 each).

Brophy et al., 2016b	Australia	Carers, service users	Not specified	Qualitative: focus groups (for carers and SUs separately)	To explore carer and service user perspectives on barriers to and strategies for reducing seclusion and restraint	Carers were more likely than service users to feel that seclusion and restraint were necessary in some situations, however other carers felt it should be banned entirely. Barriers identified across the two groups, mostly in agreement: physical environment, influence of drugs and alcohol implicit barriers like the role of ongoing trauma and stigma Strategies: strong support for peer support workers and advocacy; more carer and family involvement would reduce the need for seclusion and restraint; staff training and culture; addressing the language of seclusion and restraint - idea that technical language protects staff from acknowledging the harms and legitimises them.	(NB: paper from the same focus groups as Brophy et al. (2016a)) Strength: lived experience researcher involved in the research process and facilitating focus groups, allowing safety/validation of experiences, as well as lived experience advisory group involvement. Study gives thought to experiences of indigenous or culturally/linguistically diverse backgrounds and how this intersects. Equal representation of carers and SUs and breadth of geographical areas. Some generalisability to UK due to similar sociocultural context and healthcare systems Limitations: small focus groups due to financial constraints, not purposive sampling so subject to volunteer bias, themes presented across groups so

							may miss some nuance/difference in views

Tingleff et al., 2019	Denmark	Carers only: parents	Not specified	Qualitative: semi-structured interviews	To explore parents' perceptions of before, during, and after mechanical restraint; what meanings they ascribe to mechanical restraint; and perceptions of factors affecting the use and duration of mechanical restraint	Parents' experiences characterised by trust vs distrust: trust associated with positive sentiments about care and protection, lessening the need to assert themselves for inclusion/involvement; distrust with negative sentiments about care and protection, needing more inclusion/involvement. Descriptions of sadness/shock at witnessing MR, feeling that loved one was treated as a dangerous criminal, sentiment that staff lack skills to tolerate psychotic behaviour. Some reported MR had a calming effect on loved one and positive interactions with staff. Inclusion seen as important, wanting to be involved in MR episodes, but felt they needed to be persistent to advocate for this. Carers believed if they were present it would help to calm loved one and duration of MR could reduce. Information also seen as important but lacking, causing parents to feel insecure, frustrated and isolated.	Limitations: mostly mothers, different carers willl have different views and needs. Focus only on one form of restraint limits generalisability (but also offers detailed exploration). Forensic setting and geographical location also limits generalisability

Bilanakis et al., 2008	Greece	Carers, service users	Not specified	Quantitative	To document the attitudes of service users and their relatives towards coercive measures	80% of SUs felt seclusion or restraint was unjustified and traumatic; those who felt it was necessary still mostly thought it was harmful. 89% of relatives believed seclusion and restraint was justified and used as a last resort for preventing dangerous behaviour; stated that it was not used for punitive reasons.	Limitations: limited information on study procedures available, write-up does not state how the attitudes were measured. Limited generalisability and lack of nuance/rich experiences
Valimaki et al., 2022	Hong Kong	Carers, service users, professionals	Not specified	Qualitative: focus groups	To explore multiple viewpoints on patient aggression, its possible causes and outcomes, and ideas for prevention and management	Carers thought nurses need to better understand SUs, provide more support and determine reasons for aggression rather than relying on medication and RP, need for more communication Carers, SU and nurses all said that RP was necessary and recommended it in some instances. Restraint seen by all as a normal procedure in response to aggression. However all groups agreed restrictive environment could increase aggression Carers in agreement with SUs that lack of activity on the ward increases aggression and RP	Limitations: professionals were present in the focus groups so could have limited what people felt safe to share. Cultural context limits generalisability to UK

Raveesh et al., 2016	India	Carers, professionals	Not specified	Quantitative: questionnaire	To assess attitudes of Indian psychiatrists and caregivers toward coercion	Carers and professionals agreed coercion is related to scarce resources, security concerns, and harm reduction, and that it is necessary for protection in dangerous situations Significant difference between carer and professional perspectives on most items but carers responses were inconsistent	Limitations: utilised Staff Attitudes to Coercion Scale (SACS), which wasn't reliable for carer group (Cronbach's alpha of 0.07 compared to 0.58 in staff). Measures opinions of professionals which aren’t necessarily shared or understood by carers. Cultural context limits generalisability to UK
Martinsen et al., 2019	Norway	Carers only: young carers	Not specified	Qualitative: semi-structured interviews	To investigate young next of kin's need for information and involvement, examine how they cope with situations involving coercion relating to treatment of their relative, and to identify	Findings relating to coercion: majority were never informed about incidents of RP and had no insight into treatment plan; feelings of ambivalence and guilt; impact of coercion described in terms of stigma, ambivalence, worry, relational impacts. Discussed in relation to disclosure to young carers - RP may be under-communicated due to a desire to protect them from distress, but has the opposite effect.	Limitations: recruitment difficulties due to ethical issues. Authors acknowledge data saturation likely not reached. Cultural context may limit generalisability to UK populations Strengths: initiates knowledge-generating process for further research, addresses gap of young carers in the research

					ethical challenges		
Carers Trust Scotland, 2022	Scotland	Carers, service users	Not specified	Qualitative: semi-structured interviews	To understand perspectives on restrictive practice, experiences, and how to move to a culture of least restrictive practice in mental health inpatient settings.	Underlying theme of transparency and clear communication, e.g. making implicit expectations explicit to all parties. Participants advocated for sharing information related to restrictive practice, increasing access to activities and advocacy on wards, and improving three way communication between SUs, staff and carers. Carers found constant empathetic communication and explanation of the methods of RP most helpful, but most did not experience this. Specific suggestions discussed e.g. visual representations of ward rules, welcome pack, proactive engagement with carers e.g.	Strengths: interview guide developed from consultative interviews with service users Limitations: not as rigorous as some published studies, less detail about research procedures. Scotland NHS context differs in terms of funding/structure so implementation of findings could differ from in NHS England settings

						documenting insights about loved one to inform care	
Hotzy et al., 2019	Switzerland	Carers, service users, professionals	Not specified	Quantitative: questionnaire	To compare attitudes towards containment measures between three study sites which differ in their policies and usage of the measures	Carers aligned with SUs that experience of a particular restrictive intervention is not associated with higher approval scores; however this is the case in staff. Differences between study sites more evident in staff, could be due to being more influenced by policies vs carers more influenced by individual attitudes and values.	Strengths: use of a standardised measure which is valid for all groups Limitations: Attitudes to Containment Measures Questionnaire (ACMQ) contains some interventions which may not be used in the particular setting or country so are less relevant. Cultural context may limit generalisability to UK populations

Reisch et al., 2018	Switzerland	Carers, service users, professionals	Not specified	Quantitative: questionnaire	To compare how patients, professionals, and next of kin assess commonly used coercive measures in terms of acceptability	Rejection scores (0-5; highest is high rejection) highest amongst SUs, followed by carers, then professionals. However general agreement on which were the most rejected (net bed, mechanical restraints, and seclusion). Biggest difference with largest effect size seen in relation to IM medication: 4th most unfavourable for SU and carers, but 8th for professionals. Treatment on a locked acute ward was the only measure to show significant difference between carer and SU attitudes. Carers in agreement with professionals.	Strengths: first to compare these ratings between carers, HCP and SU; large sample with high statistical power. Limitations: potential sampling bias as those who experienced more coercive measures may be less likely to take part; as above, some interventions not used in the setting/country. Cultural context may limit generalisability to UK populations

Rippon et al., 2018	England	Carers, service users, professionals	Not specified; young people	Qualitative: focus groups and semi-structured interviews	To explore the views of health professionals, non-clinical staff, service users and relatives on the use of restrictive practices in children and young peoples' psychiatric inpatient settings	RP seen as necessary sometimes for safety; participants acknowledged potential of physical and psychological harm. Carers felt the inpatient environment itself triggered behaviours which could then lead to RP. Lack of communication experiences of not being informed about the types of RP that are used, the potential of this happening until after it happens, doing own research which can be distressing.	Strengths: conducted in response to increased use of RP in CYP settings. Use of vignettes in interviews may have helped prompt discussion/reflection. Generalisable to UK/NHS England contexts Limitation: focus groups/interviews conducted by different facilitators so could vary in engagement and style. Limited detail on some aspects of study procedure e.g. presentation shown to participants. Specialist setting, may not apply to other inpatient contexts as unique considerations with CYP

Appendix B: Participant Information Sheet

PARTICIPANT INFORMATION SHEET

Relatives and carers' perspectives on restrictive practice in inpatient settings for people with psychosis diagnoses

Researcher: Alison Byrne
Email: u2195482@uel.ac.uk

You are being invited to participate in a research study. Before you decide whether to take part or not, please carefully read through the following information which outlines what your participation would involve. Feel free to talk with others about the study (e.g., friends, family, etc.) before making your decision. If anything is unclear or you have any questions, please do not hesitate to contact me on the above email.

Who am I?

My name is Alison. I am a trainee clinical psychologist in the School of Psychology at the University of East London (UEL) and am studying for a Professional Doctorate in Clinical Psychology. As part of my studies, I am conducting the research that you are being invited to participate in.

What is the purpose of the research?

I would like to speak to relatives or carers of people diagnosed with psychosis who have experienced restrictive practices on inpatient wards. Restrictive practice includes any of the following: restraint, seclusion, forced medication, or other deprivations of liberty such as restricted access to outside space or phones. The study aims to learn more about relatives and carers' point of view on these practices: for example, the impact of them, views on why these practices might be used, and views on alternative approaches to restrictive practices. We hope that this research can amplify the voices of carers and relatives in ongoing debates around these practices, as they are often left out of important conversations despite their often vital role in the care of their loved ones. We also hope to better understand if there are unique challenges and experiences for people with psychosis.

Why have I been invited to take part?

To address the study aims, I am inviting relatives and/or carers of someone who is: a) diagnosed with any kind of psychosis, and b) has experienced 'restrictive practice' on a mental health ward, to take part. If you are related to or care for someone who meets the above criteria a) and b), you are eligible to take part.

Participation is voluntary, which means it is entirely up to you whether you take part or not.

What will I be asked to do if I agree to take part?

If you agree to take part, you will firstly be asked to sign a consent form to confirm your understanding of what is involved and that you agree to participate in the study. Then, we will arrange a date and time convenient for both of us to conduct an interview.

The interview will be conducted via Microsoft Teams; you will therefore need access to a computer or phone with a camera. Please inform the researcher if there are barriers to accessing these, and we can instead conduct the interview via phone. The interview will be approximately one hour long, and you are welcome to take breaks throughout. I ask that where possible, you join the interview in a quiet, confidential space, so that you can feel comfortable speaking openly. In order to analyse the data from the interviews, they will be video-recorded through Microsoft Teams, or audio-recorded using a secure external recording device if the interview is taking place via phone. I will let you know when the recording is starting and when it has stopped.

The interview will be more of an informal conversation, but there are some particular topics which might come up. To start, I will ask you some brief questions about your relationship to the person with psychosis, and what kind of restrictive practices you are aware that they have experienced. I will then ask you to tell me a little more about what happened. We may also talk about the impact of these experiences, your thoughts on why restrictive practice may be used, and on alternate approaches to restrictive practices.

When the interview is over, I will check how you are feeling and offer a short debrief if you are feeling distressed. You will also be given a debrief sheet with my contact details and the names of some organisations to contact if you need support.

After you have completed your interview, you will be offered a voucher to the value of £5 in return for your time. If you would like to accept this, you will need to fill out a form with some personal information, such as your name, date of birth, contact details, address, and National Insurance number. This form is processed by the university and is not shared anywhere else. This is not compulsory, so if you would not like to share these details, you don’t need to; however, please note we will not be able to offer a voucher in this case.

During the preliminary stages of analysis, I would like to check whether the emerging themes resonate with the experiences of people who took part in the interviews. We will have discussed this at the consent stage, and this is optional; you do not have to agree to this to take part in the study. If you have agreed to this, I will contact you during the preliminary stages of analysis, and ask you to fill out a short form about what you think of the themes I have found.

Can I change my mind?

After signing the consent form, you are free to change your mind about taking part in the study up until the interview date. You don't need to give a reason, and there will be no negative consequences for this. If this is the case, simply let me know via email, and your contact details will be deleted and we will not contact you again.

During the interview, you can also terminate the interview at any point if you decide you no longer wish to take part, and any recording up until that point will be deleted.

After the interview has taken place, you will have up to two weeks from the interview date to withdraw your data. This means that you can contact me within two weeks and I will be able to remove the data from your interview from the analysis. After this time has passed, please note that it will not be possible to remove your data as the data analysis will have started.

Are there any disadvantages to taking part?

Restrictive practice is a sensitive topic, and there is a chance it may be upsetting to discuss your loved one's experiences. You are welcome to either take a break or stop the interview altogether if you do become distressed during our conversation. You will be offered an immediate debrief after the interview concludes in case of any distress in the moment. You will also be given a debrief sheet, which has the researcher's contact details if you wish to arrange a short debrief phone call at a later time. It will also contain details of organisations which can provide extra support if needed.

It is also possible you may experience some minor physical discomfort from sitting at a computer/other device for around one hour. To mitigate this, the interview will be limited to one hour, and you will be able to take breaks at any time.

How will the information I provide be kept secure and confidential?

At the point of consent, you will be allocated a participant number which will be used throughout the study. After we complete the interview, the recording will be transcribed. During transcription, any names, places, or other identifying information will be removed or changed (for example, names will be given pseudonyms)and the transcript will be saved under your participant number. Only myself and my supervisor, who is overseeing the project, will have access to the full anonymised transcripts. When the project is written up, excerpts from transcripts may be used, and these will be attributed to your participant number. Your name and contact details will be stored separately from your anonymised data throughout the study, so that these cannot be linked. Once the study has concluded, your contact details will be deleted.

Both your personal details and your anonymised data will be stored securely (in separate folders) on the University of East London OneDrive, which is a secure cloud-based storage. This will be accessed via my individual OneDrive account which is password-protected. The only other person who may access this drive is my supervisor though he will only see anonymised transcripts. After the study is completed, we will retain the anonymised transcripts, anonymised demographic information, and other documents/files pertaining to the analysis of data and final interpretation. This data will be retained for a maximum of 5 years after the project has been passed and will be stored on a UEL OneDrive account. This is to allow for any amendments to the project and potential future write-up and publication.

For the purposes of data protection, the University of East London is the Data Controller for the personal information processed as part of this research project. The University processes this information under the ‘public task’ condition contained in the General Data Protection Regulation (GDPR). Where the University processes particularly sensitive data (known as ‘special category data’ in the GDPR), it does so because the processing is necessary for archiving purposes in the public interest, or scientific and historical research purposes or statistical purposes. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. For more information about how the University processes personal data please see www.uel.ac.uk/about/about-uel/governance/information-assurance/data-protection

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL’s online Repository: https://repository.uel.ac.uk/. The findings may also be written up for publication in peer-reviewed journals after the project has been passed. In all material produced, your identity will remain anonymous, in that it will not be possible to identify you personally.

You will be given the option to receive a summary of the research findings once the study has been completed, for which relevant contact details will need to be provided.

Who has reviewed the research?

My research has been approved by the School of Psychology Ethics Committee. This means that the Committee’s evaluation of this ethics application has been guided by the standards of research ethics set by the British Psychological Society.

Who can I contact if I have any questions/concerns?

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me:

Alison Byrne
Email: u2195482@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor:

Professor David Harper
School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: d.harper@uel.ac.uk
or
Chair of School Ethics Committee: Dr Trishna Patel
School of Psychology, University of East London, Water Lane, London E15 4LZ.
Email: t.patel@uel.ac.uk

Thank you for taking the time to read this information sheet

Appendix C: Consent Form Template

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Relatives and carers' perspectives on restrictive practice in inpatient settings for people with psychosis diagnoses
Researcher: Alison Byrne
Email: u2195482@uel.ac.uk

	Please initial
I confirm that I have read the Participant Information Sheet for the above study, had the opportunity to ask questions and had these answered sufficiently.	
I understand that my participation is voluntary and I can withdraw from the study at any time leading up to the interview without giving a reason. I understand that I will have two weeks after the interview date to withdraw my data, and that this will not be possible after two weeks has passed.	
I understand that the interview will be recorded, either via Microsoft Teams, or using a secure external recording device if the interview is carried out by phone. I understand that these recordings will be deleted once anonymised transcripts have been made.	
I understand that my personal information and data will be securely stored and remain confidential. Only the researcher and research supervisor will have access to this information, to which I give my permission.	
I understand that the findings from this research will be written into a thesis for academic purposes. This will contain general themes from the sample and anonymised excerpts from transcripts; it will not contain any identifying data. I understand that the findings may be written up for publication in academic journals in future.	
I consent to being contacted during the analysis stage to help check research themes and understand that I can change my mind about this at any time. (optional)	
I would like to receive a summary of the research findings once the study has been completed and have provided my contact details for this. (optional)	
I agree to take part in the above study.	

Participant's Name (BLOCK CAPITALS)

………

Participant's Signature

………

Researcher's Name (BLOCK CAPITALS)

………

Researcher's Signature

………

Date

……………………..……

Appendix D: Semi-Structured Interview Schedule

Semi-Structured Interview Schedule

Initial questions

1. How would you describe your relationship with your relative? (e.g. sibling, mother, etc).

2. Which of the following did your relative experience during their time on an inpatient ward?
    a. Restraint
    b. Seclusion
    c. Forced medication
    d. Deprivation of liberties e.g. being unable to leave the ward, having belongings taken away, being locked out of their room
    e. Other restrictive practice (please specify)

3. If you are comfortable, I'd like to understand a little more about what happened. Could you give some more details?
   Prompts: how many times, how long ago, what do you remember about the sequence of events? Allow participant to tell the story.

Areas of discussion

The following topic areas are to be used flexibly within the interview, guided by the themes the participant brings. Prompts can be used if participant requires more guidance or to draw out more nuanced information.

4. <u>Impact and perceived harms/benefits</u>
   Prompts: how did you feel when you found out this happened? What went through your mind? How did it affect you? Are there lasting effects of this? Impact on personal wellbeing, relationship with relative, relative's recovery? Were there any benefits of restrictive practice being used in this way?

5. <u>Understanding of reasoning for the restrictive practice/communication from professionals</u>
   Prompts: why do you think staff responded in this way? How did they explain what happened to you? What are your thoughts on how this information was communicated to you?

6. <u>Exploring different approaches/reducing restrictive practice</u>
   Prompts: could things have been managed in a different way? What could staff have done differently? What would you or your relative have preferred to happen in that situation?
   Prompts: de-escalation techniques, environmental changes, staff training, etc.
   Prompts: what are your thoughts on reducing restrictive practices for people like your relative who experience psychosis? What do you think are the main barriers preventing us from moving towards less restrictive practice?

Ending question

7. Are there any other aspects of your experience that we haven’t covered which feel important to speak about today?

Appendix E: University of East London Ethics Application

UNIVERSITY OF EAST LONDON

School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL FOR RESEARCH INVOLVING HUMAN PARTICIPANTS

(Updated October 2021)

FOR BSc RESEARCH;
MSc/MA RESEARCH;
PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL PSYCHOLOGY

Section 1 – Guidance on Completing the Application Form

(please read carefully)

1.1	Before completing this application, please familiarise yourself with: ▪ British Psychological Society's Code of Ethics and Conduct ▪ UEL's Code of Practice for Research Ethics ▪ UEL's Research Data Management Policy ▪ UEL's Data Backup Policy
1.2	Email your supervisor the completed application and all attachments as ONE WORD DOCUMENT. Your supervisor will look over your application and provide feedback.
1.3	When your application demonstrates a sound ethical protocol, your supervisor will submit it for review.
1.4	Your supervisor will let you know the outcome of your application. Recruitment and data collection must **NOT** commence until your ethics application has been approved, along with other approvals that may be necessary (see section 7).
1.5	Research in the NHS: ▪ If your research involves patients or service users of the NHS, their relatives or carers, as well as those in receipt of services provided under contract to the NHS, you will need to apply for HRA approval/NHS permission (through IRAS). You DO NOT need to apply to the School of Psychology for ethical clearance. ▪ Useful websites: https://www.myresearchproject.org.uk/Signin.aspx

	https://www.hra.nhs.uk/approvals-amendments/what-approvals-do-i-need/hra-approval/ ▪ If recruitment involves NHS staff via the NHS, an application will need to be submitted to the HRA in order to obtain R&D approval. This is in addition to separate approval via the R&D department of the NHS Trust involved in the research. UEL ethical approval will also be required. ▪ HRA/R&D approval is not required for research when NHS employees are not recruited directly through NHS lines of communication (UEL ethical approval is required). This means that NHS staff can participate in research without HRA approval when a student recruits via their own social/professional networks or through a professional body such as the BPS, for example. ▪ The School strongly discourages BSc and MSc/MA students from designing research that requires HRA approval for research involving the NHS, as this can be a very demanding and lengthy process.
1.6	If you require Disclosure Barring Service (DBS) clearance (see section 6), please request a DBS clearance form from the Hub, complete it fully, and return it to applicantchecks@uel.ac.uk. Once the form has been approved, you will be registered with GBG Online Disclosures and a registration email will be sent to you. Guidance for completing the online form is provided on the GBG website: https://fadv.onlinedisclosures.co.uk/Authentication/Login You may also find the following website to be a useful resource: https://www.gov.uk/government/organisations/disclosure-and-barring-service
1.7	Checklist, the following attachments should be included if appropriate: ▪ Study advertisement ▪ Participant Information Sheet (PIS) ▪ Participant Consent Form ▪ Participant Debrief Sheet ▪ Risk Assessment Form/Country-Specific Risk Assessment Form (see section 5) ▪ Permission from an external organisation (see section 7) ▪ Original and/or pre-existing questionnaire(s) and test(s) you intend to use ▪ Interview guide for qualitative studies ▪ Visual material(s) you intend showing participants

Section 2 – Your Details

2.1	**Your name:**	**Alison Byrne**
2.2	**Your supervisor's name:**	**Dr David Harper**
2.3	**Name(s) of additional UEL supervisors:**	**Dr Maria Qureshi** 3rd supervisor (if applicable)
2.4	**Title of your programme:**	**Professional Doctorate in Clinical Psychology**
2.5	**UEL assignment submission date:**	**September 2024** Re-sit date (if applicable)

Section 3 – Project Details

Please give as much detail as necessary for a reviewer to be able to fully understand the nature and purpose of your research.

3.1	**Study title:** Please note - If your study requires registration, the title inserted here must be the same as that on PhD Manager	**Relatives and carers' perspectives on restrictive practice in inpatient settings for people with psychosis diagnoses**
3.2	**Summary of study background and aims (using lay language):**	**The proposed research will explore the perspectives of relatives and carers of people with psychosis diagnoses on restrictive practice in NHS inpatient settings. To my knowledge, this will be the first study to qualitatively explore this topic in this specific group. Family members and other carers often play a vital role in the care that people with psychosis receive, but can be left out of important conversations around treatment practices both at an individual and policy level. Through interviews with relatives and carers, the study will explore the impacts of restrictive practice, their understanding of why these events happened and continue to happen, and their views on alternate less restrictive approaches. Data will be analysed using reflexive thematic analysis. It is hoped that the research will amplify carers' voices in ongoing debates around restrictive practice. It may also allow carers to contribute to developing less restrictive clinical practice, and to changing policies and government guidelines. For the purpose of this research, 'restrictive practice' will include restraint, enforced medication, seclusion, and also wider practices such as blanket bans and deprivation of liberties like access to phones or outside space.**
3.3	**Research question(s):**	**What are relatives and carers' perspectives on restrictive practice for people with psychosis diagnoses in inpatient settings?**
3.4	**Research design:**	**An exploratory qualitative design will be used for this research project.**
3.5	**Participants:** Include all relevant information including inclusion and exclusion criteria	**The study will aim to recruit around 8-10 participants. Participants will be: over 18; a relative or carer (including friends) of someone with a psychosis diagnosis; who has experienced restrictive practice in an NHS inpatient setting. 'Restrictive practice' here includes restraint, seclusion, forced medication, and**

		wider deprivations of liberty such as restricted access to outside or phones. There are no exclusion criteria.
3.6	**Recruitment strategy:** Provide as much detail as possible and include a backup plan if relevant	**Participants will be recruited primarily online, via professional networks of the researchers and organisations such as NSUN, Rethink, and Hearing Voices Network. We will also utilise research promotion platforms such as NQ Participate. Researchers may explore other avenues, such as local support groups and peer-led online spaces, however being mindful of not intruding on safe protected spaces without prior permission. Avoiding recruitment through NHS trusts will allow the researcher-interviewer to be somewhat distanced from the systems which have perpetuated restrictive practice, which may allow for more open and honest interviews. In the event that recruitment is not feasible through the above strategies, we will collect pre-existing written data from online sources such as blogs, forums, articles, and public social media posts, where relatives and carers have written about their experiences.**
3.7	**Measures, materials or equipment:** Provide detailed information, e.g., for measures, include scoring instructions, psychometric properties, if freely available, permissions required, etc.	**A semi-structured interview schedule created by the researcher for the study will be used in all interviews to guide the conversation (see Appendix X). No further measures or materials will be used. In terms of equipment, interviews will be conducted and recorded on Microsoft Teams, installed on the researcher's personal password-protected laptop. If participants cannot access Teams for any reason, interviews will instead be conducted by phone and recorded on an external encrypted recording device.**
3.8	**Data collection:** Provide information on how data will be collected from the point of consent to debrief	**After signing the consent form and agreeing to take part in the study, the participant and the researcher will organise a date and time for data collection to take place. Data will be collected via semi-structured interviews. These will take place on Microsoft Teams, or where this is not possible, by phone. At the beginning of the interview, consent will be re-confirmed verbally, and participants will have another opportunity to ask questions. Interviews will last for approximately one hour and participants will be able to take breaks if needed, as well as pausing the interview and continuing at another time. Interviews will be recorded on Microsoft Teams and the researcher will then transcribe each interview in full. The transcripts will then comprise**

		the raw data and the recordings will be deleted when no longer needed.	
3.9	**Will you be engaging in deception?**	**YES** ☐	**NO** ☒
	If yes, what will participants be told about the nature of the research, and how/when will you inform them about its real nature?	**N/A**	
3.10	**Will participants be reimbursed?**	**YES** ☒	**NO** ☐
	If yes, please detail why it is necessary.	**Participants will be not only giving up their time, but also providing valuable contributions to the research, while being asked to recount experiences which may be upsetting and are personal to them. Because they will need to provide personal details including their National Insurance number, participants may choose not to accept the voucher if they are uncomfortable with this. However, vouchers will be offered to all participants to demonstrate appreciation and compensation for their involvement.**	
	How much will you offer? Please note - This must be in the form of vouchers, not cash.	**£5 Amazon voucher**	
3.11	**Data analysis:**	**Interview recordings will be transcribed into anonymised transcripts, which will form the data to be analysed. Transcripts will be analysed through reflexive thematic analysis using Nvivo software. An inductive TA approach was chosen as we are seeking to understand participants' experiences, so analysis will be led by these rather than by predetermined themes. A reflexive approach acknowledges that the framework will be influenced by my own epistemologies and unique perspective. Participants who consent to this at the beginning of the study will be contacted during preliminary stages of the analysis for member-checking of initial themes, to ensure the framework best represents their experiences.**	

Section 4 – Confidentiality, Security and Data Retention

It is vital that data are handled carefully, particularly the details about participants. For information in this area, please see the UEL guidance on data protection, and also the UK government guide to data protection regulations.

If a Research Data Management Plan (RDMP) has been completed and reviewed, information from this document can be inserted here.			
4.1	**Will the participants be anonymised at source?**	**YES** ☐	**NO** ☒
	If yes, please provide details of how the data will be anonymised.	**N/A**	
4.2	**Are participants' responses anonymised or are an anonymised sample?**	**YES** ☒	**NO** ☐
	If yes, please provide details of how data will be anonymised (e.g., all identifying information will be removed during transcription, pseudonyms used, etc.).	**Participants will be assigned a participant number t the point of consent, which will be used throughout the study. Transcripts will be pseudonymised, with all names, places and other identifying information in transcripts censored.**	
4.3	**How will you ensure participant details will be kept confidential?**	**Identifying information such as participant names and contact details will be stored separately from their assigned participant numbers, transcripts and demographic data, to minimise the likelihood that they could be linked. In compliance with GDPR principles and the Data Protection Act (2018), only the minimum amount of data necessary for the study will be collected, and all data will be stored in UEL OneDrive, which is protected by the researcher's login information and will be accessed through a personal, password-protected computer. Only the researcher and, if necessary, their thesis supervisor (as part of overseeing the research project) will be able to access the data.**	
4.4	**How will data be securely stored and backed up during the research?** Please include details of how you will manage access, sharing and security	**All data will be stored securely in the university approved cloud service, UEL OneDrive via the researcher's account. This includes the excel spreadsheets, completed consent forms, interview transcripts, and interview recordings. The login details to this account will not be shared with anyone else and files will be accessed via a personal, password-protected laptop. Any files sent and received via email will be done via a secure UEL email address and local copies will be deleted once uploaded to OneDrive. Files containing identifiable information (e.g. participant names/contact details) will be stored in separate OneDrive folders to the anonymised transcripts in order to preserve anonymity. To protect against loss of data, all files stored in OneDrive will be backed up regularly using an external hard drive. This hard drive will only be accessible to the researcher and will be stored in a**	

		secure location. Prior to uploading to UEL OneDrive, video recordings of the interviews created within Microsoft Teams will be stored automatically in the Microsoft Stream Library. They will be immediately deleted from here upon being uploaded to OneDrive. Similarly, if interviews are audio recorded, the mp3 file will be transferred from the separate recording device into UEL OneDrive and deleted from the recording device.	
4.5	**Who will have access to the data and in what form?** (e.g., raw data, anonymised data)	**Security will be managed by password protecting all files or storing them in password-protected folders, and by storing data within OneDrive which is secure and encrypted. The primary person accessing the data will be the named researcher above. Anonymised data e.g. transcripts, excerpts from transcripts, or Nvivo files may be shared with the researcher's DoS who is overseeing the project, for example at the analysis stage, or with markers if requested at the time of submission. These will only be anonymised versions and will not be linked to any other data containing identifiable information. File names will also only contain participant numbers. Files will be shared via OneDrive Secure Links.**	
4.6	**Which data are of long-term value and will be retained?** (e.g., anonymised interview transcripts, anonymised databases)	**It is expected that the anonymised transcripts, Nvivo files/other documents pertaining to the analysis of data and final thematic framework, and demographic information will hold value after the project has been academically submitted and passed. These data will be retained in the event that the researcher and DoS pursue publication of the paper. All other data not considered of longer-term value will be deleted from UEL OneDrive at the point of the project being passed.**	
4.7	**What is the long-term retention plan for this data?**	**The data considered to have long-term value will be retained for a maximum of 5 years after the project has been passed. They will be stored on the DoS's UEL OneDrive account to ensure they are stored securely once the researcher has left the university. Only the DoS and researcher will have access to the files.**	
4.8	**Will anonymised data be made available for use in future research by other researchers?**	**YES** ☐	**NO** ☒
	If yes, have participants been informed of this?	**YES** ☐	**NO** ☐

4.9	**Will personal contact details be retained to contact participants in the future for other research studies?**	**YES** ☐	**NO** ☒
	If yes, have participants been informed of this?	**YES** ☐	**NO** ☐

Section 5 – Risk Assessment

If you have serious concerns about the safety of a participant, or others, during the course of your research please speak with your supervisor as soon as possible. If there is any unexpected occurrence while you are collecting your data (e.g., a participant or the researcher injures themselves), please report this to your supervisor as soon as possible.

5.1	**Are there any potential physical or psychological risks to participants related to taking part?** (e.g., potential adverse effects, pain, discomfort, emotional distress, intrusion, etc.)	**YES** ☒	**NO** ☐
	If yes, what are these, and how will they be minimised?	**Physical: risk of injury associated with prolonged use of IT equipment, e.g. eye strain, back or neck injuries, due to sitting at a computer/device for up to one hour for the remote interview. Plan to minimise: Interviews are limited to approximately one hour to limit time spent sitting at the computer. Participants will be informed at the beginning that they can request a break at any time. Researcher will also offer a break at the halfway point. Participants can also stop the interview and resume at another time/date. Researcher will ask participants if they are in a comfortable space at the beginning of the interview and give time for them to adjust e.g. their seating if needed. Psychological: risk of emotional distress associated with recounting difficult experiences as part of the interview. Plan to minimise: Participants will be fully informed prior to agreeing to the interview about the topics to be covered, and these will be re-iterated at the start of the interview. Participants can take breaks or stop the interview completely if feeling distressed. Participants will be offered an immediate debrief after the interview concludes, if feeling particularly distressed in the moment. They will also be given a debrief sheet with researcher contact details if they would like to get in touch for a debrief at a later time. Debrief sheet will also contain details of mental**	

		health organisations which they can contact if in need of further support, including a crisis number.
5.2	**Are there any potential physical or psychological risks to you as a researcher?**	**YES** ☒ **NO** ☐
	If yes, what are these, and how will they be minimised?	**Physical: risk of injury associated with prolonged use of IT equipment, e.g. eye strain, back or neck injuries, due to sitting at a computer/device for up to one hour for the remote interview. Plan to minimise: researcher will be using their own personal IT equipment and desk setup, which is optimised against injury. Psychological: risk of emotional distress caused by content of the interview, or behaviour of the participant e.g. verbal abuse. Plan to minimise: Researcher will be prepared for a variety of experiences to be discussed, and has also worked within inpatient settings so is familiar with the use of restrictive practices and conversations around this. In the event of any verbally abusive behaviour, participant will be informed that the continuation of this will result in the termination of the interview, and researcher will terminate the interview if this continues.**
5.3	**If you answered yes to either 5.1 and/or 5.2, you will need to complete and include a General Risk Assessment (GRA) form (signed by your supervisor). Please confirm that you have attached a GRA form as an appendix:**	**YES** ☒
5.4	**If necessary, have appropriate support services been identified in material provided to participants?**	**YES** ☒ **NO** ☐ **N/A** ☐
5.5	**Does the research take place outside the UEL campus?**	**YES** ☒ **NO** ☐
	If yes, where?	**The research is open to any individuals in the UK who fit the criteria, and therefore research activity (interviews) will take place online, via Microsoft Teams. Participants will be able to take part from their homes or any confidential setting comfortable for them. The researcher will conduct interviews from a confidential space in their home.**
5.6	**Does the research take place outside the UK?**	**YES** ☐ **NO** ☒
	If yes, where?	**N/A**

	If yes, in addition to the General Risk Assessment form, a Country-Specific Risk Assessment form must also be completed and included (available in the Ethics folder in the Psychology Noticeboard). Please confirm a Country-Specific Risk Assessment form has been attached as an appendix. Please note - A Country-Specific Risk Assessment form is not needed if the research is online only (e.g., Qualtrics survey), regardless of the location of the researcher or the participants.	**YES** ☐
5.7	**Additional guidance:** ▪ For assistance in completing the risk assessment, please use the AIG Travel Guard website to ascertain risk levels. Click on 'sign in' and then 'register here' using policy # 0015865161. Please also consult the Foreign Office travel advice website for further guidance. ▪ For on campus students, once the ethics application has been approved by a reviewer, all risk assessments for research abroad must then be signed by the Director of Impact and Innovation, Professor Ian Tucker (who may escalate it up to the Vice Chancellor). ▪ For distance learning students conducting research abroad in the country where they currently reside, a risk assessment must also be carried out. To minimise risk, it is recommended that such students only conduct data collection online. If the project is deemed low risk, then it is not necessary for the risk assessment to be signed by the Director of Impact and Innovation. However, if not deemed low risk, it must be signed by the Director of Impact and Innovation (or potentially the Vice Chancellor). ▪ Undergraduate and M-level students are not explicitly prohibited from conducting research abroad. However, it is discouraged because of the inexperience of the students and the time constraints they have to complete their degree.	

Section 6 – Disclosure and Barring Service (DBS) Clearance

6.1	**Does your research involve working with children (aged 16 or under) or vulnerable adults (*see below for definition)?** If yes, you will require Disclosure Barring Service (DBS) or equivalent (for those residing in countries	**YES** ☐	**NO** ☒

	outside of the UK) clearance to conduct the research project		
	* You are required to have DBS or equivalent clearance if your participant group involves: (1) Children and young people who are 16 years of age or under, or (2) ‘Vulnerable’ people aged 16 and over with particular psychiatric diagnoses, cognitive difficulties, receiving domestic care, in nursing homes, in palliative care, living in institutions or sheltered accommodation, or involved in the criminal justice system, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak with your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible.		
6.2	**Do you have DBS or equivalent (for those residing in countries outside of the UK) clearance to conduct the research project?**	**YES** ☐	**NO** ☐
6.3	**Is your DBS or equivalent (for those residing in countries outside of the UK) clearance valid for the duration of the research project?**	**YES** ☐	**NO** ☐
6.4	**If you have current DBS clearance, please provide your DBS certificate number:**	Please enter your DBS certificate number	
	If residing outside of the UK, please detail the type of clearance and/or provide certificate number.	Please provide details of the type of clearance, including any identification information such as a certificate number	
6.5	**Additional guidance:** ▪ If participants are aged 16 or under, you will need two separate information sheets, consent forms, and debrief forms (one for the participant, and one for their parent/guardian). ▪ For younger participants, their information sheets, consent form, and debrief form need to be written in age-appropriate language.		

Section 7 – Other Permissions

7.1	**Does the research involve other organisations (e.g., a school, charity, workplace, local authority, care home, etc.)?**	**YES** ☐	**NO** ☒
	If yes, please provide their details.	**N/A**	
	If yes, written permission is needed from such organisations (i.e., if they are helping you with recruitment and/or data collection, if you are	**YES** ☐	

	collecting data on their premises, or if you are using any material owned by the institution/organisation). Please confirm that you have attached written permission as an appendix.	
7.2	**Additional guidance:** ▪ Before the research commences, once your ethics application has been approved, please ensure that you provide the organisation with a copy of the final, approved ethics application or approval letter. Please then prepare a version of the consent form for the organisation themselves to sign. You can adapt it by replacing words such as 'my' or 'I' with 'our organisation' or with the title of the organisation. This organisational consent form must be signed before the research can commence. ▪ If the organisation has their own ethics committee and review process, a SREC application and approval is still required. Ethics approval from SREC can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committee/s.	

Section 8 – Declarations

8.1	**Declaration by student. I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor:**	**YES** ☒
8.2	**Student's name:** (Typed name acts as a signature)	**Alison Byrne**
8.3	**Student's number:**	**2195482**
8.4	**Date:**	**17/04/2023**

Supervisor's declaration of support is given upon their electronic submission of the application

Student checklist for appendices – *for student use only*

Documents attached to ethics application	**YES**	**N/A**
Study advertisement	☒	☐
Participant Information Sheet (PIS)	☒	☐
Consent Form	☒	☐

Participant Debrief Sheet	☒	☐
Risk Assessment Form	☒	☐
Country-Specific Risk Assessment Form	☐	☒
Permission(s) from an external organisation(s)	☐	☒
Pre-existing questionnaires that will be administered	☐	☒
Researcher developed questionnaires/questions that will be administered	☐	☒
Pre-existing tests that will be administered	☐	☒
Researcher developed tests that will be administered	☐	☒
Interview guide for qualitative studies	☒	☐
Any other visual material(s) that will be administered	☐	☒
All suggested text in RED has been removed from the appendices	☒	☐
All guidance boxes have been removed from the appendices	☒	☐

Appendix F: Letter of Ethical Approval

University of East London

School of Psychology Ethics Committee

NOTICE OF ETHICS REVIEW DECISION LETTER

For research involving human participants
BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

Reviewer: Please complete sections in blue | **Student:** Please complete/read sections in orange

Details

Reviewer:	**Hannah Sela**
Supervisor:	**David Harper**
Student:	**Alison Byrne**
Course:	**Professional Doctorate in Clinical Psychology**
Title of proposed study:	**Relatives and carers' perspectives on restrictive practice in inpatient settings for people with psychosis diagnoses**

Checklist

(Optional)

	YES	NO	N/A
Concerns regarding study aims (e.g., ethically/morally questionable, unsuitable topic area for level of study, etc.)	☐	☒	☐
Detailed account of participants, including inclusion and exclusion criteria	☒	☐	☐
Concerns regarding participants/target sample	☐	☒	☐
Detailed account of recruitment strategy	☒	☐	☐
Concerns regarding recruitment strategy	☐	☒	☐
All relevant study materials attached (e.g., freely available questionnaires, interview schedules, tests, etc.)	☒	☐	☐
Study materials (e.g., questionnaires, tests, etc.) are appropriate for target sample	☒	☐	☐
Clear and detailed outline of data collection	☒	☐	☐

Data collection appropriate for target sample	☒	☐	☐
If deception being used, rationale provided, and appropriate steps followed to communicate study aims at a later point	☐	☐	☒
If data collection is not anonymous, appropriate steps taken at later stages to ensure participant anonymity (e.g., data analysis, dissemination, etc.) – anonymisation, pseudonymisation	☒	☐	☐
Concerns regarding data storage (e.g., location, type of data, etc.)	☐	☒	☐
Concerns regarding data sharing (e.g., who will have access and how)	☐	☒	☐
Concerns regarding data retention (e.g., unspecified length of time, unclear why data will be retained/who will have access/where stored)	☐	☒	☐
If required, General Risk Assessment form attached	☒	☐	☐
Any physical/psychological risks/burdens to participants have been sufficiently considered and appropriate attempts will be made to minimise	☒	☐	☐
Any physical/psychological risks to the researcher have been sufficiently considered and appropriate attempts will be made to minimise	☒	☐	☐
If required, Country-Specific Risk Assessment form attached	☐	☐	☒
If required, a DBS or equivalent certificate number/information provided	☐	☐	☒
If required, permissions from recruiting organisations attached (e.g., school, charity organisation, etc.)	☐	☐	☒
All relevant information included in the participant information sheet (PIS)	☒	☐	☐
Information in the PIS is study specific	☒	☐	☐
Language used in the PIS is appropriate for the target audience	☒	☐	☐
All issues specific to the study are covered in the consent form	☒	☐	☐
Language used in the consent form is appropriate for the target audience	☒	☐	☐
All necessary information included in the participant debrief sheet	☒	☐	☐
Language used in the debrief sheet is appropriate for the target audience	☒	☐	☐
Study advertisement included	☒	☐	☐
Content of study advertisement is appropriate (e.g., researcher's personal contact details are not shared, appropriate language/visual material used, etc.)	☒	☐	☐

Decision options

APPROVED	Ethics approval for the above-named research study has been granted from the date of approval (see end of this notice), to the date it is submitted for assessment.
APPROVED - BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES	In this circumstance, the student must confirm with their supervisor that all minor amendments have been made **before** the research commences. Students are to do this by filling in the confirmation box at the end of this form once all amendments have been attended to

	and emailing a copy of this decision notice to the supervisor. The supervisor will then forward the student's confirmation to the School for its records. **Minor amendments guidance:** typically involve clarifying/amending information presented to participants (e.g., in the PIS, instructions), further detailing of how data will be securely handled/stored, and/or ensuring consistency in information presented across materials.
NOT APPROVED - MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED	In this circumstance, a revised ethics application **must** be submitted and approved **before** any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application. **Major amendments guidance:** typically insufficient information has been provided, insufficient consideration given to several key aspects, there are serious concerns regarding any aspect of the project, and/or serious concerns in the candidate's ability to ethically, safely and sensitively execute the study.

Decision on the above-named proposed research study

Please indicate the decision:	**APPROVED - MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES**

Minor amendments

Please clearly detail the amendments the student is required to make

In section 3.6 (Recruitment Strategy), the researcher indicates that if they are unable to recruit through their initial plan, they will resort to analysis of pre-existing data such as blog posts. What about the event that the researcher recruits some participants but not all (e.g., 3 participants)? If the researcher would then change strategy, what would happen with the data of those 3 participants? How and when will those 3 participants be informed of this possibility?

Due to the above questions, please clarify what will be the threshold for deciding that recruitment was not feasible. Please include a rough deadline for you to have decided this by (e.g., after 2 months).

Major amendments

Please clearly detail the amendments the student is required to make

Assessment of risk to researcher

Has an adequate risk assessment been offered in the application form?	**YES** ☒	**NO** ☐
	If no, please request resubmission with an **adequate risk assessment.**	
If the proposed research could expose the researcher to any kind of emotional, physical or health and safety hazard, please rate the degree of risk:		
HIGH	Please **do not approve a high-risk** application. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not be approved on this basis. If unsure, please refer to the Chair of Ethics.	☐
MEDIUM	Approve but include appropriate recommendations in the below box.	☐
LOW	Approve and if necessary, include any recommendations in the below box.	☒
Reviewer recommendations in relation to risk (if any):	Please insert any recommendations	

Reviewer’s signature

Reviewer: (Typed name to act as signature)	Dr Hannah Sela
Date:	**01/05/2023**

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Ethics Committee

RESEARCHER PLEASE NOTE

For the researcher and participants involved in the above-named study to be covered by UEL’s Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UEL’s Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard.

Confirmation of minor amendments

(Student to complete)

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data

Student name: (Typed name to act as signature)	**Alison Byrne**
Student number:	**2195482**
Date:	**16/06/2023**

Please submit a copy of this decision letter to your supervisor with this box completed if minor amendments to your ethics application are required

Appendix G: Debrief Information

PARTICIPANT DEBRIEF SHEET

Relatives and carers' perspectives on restrictive practice in inpatient settings for people with psychosis diagnoses
Researcher: Alison Byrne
Email: u2195482@uel.ac.uk

Thank you for participating in my research study on restrictive practice in inpatient settings for those with psychosis diagnoses.

What will happen to the results of the research?
The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online Repository: https://repository.uel.ac.uk/. It may also be written up for publication as an article in academic journals in future. In all material produced, only anonymised data will be used, and you will not be identifiable. To allow for potential future publications, anonymised research data will be securely stored by Dr David Harper, who is supervising the project, for a maximum of 5 years, following which all data will be deleted.

If you consented to being contacted to help check research themes, I will contact you during the analysis stage to discuss this further. Additionally, if you have consented to this, I will contact you once the study has completed with a summary of the main findings, which may be of interest to you.

What if I been adversely affected by taking part?
We have taken all reasonable steps to minimise distress or harm of any kind. Nevertheless, it is understandable that engaging in an interview about the experiences your loved one has had may have been emotionally distressing for you. If you would benefit from a debrief in the following two weeks after the interview date, please contact me by email and a phone call can be arranged.

If you are feeling distressed, upset or in need of some support, you may find the following organisations helpful:

Mind
Phone: 0300 123 3393
Email: info@mind.org.uk
Information page on carers' support: https://www.mind.org.uk/information-support/helping-someone-else/carers-friends-family-coping-support/support-for-you/

Rethink Mental Illness
Phone: 0121 522 7007
Email: info@rethink.org
Carers' hub: https://www.rethink.org/advice-and-information/carers-hub/

If you are in crisis and experiencing thoughts of harming yourself or others, please contact a crisis service such as **Shout** by texting 85258, or your local **NHS crisis line**. If you are unable to keep yourself safe, phone **999** or go to your nearest **A&E**.

Who can I contact if I have any questions/concerns?
If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me:

Alison Byrne
Email: u2195482@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor:

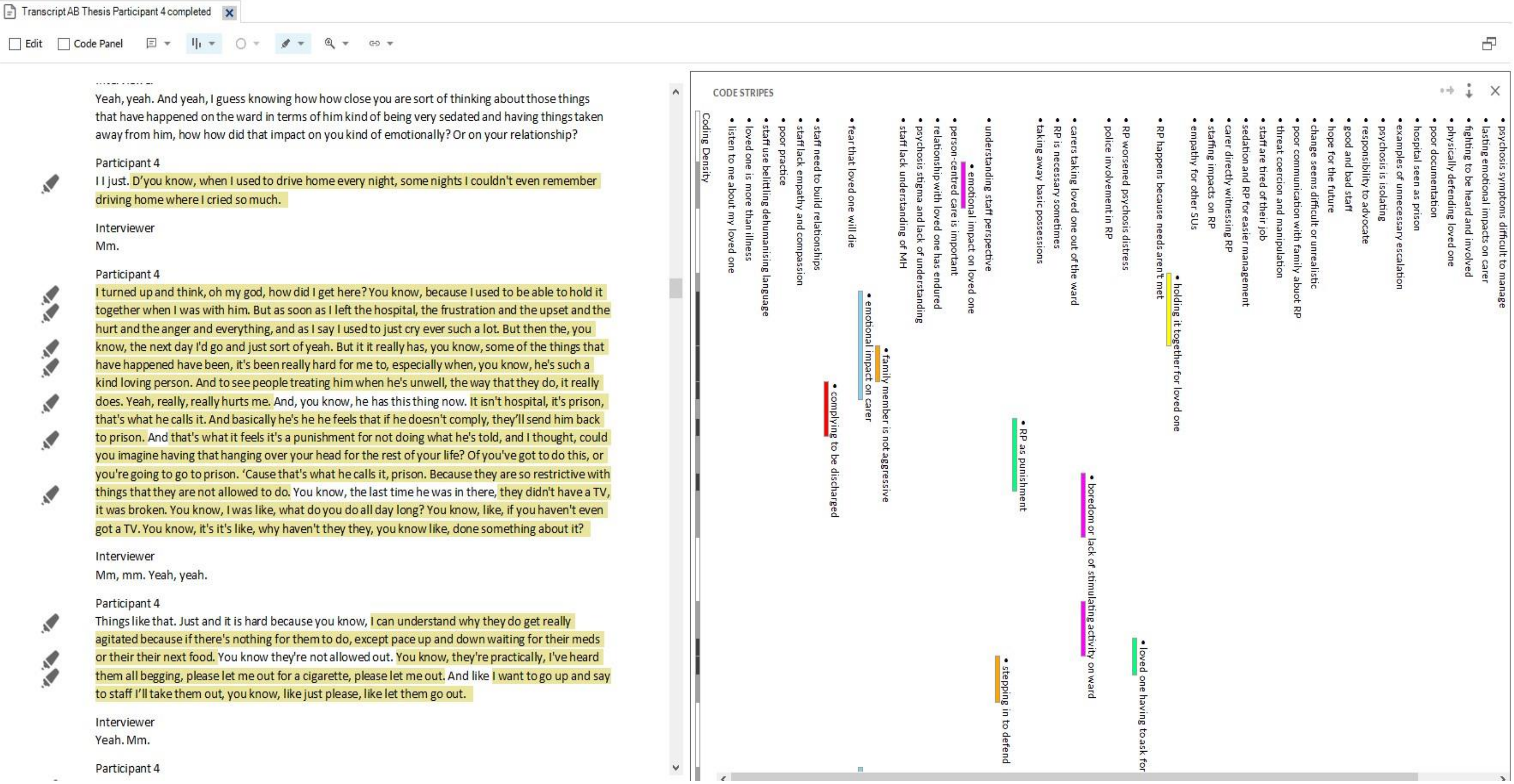
Professor David Harper
School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: d.harper@uel.ac.uk

or

Chair of School Ethics Committee: Dr Trishna Patel
School of Psychology, University of East London, Water Lane, London E15 4LZ.
Email: t.patel@uel.ac.uk

Thank you for taking part in my study

Appendix H: Example of Coded Transcript Extract



Yeah, yeah. And yeah, I guess knowing how how close you are sort of thinking about those things that have happened on the ward in terms of him kind of being very sedated and having things taken away from him, how how did that impact on you kind of emotionally? Or on your relationship?

Participant 4
I I just. D'you know, when I used to drive home every night, some nights I couldn't even remember driving home where I cried so much.

Interviewer
Mm.

Participant 4
I turned up and think, oh my god, how did I get here? You know, because I used to be able to hold it together when I was with him. But as soon as I left the hospital, the frustration and the upset and the hurt and the anger and everything, and as I say I used to just cry ever such a lot. But then the, you know, the next day I'd go and just sort of yeah. But it it really has, you know, some of the things that have happened have been, it's been really hard for me to, especially when, you know, he's such a kind loving person. And to see people treating him when he's unwell, the way that they do, it really does. Yeah, really, really hurts me. And, you know, he has this thing now. It isn't hospital, it's prison, that's what he calls it. And basically he's he he feels that if he doesn't comply, they'll send him back to prison. And that's what it feels it's a punishment for not doing what he's told, and I thought, could you imagine having that hanging over your head for the rest of your life? Of you've got to do this, or you're going to go to prison. 'Cause that's what he calls it, prison. Because they are so restrictive with things that they are not allowed to do. You know, the last time he was in there, they didn't have a TV, it was broken. You know, I was like, what do you do all day long? You know, like, if you haven't even got a TV. You know, it's it's like, why haven't they they, you know like, done something about it?

Interviewer
Mm, mm. Yeah, yeah.

Participant 4
Things like that. Just and it is hard because you know, I can understand why they do get really agitated because if there's nothing for them to do, except pace up and down waiting for their meds or their their next food. You know they're not allowed out. You know, they're practically, I've heard them all begging, please let me out for a cigarette, please let me out. And like I want to go up and say to staff I'll take them out, you know, like just please, like let them go out.

Interviewer
Yeah. Mm.

Participant 4

Appendix I: Initial Thematic Framework