

## Adverse mental health inpatient experiences: Qualitative systematic review of international literature



Nutmeg Hallett <sup>a,b,\*</sup>, Rachel Dickinson <sup>c</sup>, Emachi Eneje <sup>a</sup>, Geoffrey L. Dickens <sup>d</sup>

<sup>a</sup> School of Nursing and Midwifery, University of Birmingham, Birmingham, UK

<sup>b</sup> Institute of Mental Health, University of Birmingham, Birmingham, UK

<sup>c</sup> Birmingham and Solihull Mental Health NHS Foundation Trust, Birmingham, UK

<sup>d</sup> Department of Nursing, Midwifery and Health, Northumbria University, Newcastle Upon Tyne, UK

### ARTICLE INFO

**Keywords:**

Inpatient  
Mental health services  
Experiences  
Restrictive interventions  
Systematic review

### ABSTRACT

**Background:** Trauma has a well-established link with poor health outcomes. Adverse experiences in mental health inpatient settings contribute to such outcomes and should impact service design and delivery. However, there is often a failure to fully address these experiences.

**Objective:** To describe the spectrum of negative experiences that people identify while they are inpatients in adult mental health services.

**Design:** Qualitative systematic review of the international literature.

**Setting(s):** Inpatient mental health settings globally.

**Participants:** Analysis includes findings from 111 studies across 25 countries.

**Methods:** CINAHL, MEDLINE and PsycINFO were searched from 2000 onwards, supplemented by Google Scholar. Studies were appraised using the Critical Appraisal Skills Programme qualitative checklist. Data were synthesised using the 'best-fit' framework synthesis approach, enriched by patient and public involvement.

**Results:** Adverse mental health inpatient experiences can be conceptualised under three headings: the ecosystem (the physical environment and the resources available, and other people within or influential to that environment); systems (processes and transitions); and the individual (encroachments on autonomy and traumatisation).

**Conclusions:** This paper highlights the interplay between systemic, environmental and individual factors contributing to adverse experiences in mental health inpatient settings. By recognising and addressing these factors, we can significantly enhance patient outcomes. Application of adversity to Bronfenbrenner's ecological systems theory provides a strategic approach to improving service design and delivery, advocating for environments that prioritise patient safety, dignity and respect. However, further research is needed to validate the framework and effectively integrate these insights into practice, ultimately transforming the inpatient care experience for all stakeholders.

**Registration:** The review was registered with the International Prospective Register of Systematic Reviews (PROSPERO; CRD42022323237).

**Tweetable abstract:** Review suggests traumatic experiences in mental health inpatient settings can worsen outcomes. Urges redesign of environment, processes and autonomy to improve care @dr\_nutmeg @EmxEn @RAVresearchUoB @IMH\_UoB

### What is already known

- Trauma and adverse childhood experiences (ACEs) are associated with negative mental health outcomes in adulthood, with a

dose-response relationship indicating that increased frequency of ACEs leads to more harmful effects.

- Restrictive interventions in mental health inpatient settings, such as seclusion, restraint, and rapid tranquillisation, are all associated with

\* Corresponding author at: School of Nursing and Midwifery, University of Birmingham, Edgbaston, Birmingham B15 2TT, UK.

E-mail address: [n.n.hallett@bham.ac.uk](mailto:n.n.hallett@bham.ac.uk) (N. Hallett).

@dr\_nutmeg (N. Hallett)

- a high incidence of PTSD, reflecting the need for careful consideration of their use.
- In addition to restrictive interventions, negative experiences in inpatient settings also include ward milieu, boredom, lack of information and coercion, thus a broad spectrum of patient experiences should be addressed to significantly improve outcomes.

## What this paper adds

- This review is the first to comprehensively synthesise the wide range of negative inpatient experiences, resulting in the application of adverse inpatient experiences in mental health settings to Bronfenbrenner's ecological systems theory.
- It highlights the impact of the ward ecosystem, processes and transitions on patient experiences, and the complex interplay between individual and systemic factors in shaping inpatient adversity.
- By focusing on the full spectrum of adversities, beyond restrictive interventions, wider service design and delivery improvements could greatly enhance patient care and outcomes.

## 1. Background

High quality inpatient mental healthcare is fundamental to the recovery and well-being of patients. Despite the therapeutic intentions, many individuals report adverse experiences during their hospital stays, ranging from feelings of neglect and lack of empathy to more severe incidents of mistreatment. This is evidenced in survivor literature, with magazines such as Asylum, the radical mental health magazine, which contains numerous examples of poor mental healthcare (Not Alone Collective, 2024). Such experiences may exacerbate mental health conditions, erode trust in healthcare providers and lead to either primary trauma or exacerbation of existing trauma (Hennessy et al., 2023). According to the Substance Abuse and Mental Health Services Administration (SAMHSA, 2014), trauma refers to experiences that provoke intense physical and psychological stress responses and results from events or circumstances that an individual perceives as physically or emotionally harmful or threatening, leading to lasting adverse effects on their functioning and physical, social, emotional or spiritual wellbeing. Retraumatisation is a psychological phenomenon where an individual re-experiences or relives a previous traumatic event (Alexander, 2012). This occurs when a new event or situation triggers memories or feelings tied to the original trauma. The individual's reaction to these triggers is often heightened and influenced by their prior traumatic responses and coping strategies, leading to the resurgence of symptoms from the initial trauma. In essence, retraumatisation brings past traumatic experiences into the present, amplifying emotional distress and increasing the risk of revictimisation. Understanding this process is crucial for preventing additional harm and providing effective support to trauma survivors.

There is increasing evidence of links between trauma and subsequent ill health. The frequency and severity of adverse childhood experiences (ACEs) - stressful or traumatic events that occur in childhood (Karatekin et al., 2023) - are reportedly linked to negative mental ill health in later life in a dose-response relationship (Thompson et al., 2009). The relationship between mental ill health and ACEs has been demonstrated globally (Hughes et al., 2017). For already vulnerable adult populations, such as those with psychosis or other serious mental health conditions, adverse experiences in mental health inpatient settings may be related to, for example, Post Traumatic Stress Disorder (PTSD; Berry et al., 2013). The most restrictive interventions in mental health inpatient settings, namely seclusion, restraint and rapid tranquillisation, are commonly practised with differing frequency and varying acceptability throughout the world and are recognised sources of potential harm to patients; estimates of PTSD following restrictive interventions range from 25 % to 47 % (Chieze et al., 2019).

While the restrictive interventions described above can have clear adverse effects, other experiences in the inpatient mental health setting

can also be negative. A review of patients' perceptions of antecedents and consequences of coercion found that being subjected to professionals' control was an important negatively experienced precursor of coercion, while communication and interactions with professionals were notable along the timeline of coercion (Tingleff et al., 2017).

Research has explored the relationship between patient experiences of mental healthcare and health outcomes. High satisfaction and high-quality care are frequently correlated. According to a scoping review of satisfaction with inpatient mental health services, when patients have positive experiences with their mental health care, it tends to lead to better health outcomes (Elgendi et al., 2023). Moreover, people are more likely to actively participate in their treatment plans when they are satisfied with the care they receive, which enhances their general well-being. A systematic review of evidence from heterogeneous study designs, across disease states, and patient settings, with the exception of mental health, found consistent positive associations between patient experience and clinical safety and effectiveness outcomes (Doyle et al., 2013). The review, which included outcomes such as mortality, physical symptoms, length of stay, treatment adherence and resource use, demonstrated that positive patient experiences are often linked to improved clinical outcomes.

Staniszewska et al. (2019), in a broad review of inpatient mental health experiences, identified ward milieu, boredom and lack of information as negative experiences alongside restrictive interventions like seclusion and restraint. However, for the most part, their review provided a positive view of inpatient settings, identifying four key themes that significantly influence the experiences of mental health in-patients: the importance of high-quality relationships, avoidance of coercive practices, maintaining a healthy and safe physical environment, and ensuring patient-centred care. These themes encompass critical elements such as trust, respect, safe wards, effective communication about clinical decisions, the inclusion of therapeutic activities and family participation in care.

While Staniszewska and colleagues' review highlights positive aspects of inpatient mental health care, reflecting the experiences of some individuals, it is important to acknowledge that many patients have very negative experiences. This incongruity underscores the need for a focused review on adverse mental health inpatient experiences to comprehensively understand and address the full spectrum of challenges faced by patients. While this emphasis on positive aspects of care is perhaps understandable it may reflect the current trend towards positive psychology which in itself has been criticised for lacking a definition of 'positive' beyond 'the absence of negative experiences' (see e.g. van Zyl et al., 2024). Additionally there is no inevitable link between a focus on the positive and positive outcomes nor between a focus on negative aspects and negative outcomes (Lomas et al., 2021). From this perspective, the current paper offers a counterbalance through adoption of a focus on patients' experiences that they themselves define as negative. By examining these negative experiences, through examination of the qualitative literature capturing patients' voices, we aim to provide a balancing perspective, which can inform targeted improvements in service design and delivery, ultimately enhancing the quality of care for all patients. The aim of this review, therefore, is to describe the spectrum of negative experiences that people identify while they are inpatients in adult mental health services.

## 2. Methods

### 2.1. Design

This qualitative systematic review adheres to the Joanna Briggs Institute (JBI) guidelines (Lockwood et al., 2024), globally recognised for their comprehensive and rigorous approach to diverse forms of evidence, including non-quantitative data. However, during the critical appraisal, we opted for the Critical Appraisal Skills Programme (CASP) qualitative checklist instead of the JBI guidelines. The CASP checklist

explicitly evaluates the value of the research, an essential aspect of qualitative studies.

The protocol for this review was registered with the International Prospective Register of Systematic Reviews (PROSPERO; CRD42022323237). This review is reported according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Page et al., 2021).

## 2.2. Search strategy

The search strategy was developed using the Sample (inpatient and psychiatry), Phenomenon of Interest (harm/adversity), Design (interview, focus group, questionnaire), Evaluation (experience/satisfaction), Research type (qualitative) (SPIDER) framework. Searches were conducted in CINAHL, MEDLINE and PsycINFO searches, see Supplementary Table 1, and limited to 2000 onwards and published in English. Supplementary searches were conducted in Google Scholar; 200 results were extracted using Harzing's Publish or Perish software. Results were exported into Rayyan (Ouzzani et al., 2016) for de-duplication and screening.

## 2.3. Study selection

Titles and abstracts were screened by a single reviewer (NH) and 10% were independently screened by a second reviewer (RD). Full texts of studies retained after screening were independently assessed for eligibility by two reviewers (NH, RD) against the criteria detailed in Table 1.

## 2.4. Quality and risk of bias

The 10-point Critical Appraisal Skills Programme (CASP) qualitative checklist was used to assess study quality (CASP, 2018). Studies were not excluded based on quality; quality assessment was used to explore the robustness of our synthesis (Ryan, 2013).

## 2.5. Data extraction and synthesis

Data were extracted by a single reviewer (RD) and checked by a second reviewer (NH): authors, year, country, aim, study design, data collection, time of data collection, setting, participants and authors' themes/results with illustrative quotes.

Data were synthesised using the "best fit" framework synthesis approach (Carroll et al., 2013). The a priori framework was developed through examination of the themes identified in the review by Staniszewska et al. (2019) and from author expertise, which includes considerable and extensive experience of working in, researching and

**Table 1**  
Eligibility criteria.

|                                    | Inclusion  | Exclusion   |
|------------------------------------|--|---|
| Sample                             | Current or former inpatients   |   |
| Sample (setting)                   | Adult acute, forensic and psychiatric intensive care   | Specialist settings, e.g. child and adolescent mental health, older adults and learning disabilities settings |
| Phenomenon of interest/ evaluation | Subjective reports of inpatient experiences that were described in negative terms including admission and discharge experiences                | Experiences pre-admission or post discharge, e.g. community treatment orders                                  |
| Design                             | Any research design that captures experiences including, but not limited to, interviews, focus groups and qualitative/free text questionnaires |   |
| Research type                      | Qualitative  |   |

being a mental health inpatient: seclusion, restraint, forced medication/sedation, involuntary admission, police involvement, lack of choice and separation from family. Data that did not fit the framework were extracted and analysed thematically and the framework was adapted accordingly.

## 2.6. Patient and public involvement (PPI) reference group

PPI is detailed in the Guidance for Reporting Involvement of Patients and the Public 2nd version (GRIPP2) form (Table 2) (Staniszewska et al., 2017). The Patient and Public Involvement Reference Group (PPIRG) included five service users with varied experiences of acute and secure inpatient care. The PPI author has been involved at all stages of the review (EE).

## 2.7. Reflexivity

Reflexivity was considered at various levels throughout the review, drawing from Walsh's (2003) related typology. The review team engaged in personal reflexivity by examining how our own backgrounds in mental health influenced our approach to selecting and analysing studies. This reflexivity ensured we remained critical of our biases, particularly in interpreting the adverse experiences described by inpatients. Our collaboration with the PPI group was informed by interpersonal reflexivity. Through our interactions, we shaped the research framework to resonate with real-world experiences, thereby enhancing the credibility of our analysis. Methodologically, we reflected on our decision to use the 'best-fit' framework synthesis approach, considering how this choice aligned with our aim to thoroughly explore negative inpatient experiences. This reflective process supports methodological rigour. Contextual reflexivity allows us to situate our findings within broader societal attitudes towards mental health care. By recognising these influences, we are able to discuss how societal stigma and healthcare policies might affect inpatient experiences, highlighting areas for systemic improvement.

## 3. Results

After removal of 782 duplicates from the 4012 records identified, 3230 were screened by title and abstract, resulting in 3046 exclusions (see Fig. 1). We were unable to access five records so 179 full texts were assessed against the eligibility criteria resulting in 111 papers included in this review.

### 3.1. Study characteristics and quality

The studies spanned the globe but were predominantly conducted in Europe ( $n = 80$ ), see Supplementary Table 2. Four were conducted across multiple European countries. Most were in the UK ( $n = 42$ ). Other study locations were Sweden ( $n = 12$ ), Canada and USA ( $n = 9$  each), Norway ( $n = 7$ ), Australia ( $n = 6$ ), Ireland ( $n = 4$ ), Finland ( $n = 3$ ), Belgium ( $n = 2$ ), Germany ( $n = 2$ ), and one each in Austria, Brazil, Hong Kong, Israel, Italy, Japan, Lesotho, New Zealand, Spain, South Africa and The Netherlands.

Many studies explored experiences of hospitalisation ( $n = 22$ ) or coercion ( $n = 9$ ), whilst others focused on aspects or types of hospitalisation: involuntary admissions ( $n = 6$ ) and conversely, voluntary patients ( $n = 1$ ), and forensic ( $n = 5$ ); specific phenomena, namely seclusion ( $n = 10$ ), restraint ( $n = 7$ ), and seclusion and restraint ( $n = 2$ ); populations: women ( $n = 5$ ), people who self-harm ( $n = 3$ ) and people with a diagnosis of anorexia nervosa ( $n = 2$ ), schizophrenia ( $n = 2$ ), autistic spectrum disorder ( $n = 1$ ), depressive psychosis ( $n = 1$ ), eating disorder ( $n = 1$ ), intellectual disabilities ( $n = 1$ ) and personality disorder ( $n = 1$ ). Data collection in most studies was conducted while participants were still inpatients ( $n = 53$ ); in the remaining studies it was conducted following discharge ( $n = 35$ ) or at a combination of time

**Table 2**  
Public and patient involvement.

| GRIPP2* short form item   | Description  |
|---|--|
| Aim<br>Report the aim of the study  | 1. To ensure patient voice is heard throughout the review.<br>2. To comment on preliminary themes.<br>3. To guide final analysis.<br>4. To identify areas not covered by the literature.   |
| Methods<br>Provide a clear description of the methods used for PPIE in the study  | 1. PPIE member of the review team.<br>2. Two in-person workshops convened with members of varying backgrounds and experiences to form a PPIE Reference Group (PPIERG). Workshops facilitated by NH with support from EE (both workshops) and RD (second workshop only).<br>3. Workshops were held midway through the preliminary analysis.<br>4. The PPIERG critiqued the provisional themes and subthemes to provide content and face validity:<br>- 'trauma/retraumatisation', originally a subtheme related to practices including seclusion and restraint pervaded the whole inpatient experience and so should be captured as a theme in its own right.<br>- preliminary theme named 'loss of power' was insufficiently nuanced and suggested instead that it was an imbalance of power between staff and patients that more accurately captured the experience |
| Results<br>Outcomes—Report the results of PPI in the study, including both positive and negative outcomes   | 2. The PPIERG identified experiences that had not been captured by the literature but that they felt were important:<br>- lack of reference to racism and cultural needs was a notable omission in the framework.<br>In response, and before analysing the remaining papers, we adapted the framework to include trauma as a theme and revisited studies to capture issues about power imbalances and racism. We remained mindful of power and racism in analyses going forward.   |
| Discussion<br>Outcomes—Comment on the extent to which PPI influenced the study overall. Describe positive and negative effects  | 1. Having a PPIE member of the review team has meant that PPIE is woven throughout the study from conception to publication.<br>2. The PPIERG discussions have shaped the findings and discussion of this publication, thus supporting a more meaningful output than would have happened with review team input only.  |
| Reflections<br>Critical perspective—Comment critically on the study, reflecting on the things that went well and those that did not, so others can learn from this experience | 1. We chose to hold the workshops face-to-face rather than virtually. This may have limited the range of participants who could join to those within easy travelling distance. However, we strongly believe that meeting in person allowed for more participatory discussions than we would have achieved with a virtual format.<br>2. We had hoped to hold two workshops with the same people but were unable to. This may be because we had time constraints that limited our flexibility.   |

points ( $n = 12$ ). Eleven papers did not report the time point of data collection.

Despite variability in research methods, all studies were found to be either partially or wholly valuable, when assessed against the CASP checklist. Most studies had clear aims, appropriate methodologies and a design congruent to the aim. Data collection and analysis were also, for the most part, well-described and appropriate. However, one item that few studies achieved was the relationship between the researcher(s) and the participant(s). The absence of such details may obscure potential power imbalances and conflicts of interest, potentially distorting the findings of the review by obscuring true participant experiences and undermining the validity of the conclusions drawn. This criticism is further compounded by the notable minority of studies that lacked detail in their recruitment strategies, further introducing the potential for bias.

### 3.2. Findings

Adverse mental health inpatient experiences can be described under three main headings. 'The ecosystem' describes i) the physical environment and available resources in which adverse experiences occur and ii) other people within or influential to that environment. 'Systems' are the formal mechanisms of treatment comprising i) processes – tangible formal practices of professionals that can be experienced as adverse, and ii) transitions – discrete periods in which a change of circumstances or environment occurs. Finally, 'the individual' describes i) the encroachments on autonomy that are perceived as adverse; and ii) the traumatisation and/or retraumatisation that might be attributable to the totality of adverse experiences. For ease of reading, not all references are cited in the findings; where multiple sources are cited, examples are given. All citations and themes/subthemes are detailed in Supplementary Table 3.

### 3.3. The ecosystem

#### 3.3.1. Physical environment

Inpatient mental health experiences were often negatively impacted by poor ward conditions (Cutting and Henderson, 2002; Johnson et al., 2004; Longo and Scior, 2004) and overwhelming sensory stimuli, such as bright lighting, strong smells, and loud noises, leading to 'sensory overload', especially for neurodiverse individuals (Robins et al., 2005; Maloret and Scott, 2018). The gap between expected and provided activities and therapies (e.g. Molin et al., 2016; Ådnanes et al., 2018; Efekmann et al., 2019), frequently leading to boredom, further worsened mood and mental states (e.g. Lindgren et al., 2015; Lamanna et al., 2016; Allikmets et al., 2020). This situation was exacerbated by the perception of arbitrary removal of coping strategies and inconsistently applied rules, fostering feelings of being unheard and unfairly treated (e.g. Hughes et al., 2009; Tan et al., 2010; Wyder et al., 2015a). Wards were commonly described as prison-like (e.g. Ezeobele et al., 2014; Larsen and Terkelsen, 2014; Giacco et al., 2018) – particularly in forensic services (e.g. Haw et al., 2011; Askew et al., 2020; Tomlin et al., 2020) - with staff sometimes seen as custodial rather than caring (e.g. Haglund and Von Essen, 2005; Kim et al., 2007; Tomlin et al., 2020), particularly due to rigid routines and night-time practices that could be viewed as infantilising, contributing to a sense of insecurity and loss of individuality (e.g. Robins et al., 2005; Katsakou et al., 2011; Wyder et al., 2015b). Some people reported feeling unsafe at night (e.g. Chien et al., 2005; Lindgren et al., 2015; Veale et al., 2020), while close and intermittent observations throughout the night were seen as highly disruptive due to staff turning on lights or using torches at intervals (e.g. Gilbert et al., 2010; McBride et al., 2014; Fredriksen et al., 2020).

#### 3.3.2. Other people

The second part of the ecosystem encompassed other people with whom participants had interactions during their inpatient stay, usually the ward staff, but also fellow patients and family members. Patients

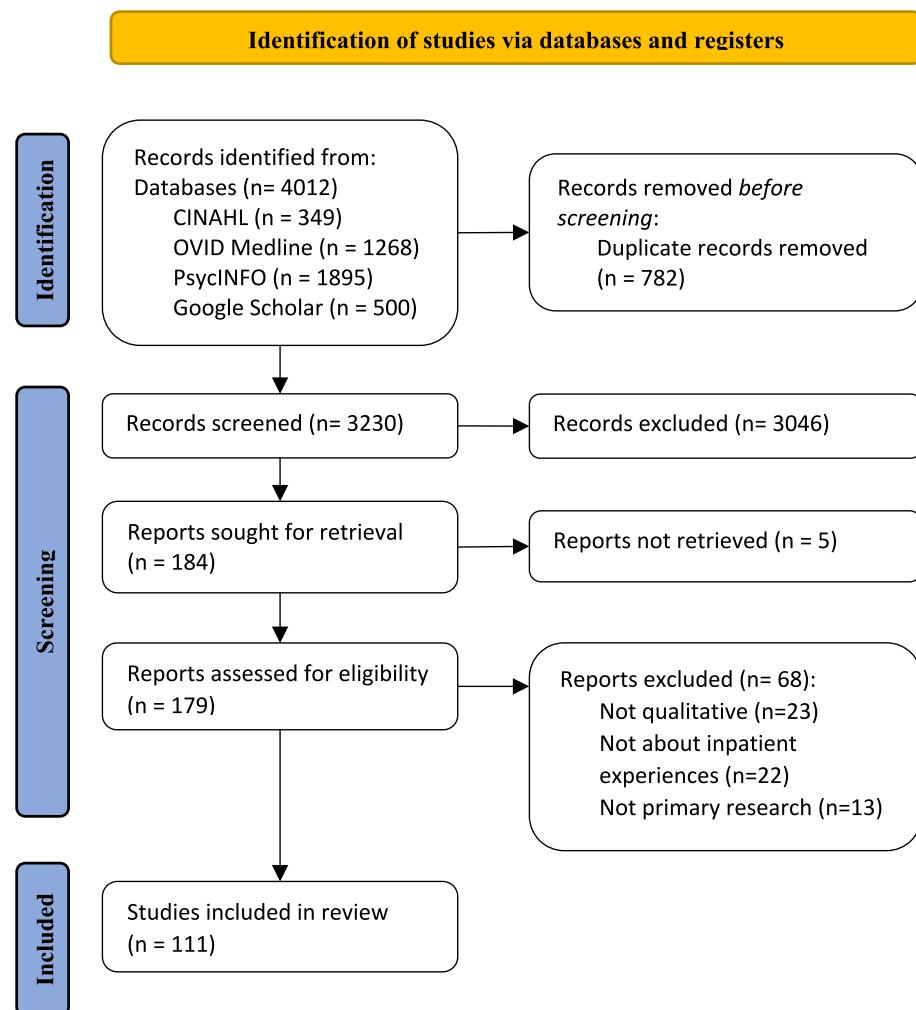


Fig. 1. Flow diagram of study selection.

often perceived staff availability as inadequate due to low staffing ratios (e.g. Niimura et al., 2016; Burn et al., 2019; Shields et al., 2022), poor staff visibility (Cutting and Henderson, 2002; Lindgren et al., 2015; Wyder et al., 2015a; Molin et al., 2016), an office-based culture (e.g. Strike et al., 2006; Rose et al., 2015; Molin et al., 2016) and perceived social distancing behaviour by staff (e.g. Fortune et al., 2010; Rose et al., 2015; Klingemann et al., 2020). The use of inaccessible language (Katsakou et al., 2011; Desplenter et al., 2013; Giacco et al., 2018) and lack of information-sharing by staff (e.g. Mayers et al., 2010; Lorem et al., 2015; Norvoll and Pedersen, 2018) were common concerns, contributing to patients feeling excluded from decision-making, undermining personal autonomy and the therapeutic nature of care (e.g. Johnson et al., 2004; Chambers et al., 2014; Murphy et al., 2017a). This disconnect between staff expectations and patient needs often left patients feeling uncared for and dehumanised, creating an atmosphere of disappointment and injustice (e.g. Cutcliffe et al., 2012; Chorlton et al., 2015; Scholes et al., 2022).

Staff attitudes, frequently seen as unprofessional, uncaring and unfair (e.g. Lu et al., 2017; Insua-Summerhays et al., 2018; Mottershead et al., 2020), contributed to a negative ward culture. Patients felt infantilised and patronised, resulting in a sense of powerlessness and disrespect (e.g. Cheetham et al., 2018; Fletcher et al., 2019; van Daalen-Smith et al., 2020). Further, staff behaviour was frequently described as dehumanising (e.g. Shattell et al., 2008; Sibitz et al., 2011; Larsen and Terkelsen, 2014). Concerns about expressing personal beliefs and emotions were prevalent, with fears of being labelled as symptomatic of

mental illness (e.g. Alexander, 2006; Nytingnes et al., 2016; Pelto-Piri and Kjellin, 2021). Some participants felt unable to express their religious beliefs (Norvoll and Pedersen, 2018; van Daalen-Smith et al., 2020) while others described concealing their emotions, particularly anger, out of fear of it increasing the risk of restraint and seclusion (e.g. Olofsson and Jacobsson, 2001; Pemberton and Fox, 2013; Lamanna et al., 2016). Issues of racism and cultural insensitivity were notable, with reports of differential treatment based on ethnicity, leading to a perception of racial bias in care practices (Secker and Harding, 2002; Gilburt et al., 2008) and being viewed as dangerous because they were black (Secker and Harding, 2002; Gilburt et al., 2008; Sweeney et al., 2015). Stigmatisation by staff, particularly towards patients with personality disorders (Lindgren et al., 2004; Chambers et al., 2014) or substance misuse issues (Chorlton et al., 2015), was perceived as a judgmental withdrawal of care.

Participants often reported experiencing vicarious trauma from witnessing distressing situations involving other patients, especially during coercive practices (e.g. Gilburt et al., 2010; Lawrence et al., 2019; van Daalen-Smith et al., 2020). This culminated in negative feelings towards both the patient and staff members involved (e.g. Meehan et al., 2000; Thibeault et al., 2010; Lindgren et al., 2015). The fear of threatened or actual assault from fellow patients was relatively infrequently reported but remained a salient factor in perceived adverse experiences (e.g. Kogstad, 2009; Jeffs et al., 2012; Veale et al., 2020).

### 3.4. Systems

#### 3.4.1. Processes

Processes encompass exposure to the application of formal aspects of mental health treatment including coercive management strategies, the use of psychotropic medication, the legal process in the form of mental health tribunals, and the monitoring of progress in the form of ward rounds.

Seclusion and restraint were described as highly distressing for participants, leading many to avoid hospital admissions for fear of recurrence (Wynn, 2004; Mayers et al., 2010; Murphy et al., 2017a; Scholes et al., 2022). This avoidance often resulted in further mental health deterioration and increased the likelihood of needing these interventions upon eventual admission (e.g. Cutting and Henderson, 2002; Strike et al., 2006; Lindkvist et al., 2021). Despite this belief, the fear continued to act as a barrier to service access.

Participants frequently expressed fear of excessive force by staff during restraint and prolonged seclusion (e.g. Johansson and Lundman, 2002; Faschingbauer et al., 2013; Askola et al., 2018). While difficult to define an objective threshold for excessiveness, many reported injury and intense fear from such practices (e.g. Wynn, 2004; Gilbert et al., 2010; Allikmets et al., 2020). Witnessing others being restrained or secluded was also traumatic, eliciting fear, shame, and humiliation (e.g. Shattell et al., 2008; Thibeault et al., 2010; Wilson et al., 2017). These experiences were often described as punitive, untherapeutic, dehumanising, and traumatising, exacerbated by poor communication and lack of proper debriefing, negatively impacting treatment compliance and patient-staff relationships (e.g. Holmes et al., 2004, 2015; Kalagi et al., 2018; Khatib et al., 2018).

The use of psychotropic medication was predominantly viewed negatively, with a reliance on medication over person-centred approaches (e.g. El-Badri and Mellsop, 2008; Lilja and Hellzen, 2008; Fixsen, 2021). Patients often felt coerced into medication (e.g. Alexander, 2006; McGuinness et al., 2013; Lorem et al., 2015), with alternatives not thoroughly explored, and refusal leading to threats of restraint, seclusion, or detention (Cutting and Henderson, 2002; Gilbert et al., 2008; McGuinness et al., 2013; Isobel, 2019). This approach was seen as punitive and controlling (e.g. Kogstad, 2009; Askola et al., 2018; Norvoll and Pedersen, 2018).

Mental Health Tribunals, though less frequently reported, were still described as problematic due to a lack of support, (Murphy et al., 2017a, 2017b) poor staff communication (Wyder et al., 2015b; Murphy et al., 2017a, 2017b; Isobel, 2019), a sense of power imbalance between the patient and the tribunal panel (e.g. Wyder et al., 2015b; Isobel, 2019; De Pau et al., 2020), and a perception of being a mere formality leading to continued detention (Wyder et al., 2015b; Murphy et al., 2017b; De Pau et al., 2020). Similarly, ward rounds were seen as intimidating and ineffective, often due to a lack of voice for the patient and poor staff-patient communication (Wagstaff and Solts, 2003; Duggins and Shaw, 2006).

#### 3.4.2. Transitions

'Transitions' describes aspects of treatment involving exposure to transition resulting from progress, or indeed regress, through the mental health system, i.e. admission, transfer and discharge.

Hospital admissions, both voluntary and involuntary, were commonly associated with fear (e.g. Russo and Rose, 2013; Wyder et al., 2015a; Molin et al., 2016). Participants often perceived voluntary admissions as coerced (e.g. Strike et al., 2006; Sweeney et al., 2015; Isobel, 2019), with police or secure transport intensifying feelings of fear, shame and stigma, especially in front of family (e.g. Bradbury et al., 2017; McGuinness et al., 2018; Klingemann et al., 2022). Police involvement was seen as punitive, resembling a custodial experience (e.g. Fenton et al., 2014; McGuinness et al., 2018; Klingemann et al., 2022), with involuntary detention under mental health legislation adding to the stigma, equating it with dangerousness (Olofsson and Jacobsson, 2001;

Buizza and Schulze, 2007; Norvoll and Pedersen, 2018).

Transfers between wards or services were also negative experiences, marked by a lack of preparation and clear communication (e.g. Wheatley et al., 2013; Parkes et al., 2015; Mottershead et al., 2020), making patients feel subjected to rather than involved in the process, leading to a loss of control (Longo and Scior, 2004; Wheatley et al., 2013; Wright et al., 2016; De Pau et al., 2020). Discharges were similarly problematic, with patients feeling unprepared due to insufficient notice and lack of involvement in planning (e.g. Chorlton et al., 2015; Wyder et al., 2015a; Lawrence et al., 2019), sometimes exacerbated by premature discharge due to insurance limits (Shattell et al., 2008), reinforcing avoidance of future admissions due to cost concerns and fear of inadequate care.

### 3.5. Individual

#### 3.5.1. Autonomy

Patients' autonomy, or specifically the threats to it, seemed central to the adverse patient experience and included issues of perceived loss of control, privacy and freedom, power and choice.

Patients frequently reported a loss of control in inpatient settings, particularly due to coercive practices leading to feelings of voicelessness (e.g. Bonner et al., 2002; Ling et al., 2015; Nytingnes et al., 2016). This lack of control over admission and treatment choices contributed to despondency and a negative perception of other aspects of their stay. Restrictions on personal items and behaviours, perceived as controlling and coercive, limited autonomy (e.g. Haw et al., 2011; Lamanna et al., 2016; Tomlin et al., 2020). Rigid ward routines, like fixed mealtimes and bedtimes, were seen as infantilising (e.g. Robins et al., 2005; Katsakou et al., 2012; Tomlin et al., 2020), as were enhanced observations, which invaded privacy and felt non-therapeutic (e.g. Pereira et al., 2005; Kuosmanen et al., 2007; Insua-Summerhays et al., 2018).

The sense of confinement was intensified by physical barriers like locked doors and restricted hospital leave, affecting both formal and informal patients (e.g. Samuelsson et al., 2000; Olofsson and Norberg, 2001; Nytingnes et al., 2016). Power imbalances were evident in the relationship between staff and patients, exacerbated by mental health legislation, which further diminished patients' sense of control (e.g. Hoekstra et al., 2004; Rojo et al., 2009; Kontio et al., 2012). Involuntary admissions and forced treatments contributed to a perceived loss of autonomy, with voluntary patients often facing 'false choices' between voluntary admission and detention, or voluntary medication and compulsion, undermining the genuineness of their consent (e.g. Pollock et al., 2004; Norvoll and Pedersen, 2018; Isobel, 2019).

#### 3.5.2. Trauma and retraumatisation

Finally, trauma and retraumatisation were evident throughout the literature. The idea that restraint could be traumatising for both patients and staff was introduced to the academic literature by Bonner and colleagues (Bonner et al., 2002). Both restraint and seclusion were described as traumatic experiences, regardless of previous trauma history (e.g. Sequeira and Halstead, 2002; Ntsaba and Havenga, 2007; Lindkvist et al., 2021). Patients reported trauma responses to previous experiences of restraint and seclusion. Those who spoke of retraumatisation primarily referred to histories of sexual or physical abuse, which they reported leading to heightened trauma responses leading up to, during and following incidents of seclusion or restraint (e.g. Sequeira and Halstead, 2002; Hagen and Nixon, 2011; Scholes et al., 2022). Frequently these experiences led to flashbacks and feelings of humiliation. Mixed-gender wards posed challenges for those with abuse histories, acting as triggers and contributing to adverse experiences (Cutting and Henderson, 2002; Duggins and Shaw, 2006; Tomlin et al., 2020). Additionally, racism emerged as a key factor, with racial traumas linked to previous personal experiences of racism and further exacerbated by interpersonal and systemic racism within institutional settings (Secker and Harding, 2002; Gilbert et al., 2008; Sweeney et al., 2015).

#### 4. Discussion

To our knowledge, this is the first review to attempt to identify and synthesise literature from primary research about the negative experiences that are described by mental health inpatients. While other reviews and individual studies provide snippets of such experiences, this is the first time that the full range of negative experiences, as described in the literature at least, have been laid bare. A previous review (Staniszewska et al., 2019) explored themes for improving inpatient experiences, which formed the basis for our “best fit” framework, comprising ward milieu, boredom and lack of information as negative experiences alongside restrictive interventions. Each of these factors was evident in the results; however, our findings revealed a far wider range of negative experiences, encompassing the totality of the inpatient experience through three overarching themes: the ecosystem, systems and the individual. There was much consensus on what constituted negative experiences across the literature, despite different ward environments, sample participants and countries of study.

These findings challenge the prevailing narrative of positive psychology, which often emphasises recovery and wellbeing without adequately addressing the real adversities patients face. By extending the focus to include profound and often systemic adversities, our review highlights the necessity for a more balanced approach. This approach must integrate positive and negative outcomes to foster holistic and genuinely supportive mental health practices. This aligns with the views of Lomas et al. (2021), who argue for a nuanced understanding of ‘positive’ that transcends the mere absence of negativity, and which thus engages with the complex realities of mental health care as articulated by patients themselves.

If we conceptualise an inpatient ward as a contained society, it is possible to apply Bronfenbrenner's ecological systems theory. This theory emphasises the role of environmental systems and the interdependent relations between individual and contextual systems (Bronfenbrenner, 1977). The theory is typically used to understand the complex systems that influence human development (Neal and Neal, 2013) and emphasises the importance of environmental factors and social influences in shaping development and behaviour. While Bronfenbrenner's theory is not typically applied directly to inpatient care, its principles can certainly inform a model of the patient experience, as presented in Table 3.

At the microsystem level, daily interactions with healthcare providers and the immediate care setting directly impact patient comfort and perceived safety. Within the microsystem, individual factors are shaped by direct interactions with care providers, other patients and the daily activities within a mental health inpatient setting. For example, a patient's history of trauma can profoundly influence their reaction to specific treatment practices like seclusion or restraint, highlighting how immediate environments impact individual outcomes and experiences. The mesosystem emphasises the importance of effective coordination between different care areas and family involvement, as poor coordination can increase patient anxiety and decrease treatment efficacy. The exosystem, which includes policies and resource availability, significantly affects care quality and respect for autonomy. On a broader scale, the macrosystem, which comprises societal values, norms and cultural beliefs, significantly affects how individuals experience and cope with mental health issues. Societal attitudes towards mental health and associated stigmas can dictate the types of support available and the prioritisation of treatments, thereby shaping the overall approach to

**Table 3**  
Model of inpatient experiences based on Bronfenbrenner's ecological systems theory.

|              | Ecological systems theory (Bronfenbrenner, 1977)  | Influence on inpatient experiences   | Applied to the review findings   | Patient perspectives and cross-layer interactions  |
|--------------|---|--|--|--|
| Microsystem  | The immediate environments with which the individual interacts directly   | Direct impact through daily interactions and the immediate care setting.   | Negative effects stem from poor physical conditions, limited personal control, and demeaning staff behaviour.<br>Positive or negative outcomes are influenced by staff                                       | Reports of sensory overload, poor ward conditions and variable staff behaviours directly affect patient comfort and perceived safety.  |
| Mesosystem   | The interconnections between the Microsystems in a person's life, such as the interaction between family and social support systems and health care providers.                  | Influences outcomes through the effectiveness of communication and cooperation between different care areas affecting the patient. | Effective coordination between care settings and family involvement is crucial.<br>Poor coordination can lead to conflicting care approaches, increasing patient anxiety and decreasing treatment efficacy.  | Concerns about the lack of coordinated care and the impact of inconsistent information sharing on treatment continuity and patient anxiety.  |
| Exosystem    | External factors that indirectly affect the person, such as policies or the availability of resources.  | Dictates the structural and resource environment for patient care, impacting treatment options and staff availability.             | Policies on treatment modalities, staffing, and privacy significantly affect care quality and respect for autonomy.<br>Resource constraints lead to suboptimal care and reduced satisfaction.                | Effects of staffing shortages and policy limitations on patient care quality, as well as the impact of external healthcare policies on treatment practices.                                      |
| Macrosystem  | The broader socio-cultural contexts that influence the smaller systems, including societal values, laws, norms and customs, within which all other layers operate.              | Shapes overarching attitudes towards mental health, influencing stigma, funding, policy priorities and public perceptions.         | Societal stigma impacts patient self-esteem and engagement in treatment.<br>Funding and policy decisions, driven by societal values, dictate the availability and quality of mental health services.         | Reflections on how societal attitudes towards mental health influence patient experiences and treatment options available within the healthcare system.  |
| Chronosystem | Involves the dimension of time, reflecting how personal and environmental characteristics change throughout a person's life, including historical changes and life transitions. | Influences experiences through critical transitions such as admission, transfer and discharge.                                     | Critical moments like admission and discharge significantly impact patient anxiety and care perception.<br>Proper management of these transitions is crucial for continuity of care and minimising distress. | Highlighted concerns regarding the timing of transitions, with patients reporting that transitions like admission, transfer and discharge can be particularly destabilising if not well-managed. |

mental health care. Lastly, the chronosystem highlights the importance of properly managing transitions like admission, transfer and discharge, as these can be particularly destabilising if not well-managed. Thus, Bronfenbrenner's ecological systems theory offers a framework for improving the mental health inpatient experience by considering these multiple layers of influence and from the perspectives of different stakeholders.

Healthcare staff can utilise the model to enhance their understanding of the healthcare experience, to enable them to provide comprehensive care that considers not just the immediate clinical needs of the patient but also the broader environmental and societal factors that can impact the care they give and the experiences of patients. This can lead to improved communication, effective coordination of care and patient-centred institutional policies. For healthcare providers, understanding this model can inform the design of treatment plans that consider all levels of influence on a patient's health. It can guide them to create supportive environments, establish effective policies and advocate for societal changes that reduce stigma and improve mental health outcomes. In essence, Bronfenbrenner's ecological systems theory provides a comprehensive framework that can guide all stakeholders to improve the mental health inpatient experience from multiple angles, leading to more effective and holistic mental health care.

While the ecosystem and systems themes identified in this review align with the layers of the ecological systems theory, as shown in [Table 3](#), the individual factors of autonomy and trauma/retraumatisation are cross-cutting themes; each ecological layer impacts and is impacted by these individual factors. As shown in [Table 4](#), there is significant overlap between how trauma and autonomy interact with the layers. For example, trauma responses are influenced by the interactions that people have within the inpatient setting, and those interactions can enhance opportunities for autonomy.

Bridging the gap between theory and practice in the context of

**Table 4**  
Interaction between individual factors and ecological systems theory layers.

| Layer        | Interaction with trauma  | Interaction with autonomy  |
|--------------|--|--|
| Microsystem  | Trauma responses are influenced by direct interactions within the inpatient setting, such as the use of seclusion or restraint, which can trigger or exacerbate trauma symptoms.                                   | Autonomy is directly affected by daily treatment activities and interactions with care providers, highlighting the need for practices that respect patient decision-making and privacy.                      |
| Mesosystem   | Coordination between different care settings (e.g., between mental health services and family support systems) can impact trauma recovery, either by providing consistent support or creating treatment conflicts. | The quality of coordination between healthcare providers and external support systems directly influences how patient autonomy is supported or constrained.  |
| Exosystem    | Hospital policies and community health resources indirectly impact trauma by dictating the treatment modalities available and the conditions under which care is delivered.  | Policies on treatment modalities and staff-patient ratios can limit or enhance the degree of autonomy patients experience, affecting their ability to influence their care plans and treatment environments. |
| Macrosystem  | Broader societal and cultural attitudes towards mental health influence the stigma associated with these issues, which can affect the treatment approaches and support systems available to patients.              | Societal norms and legal frameworks shape the overall approach to patient autonomy within healthcare systems, determining how much control patients have over their treatment decisions.                     |
| Chronosystem | The temporal changes during an inpatient stay, including the phases of admission, treatment adjustment and preparation for discharge, significantly influence trauma responses.                                    | Changes over the course of an inpatient stay, such as shifting levels of patient involvement in decision-making, influence feelings of autonomy.   |

Bronfenbrenner's ecological systems theory and the model of mental health inpatient experience described above, involves several steps. The model could enhance healthcare professional education and training by providing an easy to understand yet comprehensive framework that emphasises the interconnectedness of individual, relational and societal factors influencing mental health inpatient care, fostering a holistic and patient-centred approach. Furthermore, the approach could foster interdisciplinary collaboration providing a cross-disciplinary shared understanding from which to develop treatment plans. The model could be used to inform policy at both institutional and governmental level, with policies designed to promote patient-centred care, respect for autonomy and a holistic approach that considers all levels of the model. For example, institutional policies could be instrumental in addressing the issues with transitions, supporting trauma-informed admissions and ensuring that patients receive the information that they need to reduce the adversities related to transitions. At a governmental level, policies relating to the wider community, and community engagement, could consider the impact that societal attitudes have on mental health stigma more broadly, which impacts the inpatient experience.

This review has focused deliberately on negative experiences to synthesise a comprehensive overview and understanding of adverse experiences. In so doing it has highlighted both the role of the totality of the inpatient experience in adverse experiences and a broader range of singular experiences that can be perceived to be adverse by patients. This should not be taken to imply that patients do not have neutral or positive experiences. Neither should it be taken to imply that there can be no protective factors that might guard against adverse experiences and their impacts: such as, for example, ameliorating interventions to improve the environment, increase the capacity of people to provide a better experience, reduce coercive practices and provide better information. In addition, though not primarily, there may be individual factors for the patient that heighten the risk of adversity and its consequent impacts.

We propose that adversity develops across the domains (individual, systems and the ecosystem) rather than being distinct and separate. For example, restraint, which is within system processes, can cause trauma. It is worth noting, however, that not all patients who experience restraint also experience restraint-related trauma. This model can therefore be explored in relation to theories of resilience, which have their roots in the study of adversity.

Resilience research focuses on the processes that enable people to achieve better-than-expected outcomes in the face of adversity ([van Breda, 2018](#)). Early research focused on individual factors, such as hardness and self-efficacy, but has been criticised for aligning with neoliberalism and decentralisation of responsibility while disregarding social factors ([Pendenda and Lamattina, 2018](#)). This decentralisation of responsibility can be seen as a way for those in power to disregard adverse social systems and dynamics, such as poverty, racism, lack of access to resources and poor-quality education. [Bottrell \(2009 p335\)](#) raises the notion of resistance within resilience theory, asking 'How much adversity should resilient individuals endure before social arrangements rather than individuals are targeted for intervention?'. [van Breda \(2018, p. 9\)](#) develops this argument stating that 'In the context of structural inequality, resistance to adversity is more appropriate than resilience'.

Yet, within mental health services, there exists an underlying expectation of resilience. This review suggests that for some people at least, their mental health improves despite, rather than due to their engagement with inpatient services. The current system often places excessive emphasis on the individual's capacity for resilience, without taking into account the broader social context they find themselves in. How can someone expect to recover, or at least improve to the point of discharge, when they are surrounded by an ecosystem, and the associated processes and transitions, that create adversity?

It is noteworthy that in a phenomenological study of resilience in the lives of people who have experienced mental illness, acceptance of self,

others and situation was described as integral to being resilient (Edward et al., 2009). Perhaps accepting that services create adversity is what allows people to recover enough to be discharged. Whether this hinges on acceptance or other mechanisms, it is plausible that mitigating the adversities individuals face could markedly enhance their potential for recovery. One resilience theory posits that resilience is the interplay between the individual, adversity and positive outcomes (Vella and Pai, 2019); could reducing inpatient adversities increase resilience? It is only really possible to answer this question once inpatient adversities are understood. The conceptual model presented here serves as a foundation for this understanding.

We have highlighted that inpatient adversity is more wide-ranging than either restrictive interventions alone, or even coercion more broadly, and the international span of available research suggests that it is a phenomenon that is not restricted to one country or even continent. When exploring how to best utilise this understanding of adversity in mental health inpatient settings, it is helpful to consider how adversity has been linked to health and wellbeing in other areas. Since Felitti et al. (1998) developed the ACEs questionnaire in the late 1990s, understanding of the links between adversity in childhood and long-term outcomes have proliferate (Struck et al., 2021). Indeed there are a myriad of dimensional models specifying mechanistic pathways by which various dimensions of adversity are linked to health and wellbeing outcomes later in life (Berman et al., 2022). Measuring inpatient adversity might give a similar opportunity to specify mechanistic pathways that link to mental health outcomes. This has service-wide implications; increasing understanding of the impact of inpatient adversity will enable services to focus resources on the areas that will have the greatest impact both in the short- and long-term.

Moreover, differences in rates suggest that there is ethnicity-based inequity in hospital admissions for mental disorders. Hospitalisation for indigenous people in Australia is almost double that of other Australians (Pink and Allbon, 2008) while compulsory hospital admission is disproportionately experienced by black patients in the UK (NHS Race and Health Observatory, 2022). And once in services, there is further evidence of ethnicity-based inequity. In the UK, black patients are more likely to be restrained in the prone position than their white counterparts (NHS Race and Health Observatory, 2022), and similarly, in the USA, black patients are more likely to be physically and chemically restrained (Smith et al., 2022). It is possible, therefore, that inequity extends to all inpatient adversity, but without the means to measure it there is no way of determining the fact or extent of this claim. This review provides a framework from which to begin to understand and measure inpatient adversity.

#### 4.1. Strengths and limitations

This extensive review synthesised findings from 111 studies across 25 countries, involving over 4000 individuals. To our knowledge, this is the first review to synthesise literature on all adverse mental health inpatient experiences, rather than focusing solely on coercion-related experiences. Our aim was to identify the spectrum of adverse experiences, not to quantify them. While this broad approach is a significant strength, it also presents certain limitations. In developing the search terms, we focused on existing knowledge, which may have led to the omission of terms that could have identified studies with greater depth in areas such as tribunals and ward rounds. Further reviews in a range of areas should be considered to further develop our understanding.

A limitation of our systematic review is the potential filtering and selective representation of patients' voices. While we aimed to mitigate this by directly examining quotes from patients in the original studies, these quotes might have been selectively presented, potentially skewing the authenticity and representation of true experiences. Further compounding this issue is the general omission in the literature of detailed descriptions regarding the relationships between researchers and participants. This lack of transparency can obscure potential power

imbalances or conflicts of interest, raising serious ethical concerns and introducing biases that might affect the integrity and validity of our findings. For instance, if a researcher has a pre-existing relationship with participants, this might lead to responses that are more favourable to the researcher's hypothesis, thereby skewing results. Recognising this as a critical gap, future research should implement and clearly document ethical standards, including detailed disclosures of researcher-participant dynamics, to enhance the credibility and reliability of findings.

Additionally, secondary research relies on available evidence, which may contain biases we could not address. Few studies, other than those on restrictive interventions, explicitly aimed to capture adverse experiences, so some relevant studies may not have been identified. This is compounded by the lack of patient voice in the studies; our findings are based on participant quotes where possible, but few included patient co-researchers. This filtering process, influenced by researcher and publication biases, may affect the representation of patients' experiences. For instance, racism was identified in only five studies, suggesting this theme could have been overlooked. We believe it is likely that this reflects the research focus rather than the actual experiences of individuals.

#### 5. Conclusions

This review has shown that, on a global scale, adversity reaches far beyond the harm caused by restrictive interventions, highlighting the interplay between systemic, environmental and individual factors contributing to adverse experiences in mental health inpatient settings. By recognising and addressing these factors, we can significantly enhance patient outcomes. Application of adversity, as described in this review, to Bronfenbrenner's ecological systems theory provides a comprehensive model for understanding these interactions and serves as a foundational tool for service improvement. It advocates for a shift in focus from managing behaviour to holistically enhancing the inpatient environment in ways that respect patient dignity, promote safety and support recovery. Implementing this framework requires concerted efforts across various levels of healthcare management, from policy makers to healthcare providers. Key strategies could include revising procedural protocols to minimise the use of restrictive practices and ensure that transitions are smooth and transparent, and enhancing staff training to emphasise the important of supporting patient autonomy.

Future research is needed to validate the effectiveness of the proposed framework and to explore its integration into practice. This could include longitudinal studies to track the impact of environmental and procedural changes on patient outcomes. Additional, research should investigate the scalability of the framework across different geographical and cultural contexts to ensure its global applicability.

Our review demonstrates that while the challenges are significant, the opportunities for improving mental health inpatient care are substantial. By addressing the full spectrum of adverse experiences identified, mental health services can make strides towards environments that not only prevent harm but actively contribute to the wellbeing and recovery of individuals in their care. This approach promises not only to enhance patient outcomes but also to transform the perception and reality of mental health inpatient care globally.

#### Funding

This work was supported by the Research Development Fund, College of Medical and Dental Sciences, University of Birmingham, which funded a Research Assistant (RD) to support the review, and reimbursement for time and expenses of members of the PPIRG.

#### CRediT authorship contribution statement

**Nutmeg Hallett:** Writing – review & editing, Writing – original

draft, Validation, Supervision, Resources, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualisation. **Rachel Dickinson:** Writing – review & editing, Writing – original draft, Formal analysis, Data curation. **Emachi Eneje:** Writing – review & editing, Investigation, Conceptualisation. **Geoffrey L. Dickens:** Writing – review & editing, Validation, Supervision, Investigation, Conceptualisation.

## Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

## Acknowledgments

We would like to thank the people who participated in the public and patient involvement activities.

## Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.ijnurstu.2024.104923>.

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