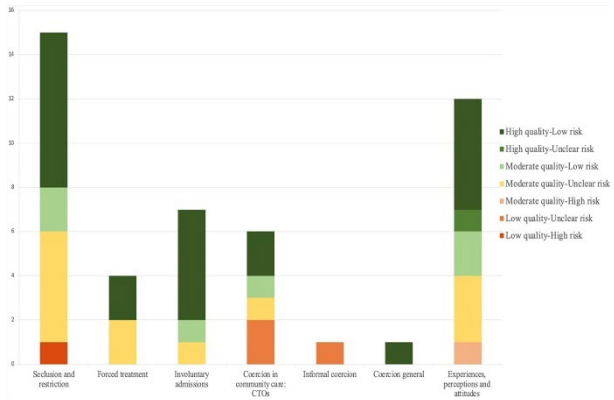
Table 2. Characteristics of included studies

Study	Participants	Comparison	Outcome measures	Comments	Risk of bias (per outcome measure)
Aragonés-Calleja, 2022	*Design:* Umbrella review. Studies included in final qualitative synthesis (n=46) • n=36 SRs (n=29 qualitative syntheses) • N=10 meta-analyses *Aim:* To gather, evaluate and synthesise the existing evidence on mental health coercion provided by the systematic reviews found in the literature. *Population:* Comprised of mental health service users, family members or primary caregivers, mental healthcare providers, decision-makers and researchers. *Search period:* until 29 April 2021. *Search databases:* Medline/PubMed, PsycINFO, EMBASE and CINAHL; repositories of systematic reviews (e.g. JBI Database, Cochrane Database)	*Intervention:* Any type of coercion (formal, informal or perceived) or restriction in mental health. *Control:* Varied, as primary studies in the systematic reviews could be intervention versus a non-exposed control group, pre-and-post cohorts, user versus non-user, as well as qualitative designs that did not mention any comparison.	*Outcomes:* Effects or consequences of restraint, including perceptions of those who use and to whom restraint is applied, health outcomes, ethical conflicts, policies and interventions to reduce restraint.	*Limitations* • Considering the design: potential omission of relevant studies. • Heterogeneity in results due to varied approaches and methodologies in the included reviews. Difficulty and lack of meta-analyses due to the diversity of methodologies. *Authors conclusion* • While the harmful physical and emotional consequences of coercive measures are well-documented, their prevalence remains high or unclear across different populations. • Professionals face a dilemma in balancing ethical principles of beneficence and maleficence, highlighting the need for a regulatory system to control and reduce coercive practices.	The quality and the risk of bias of the systematic reviews included in each category are summarised in the Figure below. Overall, 48% (n=22) were of high quality and a low risk of bias, while 2% (n=1) were of low quality and a high risk of bias. 
Douglas, 2022	*Design:* Systematic review. Studies included in final qualitative synthesis (n=9 qualitative research methods). *Aim:* To explore the physical restraint experiences of patients in acute settings. *Population:* N.R. Experiences of physical restraint by mental health patients in acute settings. Search terms: "inpatients" OR "psychiatric patient" OR "psychiatric detained patient" OR "service user" OR "mental health service user" OR "clients" OR "consumer" *Search period:* until 10 August 2021. *Search databases:* PubMed, CINAHL, PsycINFO, Cochrane Database	N.R. "restrictive interventions"	N.R. "patient experience"	Following a critical analysis of the studies key themes were identified: • 1. The bio-psychosocial impact of restraint on patients • 2. The impact of restraint on the therapeutic relationship • 3. Patient needs concerning the use of restraint *Limitations* • Time lapse between restraints and datacollection may impact patients' memory recall. • Differences in the timing of data collection across studies (ranging from days to years) can introduce inconsistencies in the findings and reduce reliability. *Authors conclusion*	Mixed-Methods Appraisal Tool (MMAT) was used in the assessment of the quality of the included studies (Hong, 2018). A total of 8 studies achieved 'high' scores and one had a 'medium' score. However, 9 studies were presented as 'high' in Table 3 in the paper.

Study	Participants	Comparison	Outcome measures	Comments	Risk of bias (per outcome measure)
				• Despite international efforts to reduce physical restraint, its continued use remains a concern due to its impact on patient experiences and therapeutic relationships. • Physical restraint can re-traumatize patients, especially those with a history of trauma, highlighting the need for mindful application by mental health professionals. • To reduce restraint use, adequate staffing, reflective forums for practitioners, and comprehensive training in de-escalation techniques and recovery-oriented care are essential.	