emerald PUBLISHING

Journal of Mental Health Training, Education and P

Staff's Understanding of The Role of Least Restrictive Practice in the Development of Obesity in Secure Psychiatric Inpatients

Journal:	*Journal of Mental Health Training, Education and Practice*
Manuscript ID	JMHTEP-08-2023-0076.R2
Manuscript Type:	Research Paper
Keywords:	secure mental health units, obesity, health promotion, least restrictive practice, ethical challenge, moral distress

Staff's Understanding of The Role of Least Restrictive Practice in the Development of Obesity in Secure Psychiatric Inpatients

Abstract

Purpose: To explore the ethical challenges of managing the weight of psychiatric patients in the least restrictive manner in secure mental health settings, and whether these could be considered as a source of moral distress for health practitioners which may be linked to staff burnout and ultimately lead to suboptimal patient care.

Design: A qualitative semi-structured interview study design was utilised to explore the understanding, views, and experiences of six staff members working on two medium secure wards in a U.K. mental health hospital using an opportunity sampling technique and Interpretative Phenomenological Analysis.

Findings: Analysis of semi-structured interviews revealed a multitude of moral events that evoked feelings of frustration, powerlessness, and anxiety related to the management of obesity in the least restrictive way, which is indicative of moral distress.

Originality: This is the first qualitative work exploring the role of least restrictive practice in the challenges associated with health promotion within secure psychiatric settings, and the effect these challenges have on mental health staff.

Research limitations/implications: Due to the small sample size and the qualitative nature of the research, the findings of the study are of explorative in nature. Further quantitative research would be required to establish a causative link between the ethical challenges associated with obesity management and staff's moral distress.

Practical implications: Addressing the healthcare professionals' knowledge deficit on how to achieve the right balance in their duty of care through inclusion of bioethics into professional discussions and training could improve staff's well-being and the organization's ethical climate.

Keywords: obesity, health promotion, secure mental health units, least restrictive practice, ethical challenge, moral distress

Introduction

Obesity is a global health concern that disproportionately affects people with severe mental illness (SMI) and is a major contributor to the lifespan reduction of up to 20 years seen in this population. (Holt, 2019; Oakley *et al*., 2013). The quality of life of individuals with SMI is also significantly worsened by obesity, given the prevalence for comorbidities such as Type 2 Diabetes, cardiovascular disease, and certain cancers (Bradshaw & Mairs, 2014; Speyer *et al*., 2019). These comorbidities are twice as prevalent in people with SMI compared to those unaffected by mental illness (Mc Namara *et al*., 2022). Thornicroft (2011) argued that this discrepancy in the quality and duration of life, which he named "a scandal of premature mortality", is a form of structural discrimination against people with SMI. Obesity is an issue that is particularly acute within secure psychiatric inpatient settings, with most patients being at least overweight or obese (Mills and Davies, 2022; Every-Palmer *et al*., 2018; Susilova *et al*., 2017). The initial stage of secure inpatient treatment seems to be the time where excessive weight gain is most risky (Davies *et al*., 2023; Levitt *et al*., 2017). For example, Davies *et al*. (2023) found in their sample of 209 medium and low secure inpatients that the average weight gained over the first 12-weeks of treatment was nearly four kilograms. The reason for greater levels of obesity in this population is not fully understood, however there is a literature base that suggests the role of biomedical (Leucht *et al*., 2023), psychiatric (Speyer et al., 2019), environmental (Davies *et al*., 2022) and psychological factors (Every-Palmer *et al*., 2018). The lack of consensus on the aetiological of obesity in people with SMI being treated in secure care adds to the complexity of its management (Spike, 2018).

It has been suggested that key contributors to health inequalities within people with SMI are moral distress and burnout experienced by psychiatric healthcare staff (Hammarström *et al*., 2019). Given the complex nature of psychiatric clientele, staff members experience a number of moral and clinical challenges that are not present within general healthcare settings (Simon *et al*., 2020). Moral distress and burnout are associated with increased staff turnover and result in suboptimal patient care (Jansen *et al*., 2022). Most of the research on moral distress in mental health settings is based on nurses' experiences (Austin *et al*., 2008) and on ethical challenges posed by procedural, physical, and

relational restrictions such as forced medication, restraint, and seclusion (Lawrence *et al*., 2021). Restrictive practices are becoming internationally recognised as harmful, with adult low and medium-secure services in the UK receiving financial incentive from the NHS to follow guidance and implement Least Restrictive Practices (LRPs) by minimising interventions related to ward routines and environment that purposely limit another's liberty, freedom, and movement (Tomlin *et al*., 2018).

The philosophy of Least Restrictive Practices (LRP) was introduced as a counterbalancing measure to the significant deprivation of liberty of secure psychiatric inpatients and is rooted in the desire to respect patients remaining rights and autonomy to choose their care pathways to promote quicker recovery and the regain of independence (Department of Health and Social Care, 2017). However, a shared understanding between staff and patients around what is considered LRP is still lacking (Sustere & Tarpey, 2019). Jansen *et al*. (2022) examined the clinical reality of nurses having to follow such policies and legislation while simultaneously trying to maintain safety and a therapeutic atmosphere in an acute psychiatric ward. This qualitative study demonstrated that unclear guidance on the appropriate level of risk for intervention created moral doubt and tension, ultimately causing moral distress. Mental health workers felt unable to meet high standards with limited resources which led to physical discomfort and feelings of defeat, shame, and guilt: key markers of burnout (Dennis & Leach, 2007).

Staff within secure inpatient settings are faced with similar moral dilemmas around managing their patients' physical health. On one hand, consuming palatable food is one of the few pleasures and avenues of control left for patients whose liberties are heavily limited. On the other hand, unrestricted consumption of energy-dense food in a constrained environment contributes to morbidity and premature mortality (Haw & Stubbs, 2011). Oakley *et al*. (2013) examined the grey area between a psychiatric hospital's duty of care and respect for a patient's choice in greater detail. They suggested that the temporal distance between gradually increasing weight and the health consequences of obesity currently preclude infringement on patients' autonomy over their lifestyle choices.

Further to this, management of secure inpatient obesity is confounded by insufficient resources, lack of support from senior management, competing treatment priorities (mental health vs

physical health), and lack of prosocial modelling within the service (Mateo-Urdales *et al*., 2020). However, patients' weight continues to increase even when facilities and staff support are available, for example, through offering lifestyle education programmes, physical activity classes and the development of individualised care plans – predominant avenues of tackling obesity in a least restrictive manner (Huthwaite *et al*., 2017). Qualitative research showed that many long-term psychiatric inpatients have an external locus of control and view weight gain as an undesirable, but unavoidable process caused by hospitalisation, medication, and leave restrictions, leaving them suffering from negative body image and stigma (Every-Palmer *et al*., 2018). The views of inpatients were supported by secure psychiatric hospital staff who attributed patients' deteriorating physical health primarily to the restrictive nature of their work setting (Davies *et al*., 2022).

Currently there has been no research to examine the ethical challenge of managing obesity in the least restrictive way, within secure psychiatric inpatient settings. The aim of the current study was to conduct an exploratory qualitative analysis of staff members' experiences of managing obesity in line with principles of LRP. The study also sought to explore the psychological impact it has on mental health workers.

Method

The current study received ethical approval from the Birmingham City University Ethics Committee and St Andrew's Healthcare. Opportunity sampling was used to recruit staff members from two medium secure wards in a mental health unit in West Midlands. Participants were recruited via the organisation email and a poster placed at nursing offices that invited participants to take part in an interview. Eligibility criteria stated that staff must have a minimum of one year experience of working in secure mental health settings. Six members of staff participated in interviews. Their pseudonyms and job characteristics can be found in Table 1.

Table I

Participant pseudonyms and job characteristics

Pseudonym	Profession	Length of employment in secure services (years)
Barry Gaff	Healthcare Assistant	27
Steve	Associate Specialist	12
Hana Mardi	Associate Specialist	3
Medic	Consultant Forensic Psychiatrist	8
Jerry	Nurse Associate	11
Donald	Occupational Therapy Technical Instructor	9

The interview schedule was informed by work conducted by Hui (2017) and Epstein and Ogden (2005). The interview schedule was reviewed and approved by the academic supervisor prior to commencing the project. The order of questions was determined by the context of the answer, with follow-up questions asked in response to the subject's developing account (Braun & Clarke, 2013). Data collection took place between October 2022 and November 2022. Interviews were conducted either face to face, or via Microsoft Teams, dependent on participant's preference. All interviews lasted between 30 and 40 minutes, were audio recorded, and transcribed verbatim. Theme constriction was discussed and reviewed with the academic supervisor. Data analysis was followed by a self-reflection exercise which included the declaration of the primary author's ethical stance and pre-existing working relationship with participants, and was also discussed with the supervisor to minimise the effect of bias in the interpretation of the results.

Analysis

The method of Interpretative Phenomenological Analysis (IPA) for the current study, as it allows the researcher to go beyond the description of phenomena and gain a deeper understanding of the subject's sense-making of their private and social worlds (Smith & Osborn, 2008). Given the niche environment of secure psychiatric settings and the corresponding homogeneity of participants, IPA is a particularly suitable idiographic method of inquiry that allows for the generation of rich and

meaningful data from a small sample size (Smith & Osborn, 2008). As per the recommendations of Smith and Osborn (2008), the first transcript was read several times with the left-hand margin being used to note comments of interest or significance. The excerpts from the first and following transcripts were entered into Excel spreadsheet, colour coded, and divided into categories to make the data more manageable for a deeper analysis. This process allowed to extract denser chunks of meaning from excerpts and cluster them into themes. Finally, the subthemes were grouped into superordinate themes.

Findings

The interpreted themes and subthemes are presented in Table 2.

Table 2

The outline of themes and subthemes

Theme	**The uphill battle of health promotion**		**Practicing in the least restrictive way: a juggling act on a tightrope**		
Subtheme	The structural asymmetry in food and activity provision	Using food as filler for the void created by detention	A difficult cost-benefit analysis	Decisional capacity: dealing with the crux of autonomy versus beneficence dilemma	Searching for the golden mean

The uphill battle of health promotion

This theme, comprised of two subthemes, revolved around the difficulty participants faced when trying to promote a healthier lifestyle to people who were placed in an obesogenic environment against their will and were regulating their negative emotions with indulgent food.

The structural asymmetry in food and activity provision

When discussing factors implicated in the development of obesity, staff recognized that patients were admitted into an environment where the amount of food was abundant, but the choice of food provided by the hospital was limited. This led patients to crave a wider variety of more indulgent foods that they purchased whilst out on leave or ordered during takeaway nights – described as "*the last meal on Earth*" (Steve) due to the amount of food that was ordered and consumed.

Yet, both structured and incidental physical activity remained limited primarily due to the availability of appropriately trained staff which restricted the use of facilities "*to one-hour slots maybe every two days*" (Barry Gaff) and difficulty accessing other destinations and by the virtue of the hospital being a secure setting.

Using food as filler for the void created by detention

Participants emphasized with patients becoming unmotivated due to being forced to live in an environment "*where there's not a lot of joy*" (Jerry). As such, consuming food was seen as an emotional coping mechanism that brought pleasure, comfort, and a form of control in response to other restrictive measures, such as seclusion. A lack of appreciation of the risk associated with unhealthy behaviours thought to be related to the patient's damaged sense of self-worth afflicted by the shame from the stigma of being placed in a secure psychiatric setting, which made participants' attempts to educate their patients about the importance of leading a healthier lifestyle counterproductive:

"S*o you have the conversation […] "Are you worried about your weight?"- "No, I am not worried about my weight". "Do you understand what will happen if you put on weight?" and they go "Well, yeah I could have a heart attack or a stroke" […] and it's like […] "Yeah, yeah, not not bothered" So […] it's really quite sad"* (Steve)

and also

"Weight gain and self-image is tied to self-esteem and when these patients are labelled as […] almost like criminals or not fit to be in society and they see themselves that way. […]so they think 'Well, things can't really get much worse' […] they don't see it as causing any damage." (Hana Mardi)

Staff felt equally despondent when trying to encourage patients to join them for physical activity and struggling to overcome an engagement barrier that they perceived to be caused by compounded poor mental and physical health, which was described as "*"a complete vicious circle"* (Donald).

Practicing in the least restrictive way: a juggling act on a tightrope

The second superordinate theme, comprised of three subordinate themes, centred on the tension that participants felt from having to balance patients' autonomy with safety requirements, and internal conflict experienced during situations in which autonomy superseded beneficence in patients with decisional capacity, leaving participants perplexed about the right course of action.

A difficult cost-benefit analysis

Participants understood the concept of Least Restrictive Practice as their duty to protect the patient's remaining rights and freedoms to promote a good quality of life during compulsory treatment. Practicing in the least restrictive way was felt as a fine balancing act between respecting patients' decisional autonomy and considering the risks associated with these decisions. The balance was felt to be "*ever changing*" (Hana Mardi) and tipped "*perhaps more towards (.) patients enjoying food […] but not completely understanding how detrimental it could be to their health in the long run*" (Medic). The imbalance in the level of restrictions was seen as conflicting with the professional obligation to provide a reasonable standard of care:

"So I know in a secure unit we have a Duty of Care and it's a balancing act and I think this is the problem with yeah […] sometimes it's not restricted sometimes enough and it's putting their erm health in jeopardy" (Donald)

Implementation of restrictions was considered directly in relation to the level and imminence of risk posed by patients' choices. With regards to dietary choices, it was felt that "*there have to be more grounds to consider restrictions*" (Medic) which would only be justified if it was "*a matter of […] serious deterioration*" (Jerry). The absence of imminent danger associated with excessive eating made the management of obesity left participants feeling helpless from being legally bound to prevent the outcomes of detrimental choices:

"It is quite hard to see people quite, quite literally eating themselves to death." (Steve)

Decisional capacity: dealing with the crux of autonomy versus beneficence dilemma

Participants understood patients' decisional capacity to be the main prerequisite to autonomy, which in relation to lifestyle choices was viewed as "*their right to make those choices that might not be right*" (Jerry). The participants empathised with the difficulty of making lifestyle changes, acknowledging that unhealthy decisions were a part of human nature as well as recognizing that staff didn't always lead by example. The situations where patients who were deemed as having mental capacity continued to make dangerous choices despite being made aware of the risk resulted in bewilderment with the appropriate time and level of intervention, leaving staff questioning their role and the potential consequences of their actions:

"So then do staff have a right to intervene? Or does because he still has capacity and he has choice that he will eat that even though it will make him extremely unwell? […] So at what point does Good Samaritan outweigh staff being autocratic and not being able to, you know, give your patient choice, rights, independence and freedom?" (Barry Gaff)

Others felt that their role was outlined in their professional code of practice to act in the patient's best interest, and experienced inner conflict from the inability to fulfil this duty.

Capacity assessment was thought to be lacking objectivity, not accounting for wider societal impacts of an individual's unwise decisions, and that the process '*has almost become a tick-box exercise*' (Hana Mardi) used to absolve the clinician from the responsibility of dealing with the ethical dilemma by observing some degree of the patient's understanding of the risks associated with their decision and their ability to communicate those risks. The responsibility was perceived as especially burdensome when one considered possible negative media publicity and in situations where clinical and bureaucratic interests clashed:

"In our culture of heavy scrutiny, heavy litigation, CQC is coming and having a look at your least restrictive practices and whether they are being implemented and followed to a tee. We on one side we're being pulled towards "Do not take responsibility, give the patient the responsibility". And

on the other side um the wider community, the […] healthcare system it's all being impacted on" (Hana Mardi)

Participants sought inclusion of the wider professional team and family members in the capacity assessment to alleviate the stress associated with decision-making and to better understand the patient through a *"holistic view of what they chose […] to do before they became ill."* (Medic)

Searching for the golden mean

Participants uniformly opposed a paternalistic approach to care and at the same time, felt the need to find *"a happy medium*" (Jerry) to resolve the doubt of whether they were doing enough to enable patients to have the best quality of life prior to and after discharge:

"*Think (.) deep down [...] from experience. I know when patients have said to me like "I don't like the way I look. I'm I'm too big. I can't get any clothes that fit me" and (.) it's like (.) is somebody failing, that's somebody failing them! I don't know.[…]I think […] if we moderate some things and potentially it would end this vicious circle*" (Donald)

Some participants offered their account of what they deemed to be a reasonable food consumption but appreciated that patients were more likely to follow the advice of their peers, especially if they could observe the positive effect of leading a healthy lifestyle, or if they directly experienced the consequences of the undesirable behaviour, such as a heart attack.

However, there was also an appreciation that leading a healthier lifestyle was a low priority for many patients and that adjusting staff expectations was necessary to prevent disappointment. The realisation that not everyone is interested in healthy living was especially hard to accept for participants directly involved in physical health promotion. The absence of effective obesity treatments that did not require a considerable investment of effort from demotivated patients led some subjects to yearn for a magic solution:

"I just wish […] wish, wish […] there was something that you could say like "You can have eat what you want and there was a magic something that you could make you literally like stay

healthy' and that would be unbelievable […]((smiling)). But yeah. But there is not and if I was, if I did, I'd be a very, very rich man. So. So yeah" (Donald)

Discussion

This qualitative study aimed to explore the ethical challenge of managing obesity in a stigmatized population that suffers from low motivation caused by having a serious mental illness and by being in a confined environment of secure psychiatric services. Although no direct comparison can be made to other studies, this research is generally in line with the existing literature on moral distress in psychiatric healthcare workers. The present study revealed that staff understood the least restrictive practice to be a necessary safeguard to the patient's remaining rights and freedoms in the face of limitations dictated by relational and procedural safety. The first interpreted theme added to the weight of literature on the obesogenic environment of secure psychiatric hospitals (Huthwaite *et al*., 2017; Johnson *et al*., 2018; Mateo-Uridales *et al*; 2020) where access to structured physical activity was dependent on the availability of trained staff, food was the centre of patients' routine and a main source of entertainment, with dietary choices being driven by medication-induced hunger, pleasure, and comfort-seeking. The perceptions of the participants in the present study support the views of 12 multidisciplinary health practitioners from a Welsh secure psychiatric service from a previous study by Davies *et al*. (2022). Frustration caused by the limited impact of health promotion attempts due to additional external limitations such as patients' low motivation and a damaged sense of self-worth, was also reflected in that study where participants showed concern over a lack of resources and staff's behaviour change skills required for better uptake of health advice. The absence of positive staff role modelling of healthy behaviours was another shared acknowledgment that amplified the constraints posed by the environment where safety took precedence over physical health.

The novelty of the present study lies in the second interpreted theme which highlighted the internal restraining factors indicative of participants' moral distress. These included a perceived sense of powerlessness in situations where patients with decisional capacity made choices considered to be detrimental to their physical health condition. Moral uncertainty was caused by a lack of clear guidance on whether and when staff are allowed to put restrictions on patients' excessive food and

drink consumption, whereas the dilemma was rooted in the difficulty to decide which value - autonomy or beneficence should take precedence in that situation. Anxiety was brought about by considering the legal consequences of a particular decision being considered either neglectful or excessively paternalistic. From one side, depriving patients of food was viewed as possible infringement on their rights which could be deemed as overly restrictive by regulatory bodies, such as CQC, and from the other side, there was a fear of repercussion from the legal system if patient was to develop serious complications associated with obesity or other preventable lifestyle-related condition. Finally, those participants who knew what would be in the patient's best interest felt unease from the incompatibility of the therapeutic action with least restrictive practice. This is in line with the findings of Jansen *et al*. (2022) on the use of coercive measures such as restraint in response to aggression where participants also experienced tension from the conflict between least restrictive policy and therapeutic requirements. The shared experience of uncertainty can be inferred from similar phrases used by participants in Jansen *et al*. (2022) research, such as *"Where to draw the line? When does it become dangerous?"* (p.5) when trying to understand the maximum level of violent behaviour that they can tolerate before implementing restraint and/or other coercive measures. The current research demonstrated that in relation to lifestyle choices, these lines were "*arbitrary*" and drawn "*in the sand*" (Hana Mardi). Similar to this research, medics in the Jansen *et al*. (2022) study were reported to be wary of making decisions that would infringe on patients' autonomy due to fear of patient complaints and scrutiny from external bodies. Although not captured in the present study, other research on nurses in critical care settings (Morley *et al*., 2020) demonstrated how the doctor's ultimate decision-making responsibility and the resultant ability to override the opinions of others led nurses to feel ignored and disregarded. Austin *et al*. (2008) argued that despite the predominance of view of doctors as very autonomous professionals, psychiatrists are in fact socially and legally constrained to act in certain ways, with one of the most difficult dilemmas faced by psychiatrists being that of a "double agent" in situations where the interests of society contradict with those of the patient. In the present research, the moral distress of medical professionals transpired to the author in feelings of being torn, frustrated, and treading on the side of caution when discussing the implementation of restrictions related to lifestyle choices. Since obesity is unlikely to be the primary reason for a person to be

admitted to the general or forensic psychiatric service, and thus not a primary treatment goal (Anderson-Shaw, 2018), it could explain the staff's reluctance to implement dietary restrictions and therefore lead to a lower prioritisation of physical health in the allocation of resources. Furthermore, the difference in the proximity of risk posed by high-calorie food compared to illicit drugs does not provide sufficient grounds to classify food as contraband (Humbyrd, 2018) which leaves persuasion and encouragement as only viable but often ineffective means of healthy lifestyle promotion for staff.

These findings suggest that for the obesity problem to be tackled more successfully, secure psychiatric services should provide more comprehensive behaviour change training to staff, or tailor existing psychotherapeutic interventions that involve teaching emotion regulation and distress tolerance skills to address excessive use of food as a coping mechanism for psychological trauma, which is an important driver of weight gain and excess morbidity in secure psychiatric population (Davies *et al*., 2024). This is especially pertinent in light of recent evidence highlighting the link between the number of Adverse ChildhooThe inclusion of bioethics into professional discussions and training could provide healthcare professionals with knowledge on how to achieve the right balance in their duty of care ultimately improving their well-being and the organization's ethical climate.

Limitations

The phenomenological nature of this research and the homogeneity of participants precludes the generalisation of results beyond the settings in which the research took place. The study sample was pragmatically driven and therefore, it is possible that data saturation has not been reached due to the time constraints of the project. Further quantitative research using validated measures of moral distress and a greater sample size that includes a wider variety of multidisciplinary team members would be required to establish the causative link between the moral events and the psychological distress of psychiatric healthcare workers involved in obesity management.

Conclusion

Overall, the findings of the current study suggest that least restrictive management of obesity within secure psychiatric settings has the potential to cause moral distress for healthcare professionals.

Feelings of frustration, powerlessness, and anxiety were evoked by environmental constraints, a legal obligation to respect patients' informed decisions despite these being detrimental to the patients' health, and uncertainty about how to strike a balance in avoiding perceived or real accusations of professional negligence or being autocratic in their decision-making. This study highlighted the multitude and complexity of issues contributing to obesity management which require further investigation.

References

Anderson-Shaw, L. (2018). "Forced calorie restrictions in the clinical setting", *The American Journal of Bioethics*, Vol. 18 No. 7, pp. 83–85. https://doi.org/10.1080/15265161.2018.1478040

Austin, D. *et al.* (2008) "The balancing act: psychiatrists' experience of moral distress", *Medicine Health Care and Philosophy*, Vol. 11 No. 1, pp. 89–97. https://doi.org/10.1007/s11019-007-9083-1.

Bradshaw, T. and Mairs, H. (2014) "Obesity and serious mental ill health: a critical review of the literature", *Healthcare*, Vol. 2 No. 2, pp. 166–182. https://doi.org/10.3390/healthcare2020166.

Braun, V., and Clarke, V. (2013). *Successful Qualitative Research: A Practical Guide for Beginners,* SAGE Publications Ltd, London.

Davies, J.L. *et al.* (2024) 'Psychological trauma predicts obesity in welsh secure mental health inpatients', *International Journal of Forensic Mental Health*, pp. 1–10. doi:10.1080/14999013.2024.2314544.

Davies, J. L., *et al.* (2022). "Staff perspectives on obesity within a Welsh secure psychiatric inpatient setting", *The Journal of Mental Health Training, Education and Practice,* Vol. 18 No. 1, pp. 44-52. https://doi.org/10.1108/JMHTEP-06-2022-0050

Davies, J. L., *et al.* (2023). "Weight gain is not associated with antipsychotic medication, sociodemographic factors, or diagnosis in a Welsh secure mental health unit", *The International Journal of Forensic Mental Health,* https://doi.org/10.1080/14999013.2023.2218287

Dennis, A. M., and Leach, C. (2007). "Expressed emotion and burnout: the experience of staff caring for men with learning disability and psychosis in a medium secure setting", *Journal of Psychiatric and Mental Health Nursing*, Vol. 14 No 3, pp. 267–276. https://doi.org/10.1111/j.1365-2850.2007.01073.x

Department of Health and Social Care. (2017, October 31). Code of practice: Mental health act 1983. GOV.UK. Retrieved January 4, 2023, from https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983

Epstein, L. and Ogden, J. (2005) "A qualitative study of GPs' views of treating obesity", *PubMed*, Vol. 55 No. 519, pp. 750–754. https://pubmed.ncbi.nlm.nih.gov/16212849.

Every-Palmer, S. *et al*. (2018) "Long-term psychiatric inpatients' perspectives on weight gain, body satisfaction, diet and physical activity: a mixed methods study", *BMC Psychiatry*, Vol. 18, No. 1 https://doi.org/10.1186/s12888-018-1878-5.

Hammarström, L. *et al*. (2019) "Controlling emotions—nurses' lived experiences caring for patients in forensic psychiatry", *International Journal of Qualitative Studies on Health and Well-being*, Vol. 14 No. 1, pp. 1-10. https://doi.org/10.1080/17482631.2019.1682911.

Haw, C., and Stubbs, J. (2011). "What are we doing about weight management in forensic psychiatry? A survey of forensic psychiatrists", *The British Journal of Forensic Practice*, Vol. 13 No. 3, pp. 183–190. https://doi.org/10.1108/14636641111157823

Holt, R. I. G. (2019). "The management of obesity in people with severe mental illness: An unresolved conundrum", *Psychotherapy and Psychosomatics*, Vol. 88 No. 6, pp. 327–332. https://doi.org/10.1159/000503835

Hui, A. (2017). "Least restrictive practices: an evaluation of patient experiences", available at https://nottingham-repository.worktribe.com/index.php/output/900983/least-restrictive-practices-an-evaluation-of-patient-experiences (accessed 20 September 2022)

Humbyrd, C. J. (2018). "Complex obesity: multifactorial etiologies and multifaceted responses", *The American Journal of Bioethics*, Vol. 18 No.7, pp. 87–89. https://doi.org/10.1080/15265161.2018.1478042

Huthwaite, M. *et al.* (2017) "Obesity in a forensic and rehabilitation psychiatric service: a missed opportunity?", *Journal of Forensic Practice*, Vol. 19 No. 4, pp. 269–277. https://doi.org/10.1108/jfp-03-2017-0007

Jansen, T.-L., *et al.* (2022). "How may cultural and political ideals cause moral distress in acute psychiatry? A qualitative study", *BMC Psychiatry*, Vol. 22 No. 1, https://doi.org/10.1186/s12888-022-03832-3

Johnson, M. *et al.* (2018) "Tackling obesity in mental health secure units: a mixed method synthesis of available evidence", *British Journal of Psychiatry Open*, Vol. 4 No. 4, pp. 294–301. https://doi.org/10.1192/bjo.2018.26.

Lawrence, D. *et al.* (2021). "Restrictive practices in adult secure mental health services: a scoping review", *International Journal of Forensic Mental Health*, Vol. 21 No.1, pp. 68–88. https://doi.org/10.1080/14999013.2021.1887978

Leucht, S. *et al.* (2023) "Long-term efficacy of antipsychotic drugs in initially acutely ill adults with schizophrenia: systematic review and network meta-analysis", *World Psychiatry*, Vol. 22 No.2, pp. 315–324. doi:10.1002/wps.21089.

Levitt, G. A. *et al.* (2017). "Weight gain in psychiatric inpatients: are interventions making a positive impact?", *The Primary Care Companion for CNS Disorders*, Vol. 19 No. 4, https://doi.org/10. 4088/PCC.17m02111

Mateo- Urdiales, A.M. *et al.* (2020) "Evaluation of a participatory approach to improve healthy eating and physical activity in a secure mental health setting", *Journal of Public Mental Health*, Vol. 19 No. 4, pp. 301–309. https://doi.org/10.1108/jpmh-11-2019-0090.

Mc Namara, K. P. *et al.* (2022). "Should antidiabetic medicines be considered to reduce cardiometabolic risk in patients with serious mental illness?", *Medical Journal of Australia*, Vol. 217 No.7 https://doi.org/10.5694/mja2.51701

Mills, S., and Davies, J. L. (2022). "Making days count: national review of patients cared for in secure mental health hospitals. The National Collaborative Commissioning Unit", available at https://nccu.nhs.wales/qais/national-reviews/making-days-count/mdc-documents/making-days-count1/ (accessed 17 July 2023)

Morley, G., Bradbury-Jones, C. and Ives, J. (2020) "What is 'moral distress' in nursing? A feminist empirical bioethics study," *Nursing Ethics*, 27(5), pp. 1297–1314. https://doi.org/10.1177/0969733019874492.

Oakley, C. et al. (2013) "A right to be fat? A survey of weight management in medium secure units", *The Journal of Forensic Psychiatry & Psychology*, Vol. 24 No. 2, pp. 205–214. doi:10.1080/14789949.2013.771279.

Simon, L. *et al*. (2020). "Clinician experiences of care provision in the correctional setting: a scoping review", *Journal of Correctional Health Care*, Vo. 26 No.4, pp. 301–314. https://doi.org/10.1177/1078345820953154

Smith, J.A. and Osborn, M. (2008) "Interpretative Phenemenological Analysis", Smith, J.A. (Ed.), *Qualitative Psychology: A Practical Guide to Research Methods,* Sage, London, pp. 53-80.

Speyer, H. *et al.* (2019). "Lifestyle interventions for weight management in people with serious mental illness: a systematic review with meta-analysis, trial sequential analysis,

and meta-regression analysis exploring the mediators and moderators of treatment effects", *Psychotherapy and Psychosomatics*, Vol. 88 No.6, pp. 350–362. https://doi.org/10.1159/000502293

Spike, J. P. (2018). "Obesity, pressure ulcers, and family enablers", *The American Journal of Bioethics*, Vol. 18 No. 7, pp. 81–82. https://doi.org/10.1080/15265161.2018.1478505

Susilova, L., *et.al* (2017). "Changes in BMI in hospitalized patients during treatment with antipsychotics, depending on gender and other factors", *International Journal of Psychiatry in Clinical Practice*, Vol 21 No 2, pp.112–117. https://doi.org/10.1080/ 13651501.2017.1291818

Sustere, E. and Tarpey, E. (2019). "Least restrictive practice: its role in patient independence and recovery", *The Journal of Forensic Psychiatry & Psychology*, Vol. 30 No. 4, pp. 614–629. https://doi.org/10.1080/14789949.2019.1566489

Thornicroft, G. (2011) "Physical health disparities and mental illness: the scandal of premature mortality", *British Journal of Psychiatry*, Vol 199 No 6, pp. 441–442. https://doi.org/10.1192/bjp.bp.111.092718.

Tomlin, J., Bartlett, P. and Völlm, B. (2018). "Experiences of restrictiveness in forensic psychiatric care: Systematic review and concept analysis", *International Journal of Law and Psychiatry*, Vol 57, pp. 31–41. https://doi.org/10.1016/j.ijlp.2017.12.006

1