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Examining the Association Between Perceived Quality of Care and Experienced Coercion Among Patients in Acute Mental Health Units in Spain: A National Cross-Sectional Study

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Keywords: coercion | fear | mental health services | patient satisfaction | quality of health care

ABSTRACT

Aim: To examine the association between perceived quality of care and the level of coercion experienced by individuals hospitalised in acute mental health units.

Design: National cross-sectional study.

Methods: Data were collected from 255 patients admitted to 12 acute mental health units across Spain. Standardised instruments assessed perceived quality of care and levels of coercion, humiliation and fear at discharge. Multiple linear regression analyses were used to explore associations between care quality dimensions and patients' experiences.

Results: Perceived quality of care was significantly associated with lower levels of perceived coercion and humiliation. All dimensions of care quality showed inverse associations, with the "secluded" dimension showing the strongest association. The

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association between care quality and perceived fear was less consistent. These findings are particularly relevant for mental health nurses, who play a central role in delivering relational care and ensuring patients' emotional safety.
Conclusion: Higher perceived quality of care is associated with lower levels of coercion, humiliation, and fear during hospitalisation in acute mental health settings.
Implications for the Profession and/or Patient Care: For mental health nursing, these results underscore the critical role of nurses in creating therapeutic environments that reduce coercive experiences. By fostering trust, promoting patient autonomy, and ensuring emotional and physical safety, nurses can significantly influence the quality of care and patient outcomes.
Impact: The study addresses the lack of evidence on how perceived quality of care influences experiences of coercion in acute mental health settings. Better perceived care quality is linked to reduced feelings of coercion, humiliation and fear. The research has direct implications for mental health nurses, clinical educators and healthcare managers aiming to improve patient experiences and reduce coercive practices in psychiatric care.
Reporting Method: STROBE reporting guideline.
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1 | Introduction

Mental health policies in Europe and globally are increasingly focused on human rights, recovery and quality of care. Understanding the experiences and perceptions of inpatients is key to assessing care quality (Staniszewska et al. 2019). However, the presence of coercive practices in mental health care settings significantly compromises care quality by negatively affecting patients' perceptions of safety, autonomy and dignity, which are fundamental elements in evaluating person-centred care (Mahdanian et al. 2023). Both the WHO and the World Psychiatric Association advocate for reducing or eliminating coercive practices in mental health care, supporting non-coercive, rights-based approaches and early intervention (Gill et al. 2024). The WHO European Mental Health Action Plan 2023–2030 (Santomauro et al. 2021) states that 'all necessary measures should be taken to promote voluntary admission and treatment, and to avoid coercion.' In this vein, the WHO's Quality Rights initiative promotes the need to assess and adopt necessary measures to protect against human rights violations (Funk and Bold 2020; Patel et al. 2023). Despite progress, recent studies still highlight ongoing human rights violations, including coercive acts in acute mental health units, underscoring the need for comprehensive models that fully incorporate human rights into all services (Mahdanian et al. 2023).

1.1 | Background

Coercion in mental health settings often involves involuntary treatment and measures such as seclusion, restraint, and forced medication. These practices are typically justified on grounds of patient safety and public protection but raise significant ethical and legal concerns. The use of coercion is a topic of debate, with arguments focusing on the balance between patient autonomy and the need for treatment (Tomcuk et al. 2023; Richter 2024).

According to Pilgrim (2019), coercion is defined as the use of the threat of force to ensure that a human being complies with the wishes of others. In the context of mental health, visible coercive practices include involuntary admissions, seclusion in a locked room, mechanical restraint, forced medication or the use of doses above recommended values. The repercussions of coercive practices extend beyond the act itself, with treated individuals reporting emotional consequences that have a long-term impact on their lives (Tomcuk et al. 2023). In this regard, evidence indicates higher levels of perceived stress and coercion associated with the use of mechanical restraint, both when used as a sole coercive measure and in combination with involuntary medication (Guzmán-Parra et al. 2019). Mechanical restraint was more stressful and coercive for patients compared to involuntary medication (Fugger et al. 2016; Mielau et al. 2016). Additionally, the results related to the combined use of coercive measures align with other studies, where the combination of different interventions was considered particularly coercive (Guzmán-Parra et al. 2019). Furthermore, studies show a high percentage of patients (12.6%) who developed post-traumatic stress disorder related to the use of combined coercive measures (Guzmán-Parra et al. 2019). Chieze et al. (2019) studied the psychological aftermath of seclusion and restraint, revealing a high incidence of post-traumatic stress disorder (between 25% and 47%).

The relationship between coercion and the quality of psychiatric care is complex. While coercion is a defined term, the concept of 'quality of care' in mental health has a multidimensional nature. According to Schröder et al. (2006), five fundamental dimensions—respect for dignity, perception of safety during care, participation in the care process, recovery orientation, and adequacy of the environment—represent the key elements that people associate with high-quality care.

The quality of care is also influenced by the implementation of alternative approaches, such as recovery-oriented models, which have been shown to reduce the need for coercion and improve treatment outcomes (Mahler 2023; Tomcuk et al. 2023).

The application of coercive measures can negatively impact the quality of care, particularly concerning patients' hospitalisation experiences, which can, in turn, lead to poorer recovery outcomes. Research findings aimed at analysing the perceived quality of care by individuals hospitalised in mental health units showed that participation—understood as the degree to which patients perceive themselves as involved in decisions about their care—received the lowest scores (Lundqvist et al. 2024). These findings are consistent with international trends reported in previous studies (Sanchez-Balcells et al. 2020; Roldán-Merino et al. 2023; Fossum et al. 2024; Lundqvist et al. 2024).

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Summary

- What does this paper contribute to the wider global clinical community?
  - Demonstrates that higher perceived quality of care significantly reduces patients' experiences of coercion and humiliation during mental health hospitalisation. This highlights the therapeutic value of environments that promote privacy, calm and emotional containment.
  - Identifies the creation of secluded, emotionally safe spaces as a critical component of non-coercive mental health care, offering a concrete target for clinical interventions, architectural design and staff training in acute mental health settings.
  - Reinforces the pivotal role of mental health nurses in shaping these therapeutic environments, emphasising their capacity to foster trust, autonomy and dignity through relational care practices that minimise coercive dynamics.

Consequently, there is a need to mitigate the perception of coercion by promoting greater patient involvement in their care process and encouraging active collaboration in treatment planning and decision-making (Fossum et al. 2024). In this regard, international studies evaluating quality in various mental health contexts have reported poorer results concerning environmental safety (Schröder and Lundqvist 2022; Lundqvist et al. 2014; Skundberg-Kletthagen et al. 2022). Both professionals and patients perceive the hospital environment as unsafe due to episodes of verbal and physical violence in psychiatric care (Samartzis and Talias 2020). Providing a safe environment is essential to protect both patients and staff, as it directly impacts recovery and the quality of care (Pelto-Piri et al. 2019).

The use of coercion in mental health care remains a controversial issue with a significant relationship to the quality of care. In inpatient units, where patients may be in crisis, the perceived quality of care can directly influence how patients experience their stay. If the care is perceived as poor quality, patients are more likely to feel coerced or even threatened, even if there is no direct physical coercion. To our knowledge, few studies have explored the relationship between perceived coercion and the quality of mental health care from the perspective of inpatients.

2 | The Study

This study aimed to examine the association between perceived care quality and the level of coercion experienced by individuals hospitalised in acute mental health units in Spain.

3 | Methods

3.1 | Design and Setting

An observational, cross-sectional and analytical study was conducted as part of a broader project titled Reserved Therapeutic Space RTS_MHNursing_Spain. The study involved 12 acute mental health inpatient units from public hospitals located in various autonomous communities across Spain. The units were selected through an invitation extended via the Spanish Association of Mental Health Nursing (AEESME), aiming to ensure territorial representativeness.

3.2 | Sample Description

The study sample consisted of patients admitted to the 12 participating acute mental health inpatient units. All patients over 18 years of age who were hospitalised in an acute unit and voluntarily provided informed consent to participate in the study were included. Patients were excluded if, at the time of recruitment, they were under mechanical restraint, had language barriers, cognitive impairment, intellectual disability or clinical contraindications identified by their therapeutic reference professional. Patients were recruited consecutively. Given the purpose of this study, the sample size was deemed appropriate, considering that for conducting multiple linear regression, it is recommended to include one variable for every 10–15 individuals (Green 1991; Austin and Steyerberg 2015).

3.3 | Outcome Measures and Instruments

3.3.1 | Quality of Psychiatric Care

To assess the quality of care received during hospitalisation, the Spanish version of the Quality in Psychiatric Care (QPC) questionnaire, validated by Sanchez-Balcells et al. (2021), was used. This instrument consists of 30 items distributed across six dimensions: therapeutic encounter, patient participation, support received, secluded environment, secure environment and discharge process. Each item is rated on a 4-point Likert scale, where 1 indicates 'strongly disagree' and 4 'strongly agree'. The total score ranges from 30 to 120, with higher scores indicating a better perception of care quality. In this sample, the QPC questionnaire demonstrated good internal consistency, with a Cronbach's alpha of 0.94 for the total scale. The subscales showed the following reliability coefficients: encounter ($\alpha = 0.91$), participation ($\alpha = 0.88$), support ($\alpha = 0.80$), secluded environment ($\alpha = 0.67$), secure environment ($\alpha = 0.68$), and discharge ($\alpha = 0.70$).

3.3.2 | Experience of Coercion

The subjective experience of coercion during hospitalisation was assessed using the validated Spanish version of the Coercion Experience Scale-18 (CES-18), developed by Aguilera-Serrano et al. (2019). This tool includes 18 items grouped into two dimensions: one related to the perception of coercion and humiliation, and the other focused on fear. Responses are collected on a 5-point Likert scale, where 1 indicates 'never' and 5 'always'. The total score ranges from 18 to 90. A score of 18 indicates no or very low perceived coercion, whereas a score of 90 reflects a high subjective experience of coercion during hospitalisation. In the present sample, the scale showed good internal consistency, with a Cronbach's alpha of 0.96 for the total scale. The subscales yielded coefficients of 0.96 for coercion and humiliation and 0.85 for fear.

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3.3.3 | Sociodemographic and Clinical Variables

Various sociodemographic and clinical variables were collected to characterise the sample and analyse their potential relationship with the perception of coercion. Sociodemographic variables included age and sex. Clinical variables included the main diagnosis, type of admission (voluntary or involuntary), number of hospitalisation days and number of mechanical restraint episodes.

3.4 | Data Collection

Data collection was carried out prior to each patient's discharge. When a new admission occurred in one of the participating units, the reference nurse immediately informed the study coordinator in that unit. The coordinator assessed the case to verify whether the patient met the inclusion criteria. Once eligibility was confirmed, the patient was informed about the study objectives and, after addressing any questions, signed the informed consent form. Subsequently, the unit coordinator—who was not involved in clinical care and was specifically trained in administering questionnaires—administered the Quality in Psychiatric Care and Coercion Experience Scale-18 instruments. Both instruments were administered simultaneously at discharge, covering the whole hospital stay. Simultaneously, complementary clinical information was extracted directly from each patient's electronic health record. All data were recorded and managed centrally using the REDCap (Research Electronic Data Capture) platform (Harris et al. 2019).

3.5 | Ethical Issues

The research was reviewed and approved by the ethics committees of all 12 healthcare institutions involved in the study. Participants were provided with clear and comprehensive information about the purpose and procedures of the study and gave their written consent before taking part. They were assured that participation was voluntary and that they could discontinue their involvement at any stage, without facing any negative consequences. To protect participants' privacy, all data were collected anonymously, and no personal identifiers were recorded. The study was conducted in line with international ethical standards for research involving human subjects, as outlined in the Declaration of Helsinki.

3.6 | Statistical Analysis

First, a descriptive analysis of the sociodemographic and clinical characteristics of the sample was conducted. Quantitative variables were described using measures of central tendency and dispersion, specifically the mean and standard deviation. Qualitative variables were expressed as absolute frequencies and percentages. To explore potential relationships between participants' sociodemographic and clinical characteristics and their perceived levels of coercion, humiliation, and fear, bivariate statistical analyses were performed. For quantitative variables, Pearson's correlation coefficient was used, while for categorical variables, independent samples *t*-tests were applied. In a second phase, multiple linear regression models were conducted to examine the association between the different dimensions of perceived quality of care and subjective experiences of coercion, humiliation, and fear; these models were conceived for exploratory–explanatory purposes to quantify associations. To avoid collinearity among QPC dimensions, seven independent models were constructed for each dimension (therapeutic encounter, patient participation, support received, secluded environment, secure environment, discharge process and total QPC score). Each model was adjusted for relevant sociodemographic and clinical variables: age, sex, number of mechanical restraint episodes, number of hospitalisation days, type of admission and main diagnosis. All models assumed a 95% confidence level, and results with *p*-values below 0.05 were considered statistically significant. The internal consistency of the instruments used was assessed using Cronbach's alpha coefficient. Data processing and statistical analysis were performed using SPSS version 27.0.

3.7 | Missing Data Management

Sample size varied across analyses due to missing values in some variables. For bivariate analyses, pairwise deletion was applied, allowing the use of the maximum available data for each specific comparison. In multiple regression models, listwise deletion was used, including only participants with complete data for all required variables, in line with methodological recommendations for this type of analysis (Sharifnia et al. 2025).

3.8 | Reporting Method

This manuscript was prepared in accordance with the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) Statement (File S1) (Von Elm et al. 2007).

4 | Results

A total of 255 patients participated in the study. The mean age was 41 years (SD = 15.12). Regarding the type of admission, 56.8% were admitted voluntarily and 43.2% involuntarily. The average length of hospitalisation was 22.42 days (SD = 20.84). The mean number of mechanical restraint episodes was 0.44 (SD = 1.37), with 22.2% ($n = 56$) of patients having experienced at least one episode. A total of 30.7% of patients were diagnosed with psychosis/schizophrenia ($n = 85$), 15.2% with bipolar disorder ($n = 42$), 14.4% with personality disorder ($n = 40$), and the remainder with other mental health conditions.

In the bivariate analysis between the various sociodemographic and clinical variables and the patients' perceived levels of coercion, humiliation, and fear, no significant differences or associations were found, except for the number of mechanical restraint episodes, which was significantly associated with perceived humiliation and coercion ($r = 0.274$; $p < 0.001$), and to a lesser extent with perceived fear ($r = 0.235$; $p < 0.001$) during hospitalisation (Table 1).

To examine the association between each dimension of quality of care and the levels of perceived coercion and humiliation on

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TABLE 1 | Relationship of patients' socio-demographic and clinical variables with the CES-18.

		Coercion and humiliation			Fear		
Variables	***n***	**Correlation coefficient (*r*)**	**Mean (SD)**	***p***	**Correlation coefficient (*r*)**	**Mean (SD)**	***p***
Age (years)	253	0.079		0.272[a]	0.113		0.116[a]
No. of episodes of mechanic containment	252	0.285		< 0.001[a]	0.248		< 0.001[a]
No. of days of hospitalisation	251	0.044		0.548[a]	0.015		0.835[a]
Sex							
Female	136		33.6 (16.9)	0.400[b]		7.2 (4.1)	0.276[b]
Male	119		35.7 (18.1)			7.8 (4.6)	
Admission mode							
Voluntary	145		33.3 (17.8)	0.230[b]		7.3 (4.4)	0.575[b]
Involuntary	108		36.4 (17.1)			7.7 (4.2)	
Mental disorders							
Psychotic disorder-schizophrenia	85		37.7 (17.3)	0.064		7.8 (4.5)	0.136
Bipolar disorder	42		39 (17.8)			8.7 (4.9)	
Personality disorder	40		31.2 (19.4)			6.9 (4.4)	
Other	86		31.51 (18.2)			6.6 (3.2)	

Abbreviations: CES-18, Coercion Experience Scale; SD, standard deviation.
[a]Pearson' correlation coefficient.
[b]Student's *t* test.

one hand, and fear on the other, regression models were constructed and adjusted for the various clinical and sociodemographic covariates. The results indicated that perceived quality of care at discharge explained part of the variation in patients' experiences of coercion. Specifically, the overall quality of care score was inversely associated with coercion and humiliation ($B = -0.35$; 95% CI = −0.48 to −0.23). Moreover, all dimensions were related, with the secluded environment dimension showing the strongest association ($B = -2.25$; 95% CI = −3.09 to −1.41), explaining the greatest variation in experienced coercion levels (Table 2).

Regarding the level of fear experienced by patients, the total QPC score also showed a negative association, although weaker ($B = -0.044$; 95% CI = −0.077 to −0.010). The relationship with specific dimensions was less consistent, and factors such as the quality of discharge or the support received during hospitalisation did not reach statistical significance (Table 3).

5 | Discussion

The aim of this study was to examine the association between perceived quality of care and the level of coercion experienced by individuals hospitalised in acute mental health units in Spain. The results revealed a clear negative association between perceived quality of care and coercive experiences. Specifically, the higher the patients rated the quality of care received at discharge, the lower their perception of coercion and humiliation—and to a lesser extent, fear.

Regarding the perception of coercion and humiliation, all dimensions of the QPC scale maintained significant associations, even after adjusting for sociodemographic and clinical variables. However, the strength of the associations varied. The Secluded dimension (which assesses aspects related to privacy, respect and protection in situations of vulnerability) showed the strongest negative association, explaining most of the variability in the experience of coercion and humiliation. This suggests that the more positively patients perceive their privacy and dignity to be preserved, the less likely they are to experience coercion and humiliation during hospitalisation. In this regard, nurses can implement practices such as ensuring private spaces for sensitive conversations, establishing routines that respect patients' moments of intimacy, and designing protocols that minimise unnecessary exposure in clinical settings. The literature highlights that experiences of loss of privacy, respect and dignity among hospitalised patients are closely linked to coercive situations, feelings of humiliation and disrespectful environments (Plunkett and Kelly 2021; Plunkett et al. 2022; Silva et al. 2023; Fossum et al. 2024).

Following this, the Discharge (clarity and involvement in discharge planning), Support (support received during hospitalisation), and Secure (sense of physical safety in the unit) dimensions also showed significant associations. In line with other studies,

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TABLE 2 | Association between QPC dimensions and coercion and humiliation experience.

Model	Independent variables	Adj R^2	*B*	*β*	95% CI
1	QPC encounter	0.17	−1.06***	−0.32	−1.49 to −0.61
2	QPC participation	0.18	−1.03***	−0.34	−1.42 to −0.62
3	QPC support	0.15	−1.44***	−0.27	−2.17 to −0.72
4	QPC secluded	0.19	−2.25***	−0.35	−3.09 to −1.41
5	QPC secure	0.1	−1.33*	−0.16	−2.47 to −0.20
6	QPC discharge	0.15	−1.65***	−0.28	−2.44 to −0.85
7	QPC total	0.21	−0.35***	−0.37	−0.48 to −0.23

Note: Adjusted for age, sex, no. of episodes of mechanic containment, no. of days of hospitalisation, admission mode and mental disorder.
Abbreviations: CI, confidence interval; QPC, quality in psychiatric care.
*$p < 0.05$; **$p < 0.01$; ***$p < 0.001$.

TABLE 3 | Association between QPC dimensions and fear experience.

Model	Independent variables	Adj R^2	*B*	*β*	95% CI
1	QPC encounter	0.08	−0.14*	−0.16	−0.25 to −0.02
2	QPC participation	0.08	−0.11*	−0.16	−0.2 to −0.012
3	QPC support	0.06	−0.08	−0.06	−0.27 to 0.107
4	QPC secluded	0.08	−0.27*	−0.17	−0.50 to −0.05
5	QPC secure	0.08	−0.34*	−0.16	−0.62 to −0.05
6	QPC discharge	0.07	−0.2	−0.14	−0.41 to 0.07
7	QPC total	0.08	−0.044*	−0.18	−0.077 to—0.010

Note: Adjusted for age, sex, no. of episodes of mechanic containment, no. of days of hospitalisation, admission mode and mental disorder.
Abbreviations: CI, confidence interval; QPC, quality in psychiatric care.
*$p < 0.05$.

this suggests that patients who experience clear and participatory discharge planning and perceive consistent relational support within a protected environment report significantly lower levels of coercion and humiliation (Elgendy et al. 2023; Berring et al. 2024; Fossum et al. 2024). In line with these findings, it is essential for professionals to promote collaborative discharge plans from the early stages of admission, with clear and tailored communication. Likewise, ensuring a stable reference figure to accompany the patient throughout the entire process may contribute to a more comprehensible and less threatening experience. From a health policy perspective, it is equally necessary to guarantee adequate structural conditions, such as safe staffing ratios and post-discharge continuity of care, that make it realistically and equitably possible to sustain this type of support.

Lastly, although the Encounter (quality of the relationship with staff) and Participation (involvement in decision-making) dimensions contributed slightly less, their significant associations underscore the importance of respectful therapeutic relationships and involving patients in decision-making to reduce perceptions of coercion and humiliation. In this regard, training in empathic communication, active listening and trauma-informed care can strengthen the therapeutic relationship and reduce the perception of imposition (Moreno-Poyato et al. 2023). Recent evidence supports this interpretation, as higher perceived coercion has been linked to weaker therapeutic relationships in community settings and lower involvement in decision-making during hospitalisation (Lee and Seo 2021; Morandi et al. 2024; Silva et al. 2024).

Regarding the level of fear experienced, only the Secure and Secluded dimensions were consistently associated with lower fear; Encounter and Participation had a weaker influence, whereas Support and Discharge did not reach statistical significance. These findings suggest that patients' fear is primarily heightened when they do not perceive the environment as safe or their personal space as protected, the quality of the therapeutic bond and participation help, but to a lesser extent. Intervening in the physical environment, reducing threatening stimuli and ensuring the presence of visible professionals trained in de-escalation may be key to reducing fear. Consistent with our findings, recent evidence emphasises that physical safety and respect for dignity are foundational to the feeling of being 'safe' in mental health units (Harpøth et al. 2022; Yan et al. 2024). From a qualitative perspective, users report that the absence of private spaces or the unpredictability of rules creates an 'atmosphere of danger' that keeps fear heightened (Jenkin et al. 2022). Additionally, the literature shows that fear is reduced when patients perceive a degree of control and can express concerns without fear of negative consequences—findings that align with the Encounter and Participation dimensions in our analysis (Vogt et al. 2024).

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However, it is important to note that the literature describes fear during psychiatric hospitalisation as a multifactorial phenomenon, influenced by immediate traumatic experiences (e.g., mechanical restraint episodes), the acute phase of illness, symptom intensity, the quality of the therapeutic relationship and the characteristics of the physical environment (Herrera-Imbroda et al. 2025). This complexity helps explain why each dimension captures only part of the issue, and none alone fully accounts for the factors that trigger or sustain fear. On the other hand, trust, the antipode and by-pass of fear, is greatly dependent on the trust being given to patients indirectly by policies and routines allowing for control over personal spaces (Missouridou et al. 2021) while restrictions of crucial control over space are associated with considerable increases in fear, aggressiveness, violence, substance misuse and trauma (Missouridou et al. 2022). Therefore, establishing minimum standards for environmental design and care processes, tailored to each unit, could reinforce patient autonomy and reduce fear.

In this regard, our findings highlight the need to design interventions that integrate safe and private therapeutic spaces, adopt person-centred care approaches, and promote shared decision-making. These strategies, although challenging in complex clinical contexts, are feasible if supported by clinical leadership, clear institutional policies, and ongoing staff training. They can help patients feel actively involved in their care process, transforming hospitalisation from an imposed experience into an opportunity for healing and recovery.

5.1 | Strengths and Limitations

This study provides virtually novel evidence, as only one previous study has quantitatively analysed the relationship between quality of care and experiences of coercion, humiliation, and fear. As such, there is a lack of comparable studies with which to contrast these findings. Since care quality and the experience of coercion were measured simultaneously, the study lacks temporal precedence, making it impossible to establish causality or a unidirectional influence. This limitation, inherent to the cross-sectional design, should be addressed in future longitudinal studies. To minimise social desirability bias, questionnaires were administered anonymously by external personnel and supplemented with data from clinical records. While these measures do not eliminate all limitations, they strengthen internal validity and provide a solid foundation for future longitudinal research.

This study offers valuable insights for identifying factors associated with coercive measures in clinical practice and their relationship with patients' perceived quality of care. For mental health nursing, these results underscore the critical role of nurses in creating therapeutic environments that reduce coercive experiences. By fostering trust, promoting patient autonomy, and ensuring emotional and physical safety, nurses can significantly influence the quality of care and patient outcomes. Integrating these findings into clinical practice can support more ethical, person-centred and recovery-oriented care models.

6 | Conclusion

The results demonstrate that higher perceived quality of care is associated with lower levels of perceived coercion, humiliation and fear. Specifically, the way patients evaluate the protection of their privacy, their sense of safety, the quality of relational support, discharge planning and their involvement in decision-making independently influences how they experience hospitalisation. These findings highlight the importance of fostering therapeutic environments grounded in respect, patient participation, and the creation of safe spaces as key elements in reducing negative experiences during psychiatric hospitalisation.

Author Contributions

A.R.M.-P., S.S.-B. and K.E.-A. contributed to substantial contributions to the conception or design of the work, or the acquisition, analysis or interpretation of data for the work. K.E.-A., J.C., E.M., A.V.R., M.C.-R., J.A.G.-S., E.M.-R., J.J.P.-M., J.P.-D.-L.-V., G.R.-R., C.S.-P., L.J.G., J.G.P., M.V.P.-B. and A.M.R.L. assisted in the collection of data from each of the participating centres. K.E.-A., S.S.-B., J.F.R.-M., C.E.L., M.T.L.-C., M.P.-L. and A.R.M.-P. helped in drafting the work or revising it critically for important intellectual content. A.R.M.-P., S.S.-B., J.C., E.M. and K.E.-A. contributed to final approval of the version to be published. Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved by S.S.-B.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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