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A systematic review and qualitative meta-synthesis of patients' experiences of assessment and detention under mental health legislation

Authors: Syeda Ferhana Akther, Emma Molyneaux, Ruth Stuart, Sonia Johnson, Alan Simpson, Sian Oram

14 **Background**

15 Understanding patient experiences of detention under mental health legislation is crucial to  
16 efforts to reform policy and practice.

17 **Aims**

18 This review aimed to synthesise qualitative evidence on patients' experiences of assessment  
19 and detention under mental health legislation.

20 **Method**

21 Five bibliographic databases were searched, supplemented by reference list screening and  
22 citation tracking. Studies were included if they reported on patient experiences of assessment  
23 or detention under mental health legislation; reported on patients aged 18 years or older;  
24 collected data using qualitative methods; and were reported in peer-reviewed journals.

25 Findings were analysed and synthesised using thematic synthesis.

26 **Results**

27 The review included 56 papers. Themes were generally consistent across studies and related  
28 to information and involvement in care, the environment, and relationships with staff, as well  
29 as the impact of detention on feelings of self-worth and emotional state. The emotional  
30 impact of detention and views of its appropriateness varied, but a frequent theme was fear  
31 and distress during detention, including in relation to the use of force and restraint. Where  
32 staff were perceived as striving to form caring and collaborative relationships with patients  
33 despite the coercive nature of treatment, and when clear information was delivered, negative  
34 impacts of involuntary care seemed to be reduced.

35 **Conclusions**

36 Findings suggest that involuntary inpatient care is often frightening and distressing, but  
37 certain factors were identified which can help reduce negative experiences. Co-production  
38 models may be fruitful in developing new ways of working on inpatient wards that provide  
39 more voice to patients and staff, and physical and social environments that are more  
40 conducive to recovery.

41 **Keywords**

42 Systematic review, meta-synthesis, qualitative, mental health legislation, patients, involuntary  
43 admission, detention

44

## 45 **Background**

46 Mental health legislation regarding involuntary hospital admission and treatment differs between  
47 countries (1), but risk to oneself and/or to others and the need for treatment are often cited as reasons  
48 for involuntary admission (2). Compared to voluntary admissions, involuntary admissions have been  
49 associated with longer stays in hospital, higher readmission rates, higher risk of being involuntarily  
50 readmitted, and a greater likelihood of dying by suicide (3). The rising rate of involuntary admission  
51 in countries including England makes it particularly important to understand this experience (4).

52 Recently, there has been increased interest in understanding patients' experiences of mental health  
53 care, with concern especially about inpatient care, where negative experiences are often reported (5).  
54 Experiences of involuntary admissions to and stays in psychiatric inpatient units are especially  
55 important given that these are experiences that patients do not consent to, so particular efforts should  
56 arguably be made to reduce their negative impacts (6). Patients' subjective views of involuntary  
57 hospital admission vary. Between 39% and 71% of patients in 11 European countries believed their  
58 involuntary admission was justified 1-month post discharge from hospital (7). In 2017, the UK  
59 government commissioned an independent review of its current mental health legislation to gain a  
60 clearer understanding of the factors contributing to this rise in involuntary admissions, particularly  
61 amongst people from Black, Asian, and Minority Ethnic (BAME) backgrounds (8). The review has  
62 placed a strong emphasis on ensuring the voice of patients<sup>1</sup> permeates throughout its eventual  
63 recommendations (8).

64 Katsakou and Priebe (2007) sought to synthesise qualitative evidence exploring patients' experiences  
65 of involuntary hospital admission and treatment (9). The review included five papers and reported  
66 both negative aspects of involuntary hospitalisation and factors that could alleviate the impact of  
67 these. Negative aspects included restrictions of autonomy and lack of participation in decision-  
68 making, meaningless and inappropriate care, non-therapeutic environments, and feeling devalued. The  
69 negative impact of these was mitigated by staff who did their best to maximise respect for patients  
70 and their autonomy and to treat them like ordinary people. The review was updated by Seed et al.  
71 (2016), who included studies from only 2006 to 2014 (10). A further 15 studies were identified.  
72 Themes identified included 'sanctuary' which reflected feelings of being kept safe in hospital and  
73 allowing a return to normality, 'loss of normality and perceived independence' as detention caused  
74 disruption to patients' lives, 'feeling terrified', and 'fluctuating emotions' which reflected the eventual  
75 acceptance and relief of being hospitalised.

76 The reviews conducted by Katsakou and Priebe (2007) and by Seed et al (2016), however, have  
77 significant limitations. Both reviews excluded papers focusing on the experiences of people detained

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<sup>1</sup> We recognise there is no clear consensus on the preferred term, but we use the term patient rather than service user following consultation with our Lived Experience Working Group.

78 in units for certain diagnoses, such as eating disorders, and those in forensic settings. Doing so may  
79 have prevented the authors identifying specific issues faced by these populations and therefore, the  
80 current review will include such populations to gain a broader understanding of the detention  
81 experience. Both reviews also excluded papers focusing on specific aspects of detention, such as  
82 restraint or seclusion, as opposed to the overall experience, despite this being a pertinent part of  
83 detention. Moreover, both reviews included a limited search strategy and restricted their results to  
84 those in the English language. Whilst Seed and colleagues broadened their search slightly, they did  
85 not run the search for years prior to 2006. In the period since Seed et al.'s search, additional relevant  
86 studies have been published (11-14) which are important to include. An updated synthesis of  
87 qualitative studies, using a broader search strategy, is warranted, to explore experiences of the process  
88 of assessment for involuntary admission and detention in hospital for people worldwide with a range  
89 of mental conditions.

#### 90 *Aims*

91 The aim of this review was to synthesise qualitative evidence of patients' experiences of being  
92 formally assessed for admission and/or the subsequent experience of being detained under mental  
93 health legislation. This included any legal processes which take place during the assessment process  
94 and during detention, such as Mental Health Tribunals.

#### 95 **Methods**

##### 96 *Protocol and registration*

97 The review initially aimed to synthesise data exploring the experiences of both patients and carers but,  
98 due to the number and heterogeneity of eligible studies, two separate reviews have been produced.  
99 The search strategy reported here pertains to both reviews, but this paper will report the experiences  
100 of patients only. The methods of the review were pre-specified in a registered protocol (PROSPERO  
101 ref CRD42018091721). The review focusing on carers' experience of the admission and detention  
102 process has been reported elsewhere (Stuart et al. (submitted)).

##### 103 *Data sources*

104 Studies were identified through a comprehensive search of five electronic databases including  
105 Medline, PsycINFO, HMIC, and Embase, accessed via the Ovid platform and the Social Sciences  
106 Citation Index database accessed via the Web of Knowledge platform. All searches were carried out  
107 in January 2018. The full search strategy for each database has been specified in the Appendix (see  
108 Appendix 1). The search was limited to studies from 1983 as this was when the Mental Health Act  
109 (1983), the current legislative framework for compulsory detention and treatment in England, came  
110 into force. The main focus of the current review was on England as this review contributed to the  
111 recent independent review of the Mental Health Act in England. Additionally, many other countries

112 have also experienced significant changes in mental health legislation since. Therefore, it is likely any  
113 data prior to 1983 would have very limited relevance to the current review. However, the authors  
114 acknowledge this is a potential limitation. No limits were placed on the language or location of  
115 publications.

116 Reference list screening and forward citation tracking were conducted for Seed et al.'s (2016) and  
117 Katsakou & Priebe's (2007) previous reviews on this topic, and also for each eligible paper from our  
118 search.

#### 119 *Study selection*

120 Citations retrieved by the search were collated in a reference management software, Endnote, and  
121 duplicates were deleted. Initially, all titles and abstracts were screened for eligibility by one reviewer  
122 (SA). The original eligibility criteria were applied to identify studies examining patients' or carers'  
123 experiences, but due to the large number of studies identified for both patients' and carers'  
124 experiences, only papers pertaining to the experiences of patients were included in the current review  
125 with carers' experiences being collated in a separate review. Studies were included if they a) assessed  
126 patients' (or carers') experiences of being formally assessed for involuntary admission and/or being  
127 detained in hospital (including appeal and tribunal processes), b) included participants over the age of  
128 18, c) reported individual interviews or focus groups, and d) were published in a peer-reviewed  
129 scientific journal. Studies were excluded if they a) used a mixed sample of both involuntarily and  
130 voluntarily admitted patients with no separate analysis for involuntary patients, b) assessed patients'  
131 (or carers') experiences of being treated involuntarily in a community setting and not a hospital  
132 setting, c) participants were under the age of 18 with no separate analysis for those over the age of 18,  
133 d) data were collected using surveys, questionnaires or reported a case study, or e) were dissertation  
134 abstracts, PhD theses, government reports, books, commentaries, editorials, conference abstracts, or  
135 reviews. 10% of papers were screened independently by a second reviewer (RS) and any  
136 disagreements were resolved with reference to a third senior reviewer (BLE).

137 Full-texts were obtained for all potentially eligible studies, and screened against the eligibility criteria.  
138 10% of these studies were screened independently by another reviewer (RS). At this stage, papers  
139 exploring the experiences of carers only were excluded.

#### 140 *Data extraction*

141 Key characteristics of eligible studies were extracted and inputted into a data extraction table  
142 produced in MS Excel. Extracted information included study author(s) and year of publication, study  
143 focus (patients or both patients and carers), study setting (including whether single site or multisite),  
144 participant information (number and characteristics e.g. gender, age range, ethnicity, and diagnosis),  
145 method of data collection, and method of data analysis.

146 *Data synthesis and analysis*

147 Thematic synthesis was used to analyse and synthesise data from papers examining patients'  
148 experiences (15) and followed a four-stage process. In the first stage, four members of the review  
149 team (SA, SO, PS, and RS) independently conducted inductive, line-by-line coding of two studies  
150 resulting in an extensive list of initial codes. In the second stage, the review team collaboratively  
151 identified descriptive themes through the discussion of similarities and differences between their  
152 initial codes, and grouped the themes into a hierarchical thematic framework. In the third stage, one  
153 reviewer (SA) applied the thematic framework to the remaining manuscripts, adding new themes and  
154 collapsing others in an iterative process of coding and analysis. Finally, SA used the descriptive  
155 themes to generate abstract analytical themes, through discussion with other review authors, going  
156 beyond the initial synthesis of the original study findings. The thematic framework was shared with  
157 the NIHR Mental Health Policy Research Unit's Lived Experience Working Group, which consists of  
158 14 service users and carers, for their comment and feedback. Quotes from included studies have been  
159 used to illustrate each theme. Any patient names mentioned in quotes are pseudonyms provided in the  
160 original papers.

161 *Quality appraisal*

162 To determine the quality of eligible studies, two independent reviewers (SA and JHS) used the CASP  
163 Qualitative Research Checklist (see Appendix 2) (16) to appraise each paper. Any discrepancies  
164 between the two reviewers were resolved through discussion.

165 *Reflexivity*

166 The first author identifies as a researcher of colour who is particularly interested in the lived  
167 experiences of severe mental illness of BAME groups. She acknowledges that her experience and  
168 research interests may have influenced the analysis. Attempts were made to minimise any undue  
169 influence by creating the initial coding framework collaboratively with three other reviewers.

170

171 **Results**

172 *Overview of included studies*

173 Fifty-six papers were included in the review (see Figure 1). Fifty focused on the experiences of solely  
174 patients and 6 focused on the experiences of both patients and carers. Thirty studies were conducted  
175 in the UK (including England and Scotland) (11, 17-45), 9 in Sweden (13, 46-53), 5 in Australia (54-  
176 58), 5 in Ireland (59-63), 2 in Norway (64, 65), and a study each were identified from Austria (66),  
177 Finland (67), Greece (14), Israel (12), and the United States of America (68). All papers identified  
178 were reported in the English language.

179

180 Figure 1: PRISMA flow diagram

181

182 Study characteristics are summarised in Table 1. Study samples ranged from 4 to 60 participants, with  
183 39 papers reporting on fewer than 20 participants. Studies generally reported the sex of participants  
184 (41 papers included both male and female participants, 5 females only, 4 males only; 6 did not report  
185 the sex of participants) but only 17 reported participants' ethnicity. Twenty-six papers reported on the  
186 experiences of detention in hospital, 16 on the experiences of both admission and detention, 7 papers  
187 reported experiences of admission only, and 7 focused specifically on coercive interventions, such as  
188 seclusion. Experiences of admission focused mainly on police involvement and whether or not  
189 patients agreed with their hospitalisation. Fifteen papers reported on studies conducted in a forensic  
190 setting.

191 Participants' diagnoses were reported by 33 studies, and included affective and non-affective  
192 psychotic disorders (including schizophrenia, bipolar disorder, and perinatal psychosis), drug-induced  
193 psychosis, unspecified non-organic psychosis, depression, anxiety, personality disorder, borderline  
194 personality disorder, anorexia nervosa, self-harming, substance use disorders, learning disabilities  
195 (including autism spectrum disorder), and dual diagnoses of mental health and substance use  
196 disorders. Some studies reported diagnoses as unavailable or 'Other'. One study focused specifically  
197 on the experience of detention of patients with anorexia nervosa (42).

198 The majority of these papers were categorised as high quality, with 77% (n=43) of papers receiving a  
199 score of 7 or above out of 9; the remainder were categorised as moderate quality with scores of 4 or  
200 above.

201

202 Table 1: Study characteristics

203

204 *Thematic synthesis results*

205 Five themes were identified: (1) information and involvement in care; (2) quality of the environment;  
206 (3) quality of relationships; (4) impact on self-worth; and (5) emotional impact of detention. Despite  
207 differences between the legislative systems of countries, patients' experiences tended to centre on  
208 these themes with few differences between different diagnoses and types of services. Patients'  
209 accounts were focused predominantly on their experiences of being in hospital while detained under



210 mental health legislation, with much less detail provided on experiences of the process of being  
211 assessed.

## 212 **Information and involvement in care**

213 Patients' experiences of involuntary admission were profoundly affected by the extent to which they  
214 were provided with appropriate and timely information and were involved in treatment decisions. In  
215 the majority of studies, participants described poor experiences in these areas, although several  
216 examples of high-quality care were also relayed.

217 Patients described wanting information about why they were being detained for treatment, how long  
218 they would be detained, and how they could access legal information about their rights and  
219 entitlements. Forensic patients described receiving conflicting information about their length of stay  
220 resulting in feelings of hopelessness. Some felt their treatment had continued for a long time and  
221 compared it to a prison sentence. In many studies, patients reported that they were not given basic  
222 information of this type, or about medication (including side-effects) or perceived progress. In the  
223 minority of cases where patients did feel they had been provided with clear information, this appeared  
224 to reduce fear and the impact of coercion, improve relationships with staff, and result in patients  
225 feeling less disempowered.

226 *The process of hospitalisation was opaque. Karen described being in a police cell and feeling*  
227 *'terrible, and majorly confused.'* *Simon was also detained by police and had no sense of what was*  
228 *happening when he was locked in a cell. In the absence of any explanation, Simon made sense of his*  
229 *situation as being under attack and in danger (Styliandis et al 2017).*

230  
231 Some patients acknowledged that their distress during admission made it difficult to listen and process  
232 the information they were given. Some also reported that too much information, particularly about  
233 side-effects, could potentially be overwhelming. A lack of information led some forensic patients to  
234 believe they would be released following their mental health assessment whilst others described their  
235 desire for as much information as possible prior to transfer to a less secure ward.

236 In the great majority of studies, patients described wanting to have involvement in decisions about  
237 their care, very often more than was offered. Good relationships with staff facilitated involvement in  
238 decision-making. Flexibility in care, such as being given permission to leave the ward, also reduced  
239 the perception of coercion. Some patients reported experiences of collaborative care, including  
240 creating treatment plans with staff, but others described their Advance Statements (a written statement  
241 expressing preferences for future care (69)) being ignored. Some patients did not view their  
242 involuntary admission as coercive as they had previously agreed that involuntary measures could be  
243 taken when they become unwell, however others felt that coercive treatment (and, indeed, the threat  
244 of involuntary admission) undermined their ability to meaningfully consent to care.

245 *[The patients] expressed feelings of failure and powerlessness, that they were not listened to, and*  
246 *whatever they did there would be some sort of coercion anyway. As one patient put it: 'If I were to say*  
247 *I agree it would be coercion anyway, it would be coercion in some way, even if I accepted it is*  
248 *coercion.'* (Olofsson & Norberg, 2001)

249

250 Carers' input to decisions was appreciated particularly when patients were too distressed to engage,  
251 but this could also leave patients feeling excluded from decision-making. Advocacy services and peer  
252 mentoring were suggested as avenues for improving involvement. Some patients suggested that  
253 involvement in decisions about their care should increase as symptoms began to abate, and  
254 highlighted that being given responsibility to make choices as soon as possible was an important part  
255 of recovery. When meaningful involvement in overall care planning was not possible, patients wanted  
256 at least to be fully informed.

257 Studies which reported experiences of legal hearings related to involuntary hospitalisation, such as  
258 Mental Health Act Tribunals in the UK (70), described some patients being pleased with the steps  
259 taken to facilitate their involvement, including being given time to articulate their thoughts, relatives  
260 and staff acting as advocates, and legal representation being available. However, others felt excluded  
261 by the presence of unfamiliar people and the formal language used. Tribunals were viewed favourably  
262 by patients as a method of upholding human rights but patients often found themselves struggling to  
263 not only access information about tribunals but also to discuss it with a member of staff.

264 Forced medication, especially if patients were unaware of which medication was being administered  
265 was a source of particular distress. Some patients indicated that if they had they been given the  
266 opportunity to make a fully informed decision, they would have complied, but instead often found  
267 themselves being offered what they perceived to be a false choice and threatened with punishment.  
268 Treatment during detention was described as comprising predominantly medication and, whilst many  
269 patients agreed that medication had been important for their recovery, the need for psychological  
270 therapies was also frequently described. In some studies, patients complained about the side-effects of  
271 medication which were difficult to tolerate and made it harder to take part in therapeutic activities. In  
272 contrast, some forensic patients stated that medication helped to reduce their symptoms which  
273 facilitated their participation in therapies. Other patients felt medication could be used to prevent the  
274 need for coercive interventions and valued the sedative effects provided they did not feel drowsy later.  
275 Finally, patients in several studies reported that they lacked information, regarding what was  
276 happening and why, while being restrained, and reported that this contributed substantially to their  
277 distress in these situations where they neither had a choice nor information about what was  
278 happening.

279 *Various experiences, including not receiving sufficient information, not being involved in treatment*

280 *decisions, perceiving professionals as having power over patients, and experiencing coercive*  
281 *measures contributed to the patients feeling out of control during their hospitalisation (Katsakou et al*  
282 *2012)*

283  
284 **Quality of the environment**

285 Physical environment was identified as important throughout the care pathway. Those initially  
286 detained in police cells for or following assessment found them cold, noisy, and distressing. Some felt  
287 they were being punished for having a mental illness. Lack of access to treatment in this environment  
288 could result in worsening symptoms, contributing to distress and agitation.

289 *Others reported being cold and hungry and lacking sleep as there was so much noise from people in*  
290 *other cells. Another reported being kept in the dark as light bulbs had been removed. (Riley et al*  
291 *2011)*

292 Safety was identified in many studies as a critical dimension of the quality of the environment. While  
293 some patients who were apprehended by police appreciated their role in ensuring their safety, others  
294 reported feeling unsafe in police cells and criticised their use as a “place of safety”.

295 *Most detainees wanted somewhere they could feel safe, a sanctuary where there were especially*  
296 *suitable facilities such as no mirrors or coat hangers, which would prevent detainees from self-*  
297 *harming while they were in custody. (Riley et al 2011)*

298 In hospital, the physical environment, safety and the availability of meaningful activities were  
299 important influences on recovery. In several studies, patients described wards as minimally decorated,  
300 un-therapeutic, and, in some cases, akin to prison. Whilst some commended staff efforts to make  
301 wards more comfortable, others criticised wards for being too noisy, overcrowded, or unclean. These  
302 aspects of the environment were also seen to prevent patients from being able to have greater  
303 involvement in decision-making about their care. Patients in forensic inpatient wards were shocked by  
304 the security measures which they suggested were reminiscent of prison and, given their expectations  
305 of hospital care, were unexpected In units where seclusion was used, seclusion rooms were described  
306 as bare, cold, uncomfortable, and lacking ventilation with forensic patients also describing such rooms  
307 as similar to prison cells.

308 *Living in such close proximity to other patients was found to be emotionally demanding, and*  
309 *participants found overcrowded wards to be stressful and anxiety-provoking. (Olsson et al 2015)*

310 In some studies, participants described fearing for their personal safety on the ward, particularly when  
311 using shared spaces. In one study, a number of female patients reported that they experienced  
312 communal spaces as risky and had been sexually harassed by male patients. Other patients also spoke  
313 of feeling unsafe on wards due to the fears of theft, physical violence and bullying. Some patients

314 reacted to these situations by staying in their rooms whilst others described meeting aggressive  
315 situations with aggressive behaviour. Lack of familiarity with the ward environment and the people in  
316 it could also foster feelings of insecurity.

317 *The physical aspects of the hospital were also described as affecting social relationships, with*  
318 *consumers discussing the influence of shared spaces between men and women on their feelings of*  
319 *safety (with women in particular feeling unsafe in communal spaces that are shared with men). (Muir-*  
320 *Cochrane et al 2013)*

321 In most studies, a proportion of patients reported that their involuntary admission had helped avert  
322 risk and protect them from harm but some felt that greater provision of timely and appropriate  
323 information could help patients feel safer. Some patients also felt that coercive interventions, such as  
324 seclusion, could protect them and others from harm. However, patients felt unsafe when coercive  
325 interventions were not delivered appropriately, for example with the use of excessive force. Some  
326 patients remarked that as their level of insight into their illness increased, so did their feelings of  
327 safety and security on the ward. Also contributing to a sense of safety were staff who were able to  
328 convey warmth and care. Some forensic patients highlighted their relief at being detained in hospital  
329 instead of prison due to increased freedom. Forensic patients in one study, which focused on a unit  
330 for male patients with severe personality disorder, recalled fearing for their personal safety prior to  
331 admission as they anticipated a violent environment based on the reputation of the high secure unit.  
332 However, upon admission they came to find these fears were unfounded.

333 Finally, boredom in the ward environment influenced experiences of detention for patients in several  
334 studies, who spoke about the need for recreational, educational or occupational activities. Whilst  
335 patients in some studies disliked the structured nature of some wards, others argued this provided  
336 relief and helped keep them busy. Some patients highlighted that there were plenty of activities but  
337 many patients were unaware of these or simply did not attend, and patients in one study highlighted  
338 that fears for their safety prevented them from attending groups. Other patients highlighted that low  
339 staffing levels limited access to activities and otherwise well-equipped recreation rooms. Some  
340 forensic patients had taken part in activities that emphasised work whilst in maximum secure units,  
341 such as machining, and subsequently found therapeutic activities on lower security forensic wards  
342 unrewarding and meaningless, whilst others felt that these activities helped broaden their horizons.

343

#### 344 **Quality of relationships**

345 A major factor affecting patients' experiences of detention was the quality of their relationships with  
346 staff, and to a lesser extent, their relationships with other patients. Patients also spoke about the

347 influence of friends and family members on their experiences of detention, and how being admitted  
348 had impacted on these personal relationships.

349 Overall, staff who were kind, respectful, and made time to speak with patients were spoken of highly.  
350 In many studies, patients spoke of wanting a trusting relationship with staff based on a human  
351 connection. In this context, some patients reported that they felt able to let staff take responsibility for  
352 their treatment and appreciated being relieved of responsibility for their care and being allowed to  
353 recover. Patients who had been detained by police officers reported they needed more mental health  
354 training but had, in several cases, been kind and gentle. Indeed, some patients highlighted the  
355 importance of non-violent interventions from police officers which could help to build trust and  
356 increase compliance. In contrast, some patients recalled encountering dismissive staff in emergency  
357 departments, who were also seen as not skilled in dealing with severe mental illnesses.

358 Negative relationships were experienced when patients perceived staff as bullying or disrespectful  
359 towards patients, and when staff did not make themselves available when they were needed which  
360 induced feelings of anger, betrayal and abandonment. Several patients, across a number of studies,  
361 believed that staff misused their power and position to humiliate or discriminate against them and felt  
362 there was a divided climate on the wards between patients and staff. Some felt that staff privately  
363 mocked them, or that coercive interventions were used as a form of punishment by staff rather than a  
364 strategy of last resort. However, patients in a few studies also acknowledged the difficult nature of  
365 the job.

366 *Patients sometimes felt that healthcare staff were not on their side, and perceived certain members of*  
367 *staff as unkind and disrespectful. They thought that healthcare staff sometimes took advantage and*  
368 *exploited their power to humiliate them. (Andreasson & Skarsater, 2012)*

369 Whilst coercive interventions were typically experienced negatively, their impact could be mitigated  
370 by kind and caring staff. Patients also valued when staff offered to discuss conflicts in private as this  
371 was an acknowledgement of their right to privacy and dignity. One patient lamented the high turnover  
372 of staff which prevented them from building a trusting relationship, and others highlighted that good  
373 relationships, and continuity of care, could be disrupted when patients were transferred between  
374 wards. Trust in staff generally increased over time as symptoms improved, but some patients found it  
375 difficult to fully trust staff at any time.

376 *The majority of patients rated trustworthiness as the basis for a good therapeutic relationship.*  
377 *Trustworthy staff were described as those patients could confide in and with whom there was mutual*  
378 *respect. This involved “acknowledgment of power differences and a sensitive approach”. The latter*  
379 *involved “being treated [and treating staff] how I would like to be treated”; “open mindedness (on*  
380 *both sides)” and being given enough individual time. Good communication was viewed as highly*

381 *important, particularly with regard to being listened to; “being believed”; and being understood.*  
382 *(Long et al 2012)*

383 In general, patients spoke positively of their relationships with other patients, who provided  
384 encouragement and support through difficult times on the ward. Witnessing other patients recover  
385 provided reassurance that recovery was possible and, in some studies, patients described how other  
386 patients’ opinions had challenged their own thought patterns. These relationships played an  
387 instrumental role in recovery. In contrast, overcrowded wards and perceptions of being treated  
388 differentially by staff could create tension and lead to conflict, and a few patients highlighted the  
389 temporary nature of relationships formed on the wards. Some patients also described issues with  
390 safety relating to other patients, as described above in “Quality of the environment”.

391 Patients also described their relationships with friends and family. Some spoke warmly of the support  
392 they received, and how continuing personal relationships reminded them of their identity. Some  
393 patients also reported that family and friends helped them to accept their involuntary admission, by  
394 reminding them that they were unwell. Families were sometimes seen to play an important role after  
395 discharge, particularly for patients who were discharged before feeling fully recovered, as their family  
396 could continue to care for them. Overall, the experience of detention was seen to be particularly  
397 difficult for those who did not have support from friends and family members.

398 However, detention could also be a source of tension in important relationships. Many expressed  
399 anger towards relatives, who they felt were responsible for their admission. Others reported feeling  
400 that they had been betrayed or abandoned by their family members. Practical factors which prevented  
401 visits, such as distance and the complexity of arrangements, were also described. Finally, patients in  
402 one study highlighted that they did not think their family members were aware of how they were  
403 treated whilst detained.

404 *Individuals described the anger they felt towards the signatory, even when they knew this was not*  
405 *warranted (Smyth et al 2017)*

#### 406 **Impact on self-worth**

407 Across many studies, patients reported reduced feelings of self-worth and self-respect following  
408 involuntary admission. Although some believed that their involuntary admission had been necessary,  
409 many patients described the experience as disempowering and dehumanising. Patients’ experiences of  
410 disempowerment were mentioned in almost every study and were consistently reported to be  
411 exacerbated by a lack of information and involvement in treatment decisions (as described in the first  
412 theme), as well as by a lack of autonomy on the ward and concerns about the potentially lasting  
413 stigma of involuntary admission. Some factors which improved self-worth were also described, as  
414 outlined below.

415 Experiences of powerlessness encompassed not only a lack of choice about treatment but also about  
416 how they spent their time on the ward; some patients felt that they lacked any autonomy. Patients  
417 complained about having to adhere to seemingly arbitrary ward routines, such as enforced bedtimes.  
418 A few studies discussed cultural and religious requests; some patients reported that their requests were  
419 respected but others had their requests rejected without justification. The paternalistic attitudes of  
420 some staff and needing to gain permission, for example to have a cup of tea or go on leave, also led to  
421 reduced self-efficacy whereby patients lacked belief in their own capacity to accomplish tasks.

422 *[Patients] need to feel that they still have some control and that the healthcare staff will make no*  
423 *more decisions about them than necessary, but instead focus on what is essential to their health and*  
424 *recovery. (Andreasson & Skarsater 2002)*

425 Patients frequently reported that they felt dehumanised during coercive interventions, although some  
426 recalled instances of staff showing genuine concern for their well-being, such as returning to the room  
427 to check on them. This helped to restore their self-esteem. Other things which were felt to improve  
428 self-worth included being treated by staff with dignity and as human beings. Patients in one study  
429 described feeling as though staff saw their individual personality, but across a number of studies,  
430 patients spoke of feeling reduced to their diagnoses with their normal variations in behaviours and  
431 emotions viewed as symptoms. Patients with eating disorders spoke of feeling under inspection when  
432 they were watched during mealtimes and some described feeling a sense of achievement when their  
433 health deteriorated, as the service was losing control of their health.

434 *Participants described feeling not capable or worthy and being changed into another kind of person,*  
435 *for example by medication. They spoke of not being allowed to have and express feelings and*  
436 *variations in mood/temper as other people normally do, and of being treated as a 'gangster', a*  
437 *'criminal', and wondered if they were dangerous to society, themselves or others because of their*  
438 *involuntary status. (Olofsson & Jacobsson 2001)*

439 A number of studies described impacts on self-worth extending beyond the period of involuntary  
440 admission. Patients felt that, as people who had been detained, they would be the subject of future  
441 stigma and prejudice both within mental health services and in wider society, compounding the  
442 marginalisation many experienced already because of their mental illness. Some patients were  
443 concerned that having been detained once would increase their risk of being detained again. Studies  
444 that focused on police involvement described patients' sense of criminalisation and shame,  
445 particularly related to being handcuffed and placed in police vehicles. Patients were concerned that  
446 neighbours may have witnessed the arrival of police or paramedics at their home, and their transfer to  
447 hospital. Some experienced detention as a threat to their efforts to manage their lives independently  
448 and reported feeling that they had lost credibility. Others spoke of feeling as if their lives had been

449 suspended while detained. In a small number of studies, patients commented on mental health  
450 legislation and described feeling that their human rights had been violated.

451 *Several interviewees reported that they felt their future was tainted due to sectioning and detention*  
452 *therefore their views [and] outlook about their chance[s] and vision of their future was pessimistic.*  
453 *(Chambers et al 2014).*

454

455 Forensic patients spoke of feeling like they would carry a life-long label as a result of committing an  
456 offence and being detained in a high secure hospital where they felt excluded from society. They felt  
457 staff did not acknowledge that they had offended whilst ill and worried about being perceived as the  
458 instigator in conflicts. Patients in forensic settings spoke about work-related activities that equipped  
459 them with skills increasing their self-esteem and confidence, and particularly liked interacting with  
460 staff as they would in a real job. One patient also described how being involved in creating a recovery  
461 programme for the high secure service had given them a sense of achievement.

#### 462 **Emotional impact**

463 Patients' experiences of, and emotional responses to, assessment for involuntary admission and  
464 detention under mental health legislation varied both within and between studies. These included  
465 some positive or neutral emotions such as appreciation or acceptance, and, more commonly, negative  
466 emotions such as anger, confusion, distress, fear, resentment, and defensiveness. Patients in some  
467 studies stated they felt worse following discharge than prior to admission, due to the impact of the  
468 involuntary admission. Fear and distress were among the most prominently discussed emotions and  
469 were seen to be caused or exacerbated by many of the factors described in previous themes, including  
470 police involvement, lack of information, and the behaviour of some mental health staff.

471 Coercive interventions were also described as having a strong negative emotional impact by many  
472 participants. Although some patients spoke of the use of restraint, seclusion, and forced medication as  
473 sometimes necessary, patients in many studies experienced these types of coercion as disempowering,  
474 frightening, and distressing, and as reminders of traumatic events from their past, including sexual  
475 abuse. In several studies, participants described feeling violated or assaulted during coercive  
476 interventions. Seeing other patients being subjected to coercive treatment also impacted on  
477 participants, who reported being scared by what they witnessed. Patients described how their  
478 powerlessness often manifested itself in anger and frustration. This was particularly the case where  
479 coercion was felt to have involved the use of excessive force, the use of force to hold patients face  
480 down, a perceived disregard for patients' dignity (including situations in which clothing was torn or  
481 removed), or where multiple members of staff were present (particularly staff of the opposite sex).



482 *The experience of seclusion evoked many unpleasant thoughts and emotions including fear, shame,*  
483 *anger and loneliness, for example “I get really scared by it” ... “It’s a horrible experience being*  
484 *stripped naked in front of people and made to put on rip proof clothing” ... “It brings on intense*  
485 *feelings of shame, embarrassment and humiliation. It’s dehumanising. It left me feeling out of*  
486 *control” (Haw et al., 2011)*

487 Patients described how anticipation and confusion regarding coercion contributed to their fears, as did  
488 being left alone following coercive interventions. Some patients reported feeling frightened when they  
489 experienced painful side-effects from forced medication, and longer-term impacts including sleeping  
490 problems and continuing worries. Often, relatively small actions by staff members were described as  
491 having made a substantial difference to how the patient felt, such as asking if they wanted the air  
492 conditioner on or checking in on them during the period of restraint. Patients described greater staff  
493 communication, a gentle manner and regard for well-being as reducing distress. These actions also  
494 helped patients to trust staff members during their admissions.

495 *Coercive practices, whilst seen as necessary in some situations, appeared to have physical and*  
496 *psychological consequences for the service user and were viewed as adverse. Patients reported that*  
497 *staff seemed to know what they needed to do to avert untoward incidents but did not act accordingly.*  
498 *(Chambers et al 2014)*

499

## 500 **Discussion**

### 501 *Summary of findings*

502 This meta-synthesis explored patients’ experiences of formal assessment and/or the subsequent  
503 experience of being detained under mental health legislation. Patients in several studies believed that  
504 their involuntary admission had kept them safe at a time when they could not recognise the severity of  
505 their illness, but negative experiences were commonly described. Similar to the two previous reviews  
506 on this topic (9, 10), key factors found to influence patient experiences across a range of countries and  
507 time periods were the extent to which they felt they were provided with accessible information (about  
508 both their care and legal rights), were involved in making decisions about treatment, and supported  
509 and cared for by staff. Additionally, this review found physical interventions, such as restraint and  
510 seclusion, were experienced particularly negatively by many patients and played an important role in  
511 the negative experiences reported in the majority of studies. This review also highlights the lasting  
512 impact of detention with a number of patients across studies reporting feelings of shame and  
513 marginalisation, particularly forensic patients who had committed an offence as well.

514 This review suggests that patients’ empowerment and confidence can be increased when they receive  
515 appropriate information, which is individualised, repeatedly delivered, and provided in accessible

516 language, and when they are given responsibility for their care. These factors can also partially offset  
517 the negative impact of coercion. These findings are consistent with the recommendations of the  
518 EUNOMIA study, which assessed the variations in clinical outcomes of coercion in 12 European  
519 countries in an effort to produce standardised recommendations for good clinical practice and  
520 minimise unnecessary infringement of patients' human rights (71). The recommendations included  
521 police officers providing patients with a full explanation of their role, the reasons for their  
522 intervention, and patients' rights. They additionally suggested that patients should be provided with  
523 the relevant information regarding their admission (including length of stay), diagnosis and treatment  
524 plan, and should be given the opportunity to inform relatives and bring any personal belongings (72).  
525 Findings are also consistent with evidence from structured care planning interventions centred on  
526 patient-centred care and increasing involvement in decision-making, which have shown promise in  
527 improving patient outcomes, including readmission (73).

528 The review also highlights how patients' perceptions of coercive interventions can depend on how  
529 these are delivered by staff and the care provided following these interventions. Patients expressed  
530 particular concern about the deployment of coercive interventions as a first line strategy and described  
531 feelings of powerlessness and (re-)traumatisation. Other research has similarly reported that patients  
532 experience coercive interventions as being harmful, inducing feelings of shame and guilt, and having  
533 the potential to re-traumatise patients, particularly female patients (74). Strategies based on trauma-  
534 informed care (75), which emphasises the creation of a safe environment that reduces the risk of (re-  
535 )traumatising patients (76), have been found to reduce the frequency and length of seclusion and  
536 restraint incidents in a number of settings (75, 77-79). However, it should also be noted that there  
537 were some instances where some patients believed that coercive interventions were helpful,  
538 particularly in preventing confrontational situations and violence. The varied perception of coercive  
539 interventions has also been reported previously (80) highlighting the importance of gaining a more  
540 nuanced understanding of when these interventions are perceived as acceptable. Despite some patients  
541 stating that their involuntary admission kept them safe, many reported that they felt unsafe on the  
542 ward and employed strategies to cope, such as retreating to their room; similar findings have been  
543 reported in relation to voluntary inpatients (81). The strategies used by inpatients to increase feelings  
544 of safety should be investigated further.

545 The quality of the environment and quality of relationships were key themes and influenced many  
546 aspects of patients' experiences, including feelings of safety and self-worth. Trust was highlighted as  
547 a central component of patient-staff relationships, consistent with previous research focusing on the  
548 role of empathy (82). However, it is important to note the difficulties that staff members, particularly  
549 nurses who spend more time with patients on wards, face in striking a balance between being  
550 empathic and performing their role as healthcare providers (82). This includes difficulties with  
551 knowing how to handle patients' experiences of trauma, concerns about over-involvement, staff team

552 dynamics, and administrative tasks which limit time spent with patients (82). Findings suggest  
553 considerable scope to reduce the negative impact of detention through improved patient-staff  
554 relationships. The Safewards Model (83) could provide a potential basis for care to prevent conflict,  
555 promote safety, and reduce the need for coercive interventions (84, 85). The model includes  
556 establishing clear mutual expectations, identifying how patients can help each other, staff receiving  
557 training in communication styles and de-escalation techniques, reassurance from staff following  
558 adverse incidents, and staff learning techniques for delivering bad news to patients. Many of these  
559 components were recommended by patients included in the reviewed studies and/or identified as  
560 factors which improved their experience of detention. Difficulties implementing the Safewards Model  
561 have, however, included high staff turnover (86), which patients in this review also highlighted as a  
562 barrier to building trusting relationships.

563

#### 564 *Strengths and limitations*

565 This review used a robust search strategy, identifying more papers than both previous reviews  
566 combined. An independent second reviewer screened random samples of citations at both the  
567 title/abstract and full screening stages, with a high level of agreement. Established techniques were  
568 used to synthesise findings. We collaborated with the NIHR Mental Health Policy Research Unit's  
569 Lived Experience Working Group to analyse and interpret data. The first author of the review also has  
570 lived experience of caring for a close family member with a serious mental illness.

571 Limitations should also be noted. For instance, the experiences of child and adolescent patients or  
572 those transitioning to adult services were not included in the scope of this review. The process of  
573 synthesising findings across multiple qualitative studies, conducted in different settings, with different  
574 legislative systems and using different methods for sampling, data collection and analysis, invariably  
575 involves the loss of nuance and simplification of findings. Moreover, quality appraisal revealed that  
576 four-fifths of papers did not adequately report the relationship between researchers and participants  
577 which made it difficult to ascertain whether researchers had any prior involvement with participants  
578 (e.g. as healthcare providers). Researchers should endeavour to improve the reporting of such  
579 relationships in future qualitative research (87, 88). We were not able to analyse data separately by  
580 patient group, including whether experiences differ by sex, gender, ethnicity, or diagnosis, due to the  
581 limited extent to which primary studies considered these questions.

#### 582 *Future research*

583 The review highlighted evidence gaps which future research should seek to address. Firstly, although  
584 studies provided detailed data on patients' experiences while detained on wards and during police  
585 involvement in admissions, evidence was almost completely lacking on experiences of assessment

586 under mental health legislation. Secondly, there is a lack of research focusing specifically on the  
587 experiences of BAME individuals who have been detained under mental health legislation. This is an  
588 important omission given that BAME patients are more likely to be detained under mental health  
589 legislation (89) and to come into contact with mental health services through the criminal justice  
590 system (90). Finally, our findings suggest a number of foci for interventions to improve experiences  
591 of detention, for example through better strategies for providing patients with information, engaging  
592 patients in decision making, and developing trusting staff-patient relationships. Staff may feel that the  
593 coercion involved in involuntary admissions negates any efforts to establish positive therapeutic  
594 relationships (91), but our findings suggest that such efforts often have a significant impact on  
595 patients' experiences. Co-produced approaches involving patients, family and friends, and clinicians  
596 in the selection, development, implementation and evaluations of strategies targeting these areas have  
597 the potential to mitigate some of the collateral harms that can result from compulsory treatment.

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649 **Declaration of interest**

650 None  
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652

653 **Author contribution:**

654 SA, EM and SJ contributed to the protocol. SA and RS conducted the systematic review and SA, RS  
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656 contributed to the interpretation of results and redrafting of the manuscript. All authors read and  
657 approved the final manuscript.

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