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REVIEW ARTICLE

A qualitative synthesis of patients' experiences of re-traumatization in acute mental health inpatient settings

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Accessible summary

What is known on the subject?:

- Research indicates many people accessing mental healthcare have trauma history and often experience re-traumatization in acute mental health inpatient settings.
- Treatment for trauma is not routinely explored as a treatment option in mental health inpatient settings and consequently mental health professionals do not draw connections between the person with trauma history and their presenting mental health problems.

What this paper adds to existing knowledge?:

- People in acute mental health inpatient units are not asked about their previous trauma histories on admission and their trauma history is not taken into consideration during interventions in particular coercive practices such as seclusion, restraint, forced medication, and involuntary admission.
- This paper provides an understanding on how to address trauma-related issues within in-patient settings and identifies practical examples of how to reduce the risk of re-traumatization.

What are the implications for practice?:

- Staff induction and training development needs can be used to help mental health professionals to be more confident and competent in assessing and identifying the history of trauma so that they can improve recognition, provide post-disclosure support, and avoid the potential for re-traumatization for inpatients.
- Physical environments need to be welcoming, homely, and have comfortable furnishing. They also require adequate space for inpatients to move around freely and have a quiet space to go to de-escalate themselves when required.

Abstract

Introduction: Rates of re-traumatization among mentally ill-health patients have risen significantly over the past decade and clinical guidelines place mental health nurses at the heart of their care.

Aim: To gather, analyse, and synthesize the evidence on people's experiences on re-traumatization in acute mental health inpatient settings.

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Method: A systematic search for qualitative studies (CINAHL, MEDLINE, ASSIA, PsycINFO, and EMBASE) was conducted. Two authors independently assessed eligibility and appraised methodological quality using Joanna Briggs's quality appraisal tool and extracted data. The analysis followed the principles of interpretative synthesis.

Results: Fourteen papers were included for thematic synthesis. Three themes emerged: (1) Quality of staff interaction; (2) Specific interventions, (Sub-theme nature of symptoms); and (3) Nature of the environment.

Discussion: Our findings demonstrate that patients are experiencing re-traumatization in acute mental health inpatient settings and that there is little being done to prevent it from occurring.

Implications for Practice: This study is the first to analyse the factors that contribute to re-traumatization and make recommendations to mental healthcare professionals to reduce the harmful practices in place in inpatient settings. It is suggested that training staff in trauma-informed care and allowing patients to be experts in their own care can reduce the rates of re-traumatization.

KEYWORDS

acute mental health, patient experience, prevention, psychological trauma, trauma

1 | INTRODUCTION

Re-traumatization amongst people accessing mental healthcare has been receiving growing attention in research but despite this, trauma exposure and re-traumatization are often not recognized in acute mental health inpatient settings (Chambers et al., 2014; Duckworth & Follette, 2012; Read et al., 2007). Prevalence of trauma amongst people accessing mental health services is approximately between 70% and 90% (Copeland et al., 2018; Neill & Read, 2022; Phipps et al., 2019; Read et al., 2016, 2018). Successive studies have shown that people with mental health conditions have experienced traumatic events and how these experiences in particular childhood trauma are causal in the development of mental disorders (Bentall et al., 2014; Mauritz et al., 2013). For instance, studies reported the association between childhood trauma with psychotic disorders (Huang et al., 2019; Morrison et al., 2003; Varese et al., 2012), substance use disorders (Oswald et al., 2021), mood disorders (Humphreys et al., 2020; Negele et al., 2015), bipolar disorder (Janiri et al., 2015; Watson et al., 2014), and any anxiety disorders (Copeland et al., 2018; Gerin et al., 2019). People in contact with mental health services who have experienced childhood trauma have longer and more frequent hospital admissions, are prescribed more medication, and are more likely to self-harm and attempt suicide (Kessler et al., 2010; Mauritz et al., 2013; Read et al., 2007; Sweeney et al., 2016). This, coupled with evidence of iatrogenic harm in mental health services, has led to the development of trauma-informed approaches (Harris & Fallot, 2001; Sweeney et al., 2018; Wilson et al., 2017).

Trauma-informed approaches (Harris & Fallot, 2001) based on the principles of trauma-informed care (TIC) are now incorporated into

the National Health Service (NHS, 2019), Health Service Executive (HSE, 2017), U.S. Department of Health and Human Services, Substance Misuse and Mental Health Administration (SAMHSA, 2014), and the Mental Health Coordinating Council (MHCC, 2013). It is grounded in and directed by an understanding of how trauma exposure affects the persons' neurological, biological, physiological, and social development and attachment (Muskett, 2014; Paterson, 2014). TIC within mental health services involves training, supervision and support of all staff, screening for trauma experiences, and sound policies that can help clinicians on how to avoid or prevent re-traumatization. TIC also focuses on preventing (re)traumatization within services (e.g., through a reduction in the use of control and restraint) and helps to understand the impact of trauma on a person's ability to survive in the present moment for instance shifting our thinking from "what is wrong with you" to "what happened to you" (Harris & Fallot, 2001; Muskett, 2014; Sweeney et al., 2016, 2018).

Definitions of re-traumatization essentially mean to be traumatized again which occurs when a person experiences something in the present that is reminiscent of a past traumatic event which can often evoke the same emotional and physiological responses associated with the original event (Duckworth & Follette, 2012; Sweeney et al., 2016, 2018). For the purpose of this review Substance Abuse and Mental Health Services Administration's (SAMHSA) (2014) definition of trauma will be used. This definition defines trauma as resulting from; an event, series of events, or set of circumstances that are experienced by the person as physically or emotionally harmful or life-threatening and that have lasting adverse effects on the person's mental, physical, emotional, and/or social well-being. Traumatic experiences can occur at any stage throughout life and

there are different categories of trauma. Type I trauma is used to identify a single incident or one-off event, commonly associated with Post Traumatic Stress Disorder (PTSD), and type II trauma/complex trauma signifies a trauma that is prolonged, cumulative, or repeated over extended periods of time and largely interpersonally generated (Copeland et al., 2018; Mauritz et al., 2013; Negele et al., 2015). Complex trauma from childhood experiences in particular is more extensive in its effects, it is also more frequent and prevalent and often has damaging and substantial impacts on both mental and physical health into adult life (Bentall et al., 2014; Sweeney et al., 2018).

Despite the high prevalence of trauma exposure and re-traumatization, patients and staff either do not draw connections between their trauma histories and their presenting problems, or they avoid the topic altogether (Sweeney et al., 2016, 2018). Given the adverse outcomes associated with trauma exposure, it is important that mental health professionals can assess and identify the history of trauma so that they can improve recognition, provide post-disclosure support, avoid the potential for re-traumatization, and enhance screening indicators for precision and effectiveness of meaningful treatment plans and services for trauma and mental distress (Read et al., 2007).

The Best Practice Guidance (2017) and National Institute for Care and Excellence Guidelines (NICE, 2011) give all health-care professionals working with people with trauma exposure and re-traumatization a clear remit to address trauma survivor's psychological health status. Studies (Cleary, 2004; Duckworth & Follette, 2012; Walsh & Boyle, 2009; Wilson et al., 2017) highlight that re-traumatization is often secondary to several everyday coercive practices and procedures including seclusion, restraint, enforced medication compliance, involuntary treatment, locked doors, ward rounds, ward rules, the environment itself, search procedures, mixed-sex patient populations, and round-the-clock observation as they are experienced by patients as emotionally unsafe and disempowering practices. Furthermore, coercive practices, such as physical restraint damages the therapeutic relationship, it has the potential for physical injuries and distress in patients and staff, develops negative attitudes towards services, and is contradictory to the caring values (MHCC, 2013).

Trauma symptoms arising from past violence, and the absence of perceived safe and supportive inpatient environments, create obstacles to effective treatment and care for consumers of mental health services (Chambers et al., 2014; Walsh & Boyle, 2009). Further studies demonstrated how 80% of participants reported that they felt they had been traumatized by being hospitalized, 66% indicated that this was severe, whilst 56% reported experiencing previous trauma prior to admission such as rape, being mugged/assaulted, relationship breakup, bereavement, and job loss (Tarrier et al., 2007), whilst half of the participants reported a prior treatment-related traumatic experience (Tessier et al., 2017). In a 10-year prospective cohort study of patients with psychosis hospitalized between 1989 and 1995, they found that 69% of participants reported that at least

one of their hospitalizations was traumatic or extremely distressing (Paksarian et al., 2014). Additionally, treatment for trauma is not ordinarily offered or explored as a treatment option in inpatient units (Kezelman & Stavropoulos, 2012). Therefore, there is a need for consolidation of the existing qualitative literature to explore the evidence on people's experiences on re-traumatization in acute mental health inpatient settings. Since there has been no previous qualitative synthesis undertaken in this area, this current review of extant qualitative literature aims to synthesize the evidence allowing exploration of people's experiences of re-traumatization.

1.1 | Aim

The aim of this review is to gather, analyse, and synthesize the evidence on people's experiences on re-traumatization in acute mental health inpatient settings, and identify practical examples of how to improve practices and reduce the risk of re-traumatization.

2 | METHODS

The protocol for this systematic review is reported in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses statement (PRISMA) (Page et al., 2021). The methods are also aligned with the Enhancing Transparency in Reporting the Synthesis of Qualitative research (ENTREQ) guidelines, a set of evidence-based items designed to enhance confidence in the syntheses of qualitative research (Tong et al., 2012). A preliminary search of the Cochrane library, Google Scholar, Open Grey database, and PROSPERO was searched to ensure no other related systematic reviews had been conducted.

2.1 | Search strategy

A population, concept, and context (PCC) framework was used to frame the selection of terms used in the search strategy and to formulate the following research question: *What are patients' experiences and views of re-traumatization in acute inpatient settings?* The population, concept, and context terms (see Table 1) were combined using Boolean operators "OR"(within columns), "AND" (between columns) and terms were searched as keywords, topics, and Medical Subject Headings (MeSH). Systematic searches of five electronic databases were conducted from inception to date of searches (December 2021): Cumulative Index to Nursing and Allied Health Literature (CINAHL), MEDLINE, PsychINFO, EMBASE, and Applied Social Sciences Index and Abstracts (ASSIA) with no date, language, or geographical limiters set owing to a dearth of research in this subject area. Forward citation tracking of retrieved articles was conducted by hand-searching reference lists of identified articles for additional studies, and we tracked citations of key studies.

TABLE 1 PCC framework

<i>Population</i> People diagnosed with mental ill-health	TI (mental health OR mental illness OR mentally ill OR mental ill health OR mental disorders OR Mental health problems OR mental health difficulties OR emotional problem OR emotional distress OR psychopathology) OR AB (OR mental health OR mental illness OR mentally ill OR mental ill health OR mental disorders OR Mental health problems OR mental health difficulties OR emotional problem OR emotional distress OR psychopathology) AND
<i>Concept</i> Experiences of re-traumatization	MM "Child Abuse" OR DE "Child Neglect" OR MM "Trauma-Informed Care" OR MM "Traumatic Experiences" OR DE "Stress" OR MM "Traumatic Experiences" OR MM "Experiences (Events)" OR MM "Trauma" OR MM "Collective Trauma" OR MM "Posttraumatic Stress" OR MM "Posttraumatic Stress Disorder" OR MM "Trauma Reactions" OR MM "Trauma Screening" OR MM "Trauma Treatment" OR retraumatise OR retraumatize OR retraumatization OR retraumatization OR re-traumatization OR Neglect* OR Sexual abuse OR sexually abus* OR sexual abus* OR abuse* OR advers* OR Adverse childhood experience OR ACE OR Victim* violence OR maltreat* OR child maltreatment OR mistreat OR emotional abuse OR psychological abuse OR PTSD OR post traumatic stress OR post-traumatic stress OR post- traumatic* OR PTSS OR posttrauma* OR trauma* OR traumatic life event* OR psychological trauma OR stress disorder* OR stress reactions OR Complex PTSD OR Complex Trauma OR AND
<i>Context</i> Acute mental healthcare inpatient setting	TI (MM "Psychiatric Hospital Admission" OR TX inpatient mental health OR TX psychiatric care OR mental health care OR TI acute mental health unit OR psychiatric unit OR mental health unit) OR AB (MM "Psychiatric Hospital Admission" OR TX inpatient mental health OR TX psychiatric care OR mental health care OR TI acute mental health unit OR psychiatric unit OR mental health unit)

2.2 | Eligibility criteria

Studies were included if (i) the primary research approach was qualitative, where people with a history of trauma admitted to an inpatient mental healthcare setting participated in interviews, focus groups, or documented their experiences; (ii) they focused on participants who experienced re-traumatization who were accessing or had accessed acute inpatient mental healthcare; and (iii) sampled participants over 18 years with self-reported or diagnoses of trauma. Studies were excluded if (i) they did not report primary qualitative narratives from participants with no history of trauma admitted to inpatient mental healthcare; (ii) they used a quantitative design such as randomized control trials, case studies, and quasi-experimental studies, and (iii) they were expert opinion or consensus statements.

2.3 | Study selection

All returned citations from the search were exported into Covidence (www.covidence.org) for de-duplication, title/abstract screening, and full-text screening. Titles and abstracts were independently screened by BH and AG against eligibility criteria with any uncertainties resolved by discussion with AH. Subsequently, BH and AG assessed the full texts of these studies to determine the eligibility criteria and AH resolved disagreements during this process.

2.4 | Quality appraisal

Quality appraisal of the included studies was conducted by two independent reviewers BH and AG using the Joanna Briggs Institute

Checklist for Qualitative Research (Lockwood et al., 2015) to assess the methodological quality, rigour, trustworthiness, relevance, and results of all studies. This tool contains 10 questions rated as "yes," "no," "unclear," or "not applicable." The quality weightings of the included studies (see Table 4) were considered when reporting and discussing the results.

2.5 | Data extraction and analysis

A Microsoft Excel data extraction form was developed and piloted for the purpose of extracting data from eligible studies. This included author, year, country of origin, study aim, methods, sample achieved and characteristics, analytic approach, and findings. Information related to how inpatients experienced re-traumatization within inpatient mental healthcare, reported themes, and recommendations were extracted. Thematic synthesis using the Thomas and Harden (2008) framework was followed as it allowed for transparent summarizing of existing qualitative research evidence, but also enabled the synthesis to go beyond the primary studies in generating new constructs and explanations. This was done in a three-step process: (1) BH and AG independently coded existing findings line by line and qualitative data relevant to the question were extracted and new descriptive codes were generated according to the meaning and content of the data and resolved any differences by discussion with AH; (2) codes were then grouped to capture their meaning, into a smaller set of new codes, and descriptive themes were developed by identifying patterns, similarities, and differences between data, keeping the synthesis close to the original findings. All authors commented on this draft summary of findings and a final version was agreed. (3) Analytical themes which went beyond themes in the primary studies were generated inductively, and analytic themes were identified with reference to the review question.

3 | FINDINGS

3.1 | Search outcomes

The search strategy yielded 11,251 studies from five databases, duplicates were removed ($n = 3063$), and 8188 studies were retained for the title and abstract screening. A total of 94 full-text papers were read after which 6 papers remained for inclusion (see Figure 1). Sixteen papers were sourced through forward citation from which 8 papers were eligible for the review. A total of 14 studies were included in this review.

3.2 | Study characteristics

Table 2 presents a summary of the characteristics of the 14 studies that were conducted between 1995 and 2021. Three studies were conducted in Australia (Brophy et al., 2016a, 2016b; Sambrano & Cox, 2013), three studies were conducted in the United Kingdom (Bonner et al., 2002; Emrich et al., 2021; Hughes et al., 2009), three studies across United States (Ezeobele et al., 2014; Lu et al., 2017;

Smith, 1995), two in the Republic of Ireland (Murphy et al., 2017; Skelly et al., 2013), one in Italy (Vallarino et al., 2019), one in Norway (Wynn, 2004), and one in Canada (Gallop et al., 1999).

All included studies were qualitative. Eight of the studies used thematic analysis/general inductive approaches (Brophy et al., 2016a, 2016b; Gallop et al., 1999; Hughes et al., 2009; Murphy et al., 2017; Skelly et al., 2013; Smith, 1995; Vallarino et al., 2019), two studies used grounded theory (Lu et al., 2017; Wynn, 2004), and two studies used phenomenological approach (Ezeobele et al., 2014; Sambrano & Cox, 2013). In Bonner et al.'s (2002) study the transcripts of the interviews were analysed using the technique of Miles and Huberman (1984), and one study used Interpretative Phenomenological Analysis (Emrich et al., 2021). Ten studies gathered data through semi-structured interviews (Bonner et al., 2002; Emrich et al., 2021; Ezeobele et al., 2014; Gallop et al., 1999; Hughes et al., 2009; Lu et al., 2017; Murphy et al., 2017; Sambrano & Cox, 2013; Vallarino et al., 2019; Wynn, 2004), three studies used focus groups (Skelly et al., 2013; Brophy et al., 2016a; Brophy et al., 2016b), and one study used group interviews (Smith, 1995). Fourteen of the studies recruited participants from either currently in inpatient mental healthcare or had previous experience of being admitted to inpatient mental healthcare.

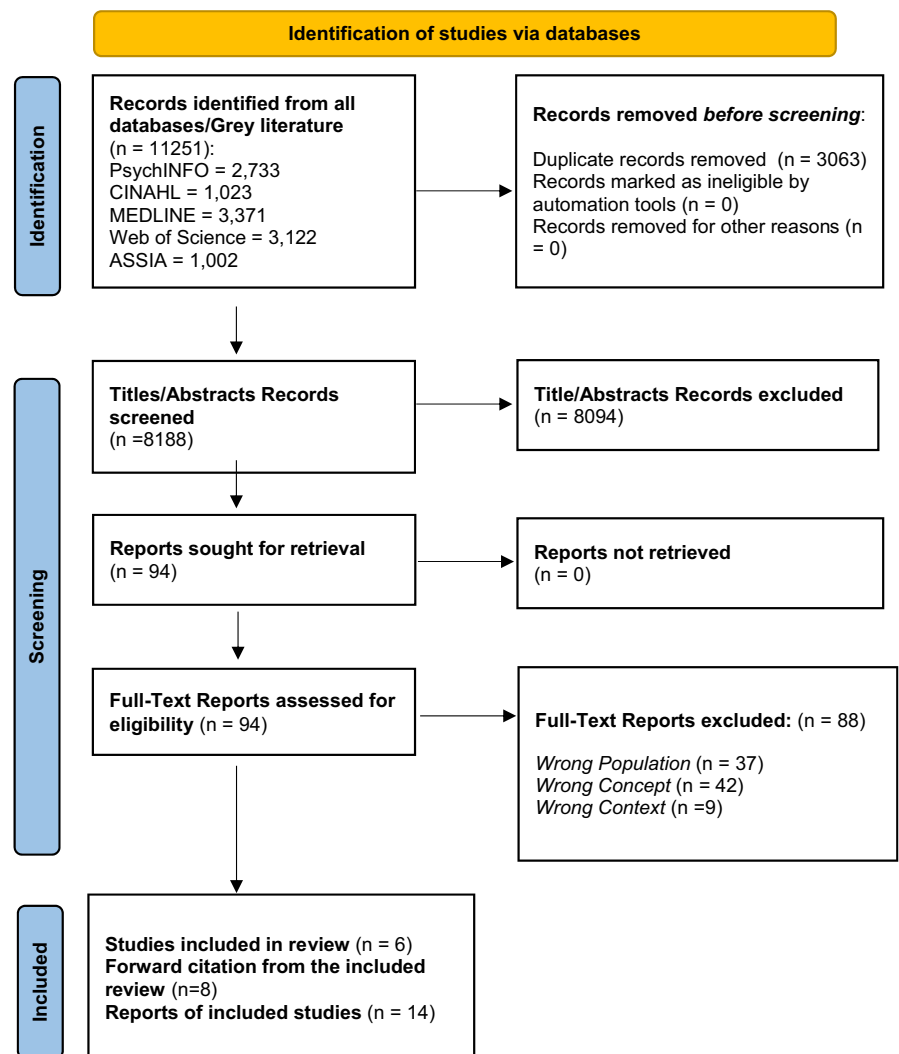


FIGURE 1 The PRISMA diagram

TABLE 2 Study characteristics

Author, year and country	Ethical approval	Study aim and methodology	Data collection methods	Recruitment methods
Vallarino et al. (2019) Italy	Ethics Review Board of the University of Pavia Ethical approval were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration.	To explore experiences of mental health care reported by individuals diagnosed with Bipolar Disorder to gain a broad understanding of their expectations, views, and evaluations of key aspects of services received Qualitative study	Semi-structured individual interviews Video-recorded Participants $n = 9$ No breakdown between male/female data provided	Convenience sampling- using participants from a psychoeducation programme Online advertisements on a mental health users network
Lu et al. (2017) United States	The study was carried out in accordance with the recommendations of Rutgers RBHS Institutional Review Board and Dartmouth College Institutional Review Board. All subjects gave written informed consent in accordance with the Declaration of Helsinki.	To evaluate subjective experiences related to psychotic symptoms and treatment in clients with multiple psychotic episodes. Aspects of symptoms and treatment that were perceived as traumatic as well as emotional reactions to the most traumatic aspect of symptoms and treatment Qualitative study	Quasi-structured interviews Field notes by interviewers were used to maintain a record of responses Participants $n = 63$ Male $n = 36$ Female $n = 27$	Convenience sampling using participants from an inpatient psychiatric unit and an urban state psychiatric hospital
Murphy et al. (2017) Republic of Ireland (ROI)	Research Ethics Committees of National University of Ireland Galway, Galway University Hospitals Clinical Research Ethics committee and Roscommon Hospital Ethics Committee	To explore the experiences of people admitted involuntarily under the Mental Health Act 2001 in the Republic of Ireland Qualitative descriptive design	Face-to-face semi-structured interviews Audio recorded Participants $n = 50$ Male $n = 29$ Female $n = 21$	Purposeful sampling – participants were recruited from a larger cohort of individuals who had participated in a quantitative prospective study of attitudes towards admission and care which was conducted with a representative cohort of service users from three inpatient psychiatric in ROI
Brophy et al. (2016a) Australia	University of Melbourne (Ethics ID 1340647), being considered first by the Population and Global Health Human Ethics Advisory Group and then by the Health and Sciences Human Ethics Sub-Committee.	To obtain both consumer and carer perspectives on poor practice and the use of seclusion and restraint in mental health settings Qualitative design	Focus groups Consumer focus groups $n = 5$ Supporter focus groups $n = 5$ Audio recorded Consumers $n = 30$ (Males $n = 13$; Females $n = 17$) Supporters $n = 36$ (Males $n = 7$; Females $n = 29$)	Convenience sampling
Emrich et al. (2021) United Kingdom	NHS Health Research Authority and it also adhered to the British Psychological Society guidelines on human research ethics	To explore the subjective experiences of recovery from psychosis from the perspective of service users receiving acute mental health inpatient treatment Qualitative design	Semi-structured interviews Audio recorded Participants $n = 10$ Males $n = 9$ Female $n = 1$	Purposeful sampling-participants were recruited from three mental health hospitals in outer London and Essex
Bonner et al. (2002) United Kingdom	All procedures were approved in advance by the relevant NHS local Research Ethics Committee	To establish the feasibility of semi-structured interviews with patients and staff in the aftermath of untoward incidents involving physical restraint. To gather information on the factors that both patients and staff groups found helpful and unhelpful during and in the aftermath of restraint and to explore the lived experience of restraint. Qualitative design	Semi-structured interviews Tape recorded Patients $n = 6$ Staff $n = 12$	The secretary of one of the researchers (NW) made daily phone calls to the participating wards to ascertain if any untoward incidents involving restraint had occurred. The researchers were then contacted by the secretary and informed. The researchers liaised with the ward teams to check the nature of the incident and the identities of the participants.

Data collection process	Data analysis	Findings
Location: participants chose the location which would enable them to feel most comfortable. Interview privacy: Only one researcher and the participant present	Thematic analysis The data analysis procedure used techniques described by Veseth et al. (2013) and Crowe et al. (2015)	Five core themes identified: <ol style="list-style-type: none"> 1. Mixed feelings about the diagnosis -some found it both confusing and a relief 2. Role of psychological interventions-little access unless they paid private 3. Job as a safe haven-identified as a protective factor 4. Relationship with clinician-some participants were reluctant to discuss personal issues and often feared that their discussions would lead to a hospital admission 5. Hospital admissions-found compulsory admissions distressing made them feel disempowered and socially isolated – 7 participants reported a prior history of distressing compulsory admissions. Some were completely unaware of what was happening and reported feelings of failure, social isolation, disempowerment, and shame.
Interview location: not stated Interview privacy: not stated	Grounded theory	The three main themes were identified: <ol style="list-style-type: none"> 1. Emotions associated with traumatic aspects of psychosis 2. Traumatogenic aspects of psychiatric treatment 3. Emotions associated with traumatic aspects of psychiatric treatment Participants reported a number of traumatic aspects of experiencing psychotic symptoms including frightening hallucinations, suicidal thoughts/attempts, thoughts/attempts to hurt others, paranoia/delusions, and bizarre/disorganized behaviour or catatonia. Traumatic aspects of psychosis elicited emotions including anger and sadness. Many participants found aspects of treatment to be traumatic including being forced to stay in hospital for a long time; experiencing upsetting side-effects; coercive treatments, including involuntary hospitalization, use of restraints, and forced medication; being exposed to aggressive patients; and mistreatment by professionals. These experiences elicited emotions of anger, sadness, distrust, and a sense of helplessness. Findings suggest both experiences of psychosis and psychiatric treatment to be potentially traumatic and can be a powerful barrier to engaging people in mental health services and facilitating recovery.
Interview location: not stated Interview privacy: not stated	Inductive Thematic analysis Using software package Nvivo	Participants reported mixed experiences which comprised both positive and challenging aspects. Four themes emerged consistently across the trajectory of participants' involuntary admission experiences. The four themes are "feeling trapped and coerced," "feeling disengaged and unsupported," "admission induced distress," and "person-centred encounters." 38% of participants indicated that aspects of their involuntary admission had a detrimental and prolonged negative impacts on their mental health. 24% of participants likened the impact of their detention and admission to that of enduring trauma.
Locations of focus groups: Melbourne, Shepparton, Perth, Brisbane, and Sydney	General inductive approach Software package Nvivo 10	Six themes emerged from the analysis, these being; human rights, trauma, control, isolation, dehumanization, and "othering" and anti-recovery. Examples of poor practice identified by focus groups included the use of excessive force, lack of empathy/paternalistic attitudes, lack of communication and interaction, and a lack of alternative strategies to the use of seclusion and restraint. The main factors identified by participants as contributing to poor practice include organizational culture, the physical environment, under-resourced mental health services, and fear and stigma. Participants made a link between the trauma experienced as a result of seclusion and restraint, and the subsequent impact this had on the person's recovery, sense of trust in the world, and relationships with service providers.
Location of interviews: in the ward's quiet room	Interpretative Phenomenological Analysis	Five superordinate themes emerged: <p>"my future is just being ripped out in front of me": living with psychosis is a struggle; "would you want to be in here?": traumatic experience of being in hospital; "I know roughly why I got ill anyway and what caused this": A journey towards reaching an understanding; recovery/rehabilitation/ recuperation: a process of evolution; and "you need all the help you can get": facilitators of recovery</p>
Location of interviews: not stated	Transcripts of the interviews were analysed independently by three members of the research team using the technique of Miles and Huberman (1984)	The incidents generated strong emotions for all concerned. The patients valued staff time and attention but felt that they received too little attention. Both nurses and patients discriminated between permanent and temporary staff. Patients reported feeling upset, distressed, and ignored prior to the incidents and isolated and ashamed afterwards. Post-incident debriefing was valued by all but was patchy for staff and rarer still patients. Patients feared the possibility of being restrained. Half of the patients and several staff members reported that the incidents had reawakened distressing memories of previous traumatic events. Disturbingly, three patients reported that being restrained brought back memories of previous violent incidents, including in one case the experience of having been raped, and in another case the experience of having been abused in childhood. Members of the nursing staff also reported experiences of re-traumatization by the occurrence of violent incidents.

(Continued)

TABLE 2 (Continued)

Author, year and country	Ethical approval	Study aim and methodology	Data collection methods	Recruitment methods
Hughes et al. (2009) United Kingdom	None identified	To explore patient's perceptions of the impact of involuntary inpatient care on self, relationships and recovery. Qualitative design	Semi-structured interviews Audio taped Patients $n = 12$ Male $n = 5$ Females $n = 7$	Purposeful sampling of patients who had an experience of involuntary inpatient care.
Sambrano and Cox (2013) Australia	Queensland University of technology Hospital Human Research Ethics Committee Support was sought from the Indigenous Elders in the region and gained from the Moreton Bay Regional Elder's council (MBREC)	To explore how indigenous people experienced the controversial practice of seclusion. Qualitative design	Interviews Recorded and transcribed Patients $n = 3$ Male $n = 2$ Female $n = 1$	Purposeful sampling of patients who identify as Aboriginal person or a Torres Strait Islander or both and who have been placed in seclusion within an acute mental health facility
Ezeobele et al. (2014) United States	Hospital research committee and the institutional Review Board	To explore and describe the psychiatric patients' lived seclusion experience Qualitative design	Semi-structured interviews Transcribed verbatim Patients $n = 20$ No breakdown between male/female data provided	Purposive sampling of psychiatric patients who were secluded in an acute hospital in South-western United States
Wynn (2004) Norway	The regional Ethics Committee and the Norwegian Social sciences Data Services	To explore inpatients experiences regarding restraint Qualitative design	Interviews Recorded on tape Author took notes Patients $n = 12$ No breakdown between male/female data provided	Purposive sampling of patients recently subjected to restraint
Gallop et al. (1999) Canada	None identified	To explore the experiences of women who were hospitalized in psychiatric settings, restrained, and given forced medication. Qualitative design	Open ended interviews Audio taped Patients $n = 10$ Female $n = 10$ Male $n = 0$	Purposive sampling Notices posted at treatment centres recruited participants with a history of sexual abuse who have experienced restraint/forced medication in a psychiatric institution within the past 5 years participated in the study

Data collection process	Data analysis	Findings
Location of interviews = not stated	Thematic analysis of the transcripts	<p>Three themes were identified. The process of being involuntarily admitted. During involuntary hospitalization. After discharge.</p> <p>The main theme of participants' experiences of involuntary hospitalization had three sub-themes. Views of self, experience of relationships and interactions, and medication.</p> <p>Loss of identity, reduced self-efficacy, loss of control. Finding physical restraint traumatic.</p>
Location of interviews = Not stated	Phenomenological assumptions of Hans-Georg Gadamer	<p>Five themes emerged. The criminalization of clients, experience being punished, use of force, intense feelings of powerlessness, dehumanizing effects of treatment, and experiences of abuse and neglect.</p> <p>Even though the acts of force were legal this did not negate the trauma experienced by these participants during such events.</p> <p>Participants spoke about "being outnumbered" and intimidated.</p> <p>As the study's participants were keenly aware, Indigenous deaths in custody were the subject of the highly publicized 1991 Royal Commission into Aboriginal Deaths in Custody (RCIADIC; Cunneen (2001). The extreme physical force Daniel describes, coupled with the continuing high rates of deaths in custody (ABS 2012), not surprisingly, contributes to the fear of dying or being killed by the participants described when secluded. Below, Peter describes this fear: "They could a strung me up with my socks or something like that. Said I got access to my socks and hung myself. They would cover it all up, the fucking white pricks ... it makes me angry. They do that to, you know, all the Murris" [Murris is the term that some Indigenous people in southeast Queensland and the border regions of New South Wales use as a cultural identifier].</p>
Location of interview: Not stated	Phenomenological study using Husserlian's philosophy	<p>Four themes were uncovered: (1) alone in the world; (2) staff exert power and control; (3) resentment towards staff; and (4) time for medication</p> <p>Participants reported the seclusion experience as a negative event. Being secluded deprived them of freedom and reawakened past feelings of hurt.</p>
Location of interviews: not stated	Grounded theory	<p>Four common experiences were identified. Patients' views about if/how restraint could have been avoided. Patients' experiences of the use of restraint, patients' thoughts about the consequences of having been restrained.</p> <p>While in restraint, some of the patients were reminded of prior restraint episodes. One male patient had spent much time in somatic hospitals as a child, and the restraint episode brought back difficult feelings from that period. Two of the three female patients interviewed stated that being physically restrained brought back memories of prior sexual assault. One reported flashbacks while in restraint and said it reminded her of "awful things that happened to me as a child."</p> <p>Some of the patients expressed the belief that being restrained violated their integrity. Most felt that they had been unfairly treated. One of the patients said: "I think they treated me badly." A few felt the restraint experience had been wholly negative, and a male patient stated: "it's not a good thing for me, I don't think so"</p>
Location of interview: private office or client's home	Thematic analysis Ethnographic software program	<p>Results:</p> <p>What lead to restraint</p> <p>The experience of hospitalization- 3 themes</p> <ul style="list-style-type: none"> • Not being believed • Not being heard—meant they felt ignored and their perspective and life events were not considered important or validated. According to these women, staff expressed little concern about a history of abuse and how this might affect her current problems or experience of hospitalization or both • Not being human—Hospitalization as described by these women was an oppressive experience. "The worse thing they can do is treat us like a child and punish us.... It seems like a control issue.... It was very demeaning" (10). <p>The experience of restraint as terrifying, being rendered powerless—They had no voice. Often they felt cut off and isolated. For many women with histories of abuse, childhood has been marked by experiences of abandonment and powerlessness. Restraint was viewed as degrading and dehumanizing.</p> <p>Consequences and links to previous experiences—Restraint precipitated flashbacks, nightmares, and anxiety for all. For one woman who had experienced physical and sexual abuse in her marriage, including being tied up and raped, restraint evoked terrifying memories, and stated, "The fear of being tied up was extreme and it just made me sick" (05)</p> <p>One woman recovered memories of childhood sexual abuse during restraint: "It brought it all back. I felt—I actually physically felt like I was being raped that whole night long." (10). It took her many months to separate the restraint in the hospital from childhood abuse. Another woman described having nightmares and flashbacks of being pinned down for many months after restraint: "I did have flashbacks as well. The nightmares were similar to the flashbacks" (02). Yet another woman described being restrained as being raped. Her father had often exposed her buttocks in front of others and spanked her in front of other males: "Like one time I felt as if I was being raped. Because they pulled the pants down and it's—it's—like you're being undressed" (04).</p>

(Continued)

TABLE 2 (Continued)

Author, year and country	Ethical approval	Study aim and methodology	Data collection methods	Recruitment methods
Skelly et al. (2013) Ireland	Ethical approval was obtained from the ethics committee of the service in which it was conducted St Patricks University Hospital	To explore service user perspectives on what constitutes good quality mental health care. Qualitative design	Focus groups $n = 6$ Audio recorded Participants $n = 29$ Inpatients $n = 21$ Outpatients $n = 8$ Male $n = 15$ Female $n = 14$	Purposeful sampling from current inpatients and outpatients of an independent mental health service based in a large Irish City with a nationwide catchment area. Eligibility of potential participants via examination of medical records and consultation with the treating team. Eligible inpatients were approached in person and eligible outpatients were contacted in person or by phone.
Brophy et al. (2016b) Australia	University of Melbourne Ethics ID 1340647	To obtain consumer and their supporters' perspectives on barriers and strategies to reducing seclusion and restraint in mental health settings. Qualitative design	Focus groups ($n = 10$) Consumer focus groups $n = 5$ Supporter focus groups $n = 5$ Audio recorded Participants $n = 66$ Consumers $n = 30$ Male $n = 13$ Female $n = 17$ Supporters $n = 36$ Male $n = 7$ Female $n = 29$	Convenience sampling and some purposive sampling Participants self-selected and opted into the groups after receiving information through peak bodies and support services in each state
Smith (1995) United States	None identified	To explore inpatients experiences of restraints with a prior history of rape. Qualitative design	Group interviews Patients $n = 4$ Females $n = 3$ Male $n = 1$	Convenience sampling from a group meeting for manic depressive and depressed clients Follow-up interviews were done with their permission

3.3 | Participant characteristics

The characteristics of all the participants from all 14 studies are summarized in Table 3. The total collective review sample ($n = 372$) consisted of inpatients/outpatients ($n = 288$) and staff/supporters ($n = 84$). Sample sizes ranged from 3 to 66. Participant ages ranged from 18 to 70+ and eight studies (Emrich et al., 2021; Ezeobele et al., 2014; Gallop et al., 1999; Hughes et al., 2009; Lu et al., 2017; Smith, 1995; Vallarino et al., 2019; Wynn, 2004) reported the mean age which ranged from 27.5 to 46.2 years. Ten of the included studies (Brophy et al., 2016a, 2016b; Emrich et al., 2021; Gallop et al., 1999; Hughes et al., 2009; Lu et al., 2017; Murphy et al., 2017; Sambrano & Cox, 2013; Skelly et al., 2013; Smith, 1995) reported on the gender characteristics of participants ($n = 313$), 56% were female ($n = 176$) and 44% were male ($n = 137$). However, no breakdown on ethnicity data was reported in the same manner, and therefore it was not possible to provide an aggregate.

All participants from the patient group had experience as inpatients in mental healthcare. Four studies (Ezeobele et al., 2014; Hughes et al., 2009; Murphy et al., 2017; Skelly et al., 2013) had

participants who were detained involuntarily within the mental health services ($n = 91$). Ten studies (Bonner et al., 2002; Emrich et al., 2021; Ezeobele et al., 2014; Gallop et al., 1999; Hughes et al., 2009; Lu et al., 2017; Sambrano & Cox, 2013; Skelly et al., 2013; Vallarino et al., 2019; Wynn, 2004) reported on participant status, inpatients ($n = 133$), and outpatients ($n = 41$).

A number of participants ($n = 35$) had experienced restraint while inpatients (Bonner et al., 2002; Gallop et al., 1999; Sambrano & Cox, 2013; Smith, 1995; Wynn, 2004). Some participants ($n = 25$) experienced seclusion while inpatients (Ezeobele et al., 2014; Sambrano & Cox, 2013; Smith, 1995). Some studies (Ezeobele et al., 2014; Sambrano & Cox, 2013; Smith, 1995) reported rates of seclusion that varied. Sambrano and Cox (2013) stated that participants previously experienced seclusion ranging from 4 to 15 times.

3.4 | Quality appraisal

Table 4 presents the quality of the included studies using the JBI Checklist for Qualitative Research (Lockwood et al., 2015). All of the studies clearly stated their aims, and qualitative methods were

Data collection process	Data analysis	Findings
Location of focus groups: conducted within the service but outside of the ward environment	Inductive thematic analysis that incorporated investigator triangulation	<p>Seven interrelated themes were found.</p> <ol style="list-style-type: none"> 1. Staff should be proactive 2. Staff should engage with patients in a meaningful way 3. Staff should show warmth and balance 4. Care should be collaborative 5. The inpatient environment should be safe 6. The inpatient environment should be social 7. Best practice guidelines should benefit patients <p>One participant described a "very hurtful experience" in which a psychiatrist interrupted their consultation to berate another patient. Participants also spoke about aspects of the hospital environment that made them feel unsafe. One participant described his past experiences, "a long time back," of a small proportion of staff who made patients feel fearful and "got a kick out of hurting others."</p>
Location of focus groups: held in four Australian state capitals and a regional city	General inductive approach NVivo 10 qualitative analysis software	<p>Four themes emerged</p> <ol style="list-style-type: none"> 1. Barriers to reducing seclusion and restraint 2. Explicitly identified barriers 3. Implicitly identified barriers 4. Strategies to prevent and eliminate seclusion and restraint <p>Participants discussed how trauma resulted from coercive practices, and how past traumas can be revisited during restraint or seclusion. Trauma experienced through restraint and seclusion was linked to the subsequent impact on a person's recovery and ongoing relationship to services.</p>
Location of interviews: not stated	Thematic analysis	<p>Common experiences associated with both rape and physical restraint: Agitation, anger, anxiety, confusion, depression, domination, flashbacks, guilt, humiliation, isolation, loss of dignity, pain, panic, sexual dysfunction, torture, and vulnerability.</p> <p>Case example 2: perceived the experience of restraint and seclusion as revictimization. The client a rape victim at age 12 perceived the situation of being placed in a 5-point restraint, faced down following attempting to hang herself while an inpatient in a psychiatric ward. She explained how the experience was a re-enactment of her prior rape.</p> <p>Furthermore, that night she reports seeing her personal belongings (including a teddy bear) in the hallway and went to knock on the door to request the teddy bear. She reports being immediately grabbed, and placed in leather restraints face down. "Why? What have I done?"</p>

appropriate for all studies and justified their choice of the analytic approach. None of the studies explicitly stated their philosophical perspective underpinning the research nor any consideration of researcher reflexivity was reported.

3.5 | Themes and sub-theme identified in the analysis

Three analytical themes were identified: (1) Quality of staff interaction; (2) Specific interventions (Sub-theme nature of symptoms); and (3) Nature of the environment. The studies that contributed to each of the themes and sub-theme are presented in Table 5 and quotations are included to illustrate the themes.

3.5.1 | Quality of staff interaction

The quality of staff interaction was a huge factor for many participants in the studies. Re-traumatization occurred in response to interactions with a range of staff. The data indicates, negative interactions

with psychiatrists, for example where there was a lack of choice, such as limited options, i.e., medication or admission to hospital:

I can recognize some of the early signs of hypomania, but you know it's a sort of poisoned red apple... it's so attractive, I am afraid of telling my psychiatrist because you know what are the options: medications or hospitalization!

(Vallarino et al., 2019 p.133)

Patients describe re-traumatization occurring even prior to admission at the moment they were apprehended by either the police or the assisted admission team:

I was sure that someone I knew would come and help me. Trying to find a voice, like, I remember lying down on the floor, all the men [members of the assisted admission team] pushing me down and I was trying to find a voice I could recognise, someone I knew to say "please, help me. I haven't done anything wrong".

(Female, 30, ID19) (Murphy et al., 2017 p.24)

TABLE 3 Participant characteristics

Author and year	Number of study participants	Participants age	Participants ethnicity	Mental health status/admission types
Vallarino et al. (2019)	Total = 9 No breakdown between male/female data provided Response rate: not reported	Age range: 37–56 Mean age: 46.2 No breakdown between male/female data provided	Cases: Italian (n = 9)	Bipolar Disorder n = 9 Inclusion criteria outlined participants had to have 2 years or more of treatment by any mental health service All were outpatients at the time of study
Lu et al. (2017)	Total = 63 Male = 36 Female = 27 Response rate: not reported	Age range: not reported Mean age: 34.43 No breakdown between male/female data provided	Cases: White (n = 24) African American (n = 20) Hispanic (n = 16) Other (n = 3)	Bipolar disorder n = 17 Psychotic or delusional disorder n = 10 Schizoaffective disorder n = 12 Schizophrenia n = 22 Other mood disorders n = 2 Inclusion criteria outlined participants had to have a presentation for treatment for a psychotic episode within the 6 weeks prior to the study commencing The study was conducted at an inpatient psychiatric unit and an urban state hospital which included both acute inpatient care, and intermediate and longer term treatment. Participants had on average over 8 hospitalizations. Traumatic events Serious accident n = 28 Natural disaster n = 13 Physical assault by family n = 37 Physical assault by stranger n = 30 Sexual assault by family n = 23 Sexual assault by stranger n = 21 Military combat/war zone n = 1 Sexual contact younger than 18 n = 27 Imprisonment n = 16 Torture n = 16 Life-threatening illness n = 3 Other traumatic event n = 27
Murphy et al. (2017)	Total = 50 Male = 29 Female = 21 Response rate: not reported	Age reported: 18–65+ Mean age: not reported 18–24 males = 2 Females = 2 25–34 males = 6 Females = 4 35–44 males = 10 Females = 7 45–54 males = 6 Females = 3 55–64 males = 5 Females = 2 65+ males = 0 Females = 3	Cases: Irish (n = 42) English (n = 3) Iranian (n = 1) Malaysian (n = 1) Spanish (n = 1) French (n = 1) Slovenian (n = 1)	Non-effective psychotic disorder n = 26 Affective psychotic disorder n = 16 Alcohol use disorder n = 3 Other n = 2 No diagnosed mental disorder n = 2 Diagnosis not available n = 1 7 participants had their involuntary admissions initiated from within the approved centre 43 were transferred from the community to the hospital under the MHA 2001 (37 were subsequently detained and 6 were held for a period of 24 hours but not found to meet the criteria for detention) 24 participants it was their first admission under the MHA 2001 9 participants had one prior detention 7 participants had 2–3 prior detentions 5 participants had 4–5 prior detentions 2 participants had 6–7 prior detentions 1 participant had 8–9 prior detentions 1 participant had 16–17 prior detentions

TABLE 3 (Continued)

Author and year	Number of study participants	Participants age	Participants ethnicity	Mental health status/admission types
Brophy et al. (2016a)	Total = 66 Consumers = 30 (Male = 13; Female = 17) Supporters = 33 (Male = 7; Female = 29) Response rate: not reported	Age range: 20–70+ Mean age: not reported No breakdown between male/female data provided	Cases: Vietnamese, Italian, Greek, Dutch, Other European backgrounds. No breakdown of numbers provided for ethnic backgrounds	Not reported Consumers had either experienced seclusion or restraint directly, witnessed these practices as inpatients or were consumer advocates who directly supported people who had experienced seclusion and restraint. Supporters had experienced a family member or person close to them being secluded or restrained.
Enrich et al. (2021)	Total = 10 Males = 9 Female = 1 Response rate: not reported	Age range: 21–57 Mean age: 39.2 21–29 Males = 2 Female = 1 30–39 Male = 1 Female = 0 40–49 Male = 4 Female = 0 50–57 Male = 2 Female = 0	White British $n = 8$ (males = 7; Female = 1) Indian $n = 1$ (male) Iraqi English $n = 1$ (male)	Bipolar affective type 2 ($n = 2$ male) Bipolar ($n = 2$ male) Schizophrenia ($n = 2$ male) Paranoid schizophrenia ($n = 3$ male) Schizoaffective disorder ($n = 1$ female) All participants were currently mental health inpatients. Length of current hospital admission varied from 18 days to 611 days. 5 participants had 2 admissions 1 participant had 4 admissions 1 participant had 9 admissions 1 participant had 10 admissions 1 participant had 10+ admissions 1 participant had 25 admissions
Bonner et al. (2002)	Total = 18 Patients $n = 6$ Staff $n = 12$ No breakdown between male/female data provided Response rate: not reported	Age range: not reported Mean age: not reported No breakdown between male/female data provided	No ethnicity details reported.	Not reported. Current inpatients who had experienced restraint.
Hughes et al. (2009)	Total = 12 Male $n = 5$ Female $n = 7$ Response rate: not reported	Age range: 19–62 Mean age: 39 No breakdown between male/female data	No ethnicity details reported.	Bipolar affective disorder $n = 6$ Borderline personality disorder $n = 2$ Schizophrenia $n = 2$ Depression $n = 2$ Current outpatients $n = 11$ Current inpatient under section $n = 1$ <ul style="list-style-type: none"> • All the participants had previous experience of involuntary inpatient care • The participants had between 2 and 34 years contact with mental health services • The range of previous hospital admissions 1–20 • The number of compulsory hospitalizations ranged from 1 to 10 • The duration since the last hospitalization ranged from current – 7 years

(Continues)

TABLE 3 (Continued)

Author and year	Number of study participants	Participants age	Participants ethnicity	Mental health status/admission types
Sambrano and Cox (2013)	Total $n = 3$ Male $n = 2$ Female $n = 1$ Response rate: not reported	Age range: not reported Mean age: not reported No breakdown between male/female data	Aboriginal $n = 2$ Aboriginal and Torres Strait Islander $n = 1$	Not reported Each participant had a long history of contact with mainstream mental health services and had been secluded between 4 and 15 times The most recent episode of seclusion occurred within an acute mental health facility between 2005 and 2009 All were current outpatients at a metropolitan mental health service. The two men had both been incarcerated within the criminal justice system
Ezeobele et al. (2014)	Total $n = 20$ Male $n = 12$ Female $n = 8$ Response rate: not stated	Age range: 19–53 Mean age: 27.5 No breakdown between male/female data	No ethnicity details reported.	Bipolar recurrent episode with psychosis $n = 11$ Paranoid schizophrenia $n = 6$ Schizoaffective disorder $n = 1$ Depressive disorder $n = 1$ Psychosis not otherwise specified $n = 1$ All patients were in a psychiatric acute care hospital. The frequency of seclusion ranged from 1 to 2 times. One of the commonalities among these patients was their involuntary status with a high risk for violent acts against others. The majority of patients admitted (85%) are involuntary admissions and brought in by law enforcement under a court warrant. The inpatient wards are mixed in terms of gender and diagnosis with an average length of stay of 7–10 days.
Wynn (2004)	Total $n = 12$ Male $n = 9$ Female $n = 3$ Response rate: not stated	Age range: 21–60 Mean age: 39 No breakdown between male/female data	No ethnicity details reported.	Paranoid schizophrenia $n = 7$ Bipolar disorder manic phase $n = 3$ Emotionally unstable personality disorder $n = 2$ All participants were inpatients in the Psychiatric Department at the University Hospital of Northern Norway 9 patients had been restrained one or more times in addition to the present either during the current or prior hospitalizations. 7 patients had been both physically and pharmacologically restrained during the same incident The duration of the restraint episodes varied from 2 to 15 hours
Gallop et al. (1999)	Total $n = 10$ Female $n = 10$ Male = 0 Response rate: not stated	Age range: 32–53 Mean age: 39.8 All females	No ethnicity details reported.	Depression $n = 6$ Posttraumatic stress disorder $n = 1$ Schizophrenia $n = 1$ Borderline personality disorder $n = 1$ Dissociative identity disorder $n = 1$ All 10 participants had experienced restraint/forced medication in a psychiatric institution within the past 5 years. All participants had experienced multiple hospitalizations ranging from 5 to 10+ 5 participants indicating 10 or more. All participants reported experiencing Child Sexual Abuse (CSA) and 5 participants reported physical abuse as a child.
Skelly et al. (2013)	Total $n = 29$ Male $n = 15$ Female $n = 14$ Inpatients $n = 21$ Outpatients $n = 8$ Response rate: not stated	Age range: 25–75 Mean age: not reported No breakdown between male/female data	No ethnicity details reported.	Psychotic disorder $n = 10$ Bipolar disorder $n = 19$ All participants were recruited from an independent Irish Mental Health Service 9 participants reported previous involuntary admissions 13 reported experience of other mental health services

TABLE 3 (Continued)

Author and year	Number of study participants	Participants age	Participants ethnicity	Mental health status/admission types
Brophy et al. (2016b)	Total n = 66 Consumers = 30 (Male = 13; Female = 17) Supporters = 33 (Male = 7; Female = 29) Response rate: not reported	Age range: 20–70+ Mean age: not reported No breakdown between male/female data provided	No ethnicity details reported.	Not reported All the consumers had either experienced seclusion or restraint directly, witnessed these practices as in-patients or were consumer advocates who had directly supported people who had experienced seclusion and restraint. The supporter group consisted of people who had experienced a family member or person close to them being secluded or restrained. These included parents, siblings, marital partners, and two people who had advocacy roles.
Smith (1995)	Total n = 4 Female n = 3 Male n = 1 Response rate: not reported	Age range: 23–45 Mean age: 31.5 Male 28 Females 23, 30, 45.	No ethnicity details reported.	Bipolar disorder n = 1 Not reported for n = 3 Group meetings for manic depressive and depressed clients several individuals compared their experiences. Case 1—admitted herself to the hospital Case 2—attemped to hang herself while an inpatient on a psychiatric unit Case 3—had been in a psychiatric institution Case 4—admitted herself into an open psychiatric unit at a local hospital

Female participants in particular indicated that interaction with male staff was in itself ill-considered and of poor quality, resulting in traumatizing and re-traumatizing interactions. This occurred particularly where female patients were subject to restraint or injection by male staff:

While they're [males] ripping my clothes off ... I was nude.... They pulled my pants down and my underwear went down with it, and that was very embarrassing
(Gallop et al., 1999 p.411)

The data also illustrates that being harassed by staff and verbally abused also caused much distress. This caused patients to attempt to please the staff by keeping them happy:

Verbal abuse by staff [was the most traumatic aspect of treatment]. They make fun of our feelings, make me behave the way I don't want to. If I don't keep staff happy they will drop my level like a punishment.
(Lu et al., 2017 p.6)

Patient data also highlighted that lack of clear communication and explanation to patients going through the involuntary process was re-traumatizing:

They could at least have someone there to explain things a bit better because you don't get a good explanation about it [role of Tribunal]. You get told that you're going involuntary and that's it. You've no opinion like. In this day and age I just felt that was wrong
(Male, 23, ID37) (Murphy et al., 2017 p.24)

The data also indicates that where staff were seen to be unapproachable, showing little interest in patients there was a negative impact on patients:

My key worker has no dealings with me whatsoever and I may even pass her in the corridor and she doesn't even say hello, never mind actually to discuss your care. You know..... You're supposed to see your key worker within seventy two hours and I presume I did because I've vague recollections of her talking to me, but lately when I've been well, in inverted commas, she has shown no interest whatsoever. At the point where I'm ready to sort of communicate
(Skelly et al., 2013 p.1680)

Even in key legal settings such as tribunals participants found they were unable to talk openly, as their consultant would interrupt and would have to depend on what their solicitor would say:

I don't really get to say anything in there. So if I go to say anything Dr. [consultant's name] will butt in and

TABLE 4 Quality appraisal

	Vallarino et al. (2019)	Lu et al. (2017)	Murphy et al. (2017)	Brophy et al. (2016a)	Emrich et al. (2021)
Is there congruity between the stated philosophical perspective and the research methodology?	Unclear	Unclear	Unclear	Unclear	Unclear
Is there congruity between the research methodology and the research question or objectives?	YES	YES	YES	YES	YES
Is there congruity between the research methodology and the methods used to collect data?	YES	YES	YES	YES	YES
Is there congruity between the research methodology and the representation and analysis of data?	YES	YES	YES	YES	YES
Is there congruity between the research methodology and the interpretation of results?	YES	YES	YES	YES	YES
Is there a statement locating the researcher culturally or theoretically?	NO	NO	NO	NO	Unclear
Is the influence of the researcher on the research, and vice-versa, addressed?	NO	NO	NO	Unclear	YES
Are the participants, and their voices adequately represented?	YES	YES	YES	YES	YES
Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?	YES	YES	YES	YES	YES
Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?	YES	YES	YES	YES	YES

Note: KEY: Green = Yes, Red = No, Orange = Unclear.

[...] ...and you felt like you didn't get a chance to say anything only what the solicitor said
(Female, 68, ID4) (Murphy et al., 2017 p.24)

Patients suggest that everyone within the hospital environment from volunteers to security guards should be educated about how to manage patients with agitated behaviour rather than physically restraining them:

Education, and everybody talks about doctors and nurses receiving education, that's great, but the volunteers at the hospitals and the security guards really need to be educated that because somebody's displaying agitated behaviour does not give you the right to come and restrain them physically.
(Brophy et al., 2016a p.6)

Another negative consequence for patients was noted as arising out of poor communication between doctors and nursing staff:

I was told that I wasn't allowed out. Then [Doctor A] gave me a new medicine card and told me to go to the pharmacy, so I went to pharmacy for my drugs and came back and they (the staff) were searching for me.
(Bonner et al., 2002 p.468)

This kind of confusion and inconsistency amongst staff was seen as further adding to the power imbalance between patients and staff.

Dismissive staff, focused on paperwork rather than patient interactions, staff not listening to patient concerns, and staff using threats of restraint to silence patients, were cited as causing patients to adopt problematic strategies. These ranged from losing their temper, screaming, and shouting to get what they want, at the risk of physical restraint or losing their spirit:

I asked [the nurse] to use the phone and he said, 'use the pay phone', and I said to him, 'it's private and not for everyone to hear', and I was basically ignored. He says, 'Sorry, we're too busy' [for you to use the phone in the office]. and it's not until I start the screaming and the shouting and losing my temper that anything is done.
(Bonner et al., 2002 p.468)

Patients described that when staff would not listen to their wishes about care, specifically medication it negatively impacted their mental health, making them feel more frightened and alone:

All the nurses do is come in to torture you, stick needles in you. I cried, I screamed for help, I begged for mercy. No one ever responded to me. No one cared if I was dead or alive. I will never allow myself to be taken to a psychiatric institution again; I will kill myself first. Death is far preferable to life in such a place where torture is accepted as the norm. How can anyone working in such places think they are 'helping' anyone?

(Smith, 1995 p.25)

Bonner et al. (2002)	Hughes et al. (2009)	Sambrano and Cox (2013)	Ezeobebe et al. (2014)	Wynn (2004)	Gallop et al. (1999)	Skelly et al. (2013)	Brophy et al. (2016b)	Smith (1995)
Unclear	Unclear	Unclear	Unclear	Unclear	Unclear	Unclear	Unclear	Unclear
YES	YES	YES	YES	YES	YES	YES	YES	YES
YES	YES	YES	YES	YES	YES	YES	YES	YES
YES	YES	YES	YES	YES	YES	YES	YES	Unclear
YES	YES	YES	YES	YES	YES	YES	YES	Unclear
NO	NO	NO	NO	NO	NO	NO	NO	NO
NO	YES	NO	NO	Unclear	NO	YES	YES	NO
YES	YES	YES	YES	YES	YES	YES	YES	YES
YES	NO	YES	YES	YES	YES	NO	YES	NO
YES	YES	YES	YES	YES	YES	YES	YES	YES

In addition to the negative consequences of some staff interactions, poor staffing levels contributed to negative incidents where staff under pressure resorted to restraint and seclusion of patients rather than more appropriate responses:

Seclusion could have been avoided if the nurses were empathetic ... uh ... spoke to me in a positive way and acted as if ... ah ... um ... their supervisor was present ...
[Ricky] (Ezeobebe et al., 2014 p.308)

Participants often compared their admission to be like being at school again due to being told what to do by staff and being blamed when there was a problem:

I felt like I was back at school, cause they were administering the drugs, I was to take the drugs. If I didn't take the drugs it was my problem that I was coming back in. There was no sense of, you know, you have to have some part in what we going to give you: "Are you happy with what we're giving you? Why aren't you happy?"
(Skelly et al., 2013 p.1678)

Even where patients proactively sought changes, the data describes how requests would not be facilitated:

I was in for three months. I wrote and wrote letters to say that I wanted to move to a lady female doctor

or somebody who would understand me. And nobody could do that.

(Skelly et al., 2013 p.1678)

A striking response to the mistrust that incidents of poor quality staff interactions was that patients felt the need to both comply with and lie to staff to get discharged from the hospital sooner:

I did whatever they wanted, I answered the way I knew they wanted me to answer. The staff terrified me. I would never have told them the truth about how I felt: surely they would only "rape" me again. I feel betrayed, victimized, dehumanised. When they told me to take my clothes off for a strip search, I simply complied. They had already taken away all sense of self, all dignity. I could no longer defend myself. There was nothing left to defend myself. I did exactly what I was told to do, when to do it, how to do it. I lied about how I felt in order to get out of that prison. It took a week, but I was finally set free, my hands still swollen, my right thumb painfully numb at all times.

(Smith, 1995, p.25)

Patients contrasted the negative experiences they had with what they would have liked to experience, specifically around discussion of previous trauma:

TABLE 5 Analytic themes. Three main themes were elected from our findings: (1) Quality of staff; (2) Specific interventions, Sub themes (2a) nature of symptoms; and (3) Nature of the environment

<p>1. Quality of staff</p>	<p>"My therapist is aware of my feelings before I tell him.... When I am standing at the door before entering in his office, I know he can understand at first sight if I am going up!" (Vallarino et al., 2019 p.133)</p> <p>"Sometimes I feel my thoughts running, my sleep starts to be very fragmented, I become more talkative... I can work better and faster. I can get so much done. I can recognize some of the early signs of hypomania, but you know it's a sort of poisoned red apple... it's so attractive, I am afraid of telling my psychiatrist because you know what are the options: medications or hospitalization!" (Vallarino et al., 2019 p.133)</p> <p>"The psychiatrist said that pregnancy could have dangerous effects on mood and increase risk of relapses and the responsibility of being a good parent could be very stressful for me. I was depressed and I followed her recommendations for many years. Four years ago, she moved to another service and my new psychiatrist understood immediately my deep desire to become a mother. We made a plan and three months later I became pregnant! My little child is growing well, she is a joyful and smart young girl." (Vallarino et al., 2019 p.133)</p> <p>"Staff was taking clothes off for me when I took shower." (Lu et al., 2017 p.5)</p> <p>"Last hospitalization, I felt harassed by pts' and staff." (Lu et al., 2017 p.5)</p> <p>"The fact that I was restrained by three guys was the most traumatic." (Lu et al., 2017 p.6)</p> <p>"Verbal abuse by staff [was the most traumatic aspect of treatment]. They make fun of our feelings, make me behave the way I don't want to. If I don't keep staff happy they will drop my level like a punishment." (Lu et al., 2017 p.6)</p> <p>"I suppose it started off with the Gardai [Irish police] and they took a very caring 26 attitude. They seemed concerned. [...] When I got here [hospital] then, it was the nurse that actually brought me in, that kind of ran me through everything that kind of signed me in to the ward. It was caring as well. She was actually talking to me. [...] I just think that engagement in itself helped relax me. [...]" (Male, 37, ID5) (Murphy et al., 2017 p.26)</p> <p>"To be honest it was just like me walking in myself. That's how it felt. It didn't feel bad. It really didn't in fairness. I was treated just like any other person that would walk in off the street, I'd say. They weren't bad-minded to me or talk down to me or, they just treated me like a normal person, which was good, do you know" (Female, 44, ID50) (Murphy et al., 2017 p.26)</p> <p>"And then she said "if you ever need to talk, just get the nurses to get me and I'll talk to you" like, you know. She's very down-to-earth. Very civil and everything like, you know. [...] Because she'd talk to you like she was a friend of yours like, you know" (Male, 47, ID33) (Murphy et al., 2017 p.26)</p> <p>"And they're willing to listen and even though they go by the book as well, they're willing to adjust" (Male, 39, ID29) (Murphy et al., 2017 p.26)</p> <p>"No, I was given plenty of information [about detention]. I had somebody come to me and talk to me. They gave me the mental health booklet. Somebody talked to me about the tribunal. Nurses came over to me regularly and asked me what was going on. They were very insightful at the time; I found regarding what was happening to me and what would possibly happen next." (Male, 37, ID5) (Murphy et al., 2017 p.26)</p> <p>"I don't really get to say anything in there. So if I go to say anything Dr. [consultant's name] will butt in and [...] ...and you felt like you didn't get a chance to say anything only what the solicitor said" (Female, 68, ID4) (Murphy et al., 2017 p.24)</p> <p>"I was sure that someone I knew would come and help me. Trying to find a voice, like, I remember lying down on the floor, all the men [members of the assisted admission team] pushing me down and I was trying to find a voice I could recognise, someone I knew to say "please, help me. I haven't done anything wrong." (Female, 30, ID19) (Murphy et al., 2017 p.24)</p> <p>"So, I kept getting these letters [about tribunal] then, all the time getting these letters. I'd come back from lunch and there would be a letter on my pillow, which was very annoying because there was no one to talk to about it" (Female, 60, ID30) (Murphy et al., 2017 p.24)</p> <p>"They could at least have someone there to explain things a bit better because you don't get a good explanation about it [role of Tribunal]. You get told that you're going involuntary and that's it. You've no opinion like. In this day and age I just felt that was wrong. [...] Just to have someone there to explain things a bit better really. At least that way then you know what's going on" (Male, 23, ID37) (Murphy et al., 2017 p.24)</p> <p>"The last time it started with the police tackling me and putting me in a paddy wagon but putting me on my stomach and leaving the cuffs on that was about the worst part of it...I was saying I can do no harm and I still got tackled." (Brophy et al., 2016a p.6)</p> <p>"Education, and everybody talks about doctors and nurses receiving education, that's great, but the volunteers at the hospitals and the security guards really need to be educated that because somebody's displaying agitated behaviour does not give you the right to come and restrain them physically." (Brophy et al., 2016a p.6)</p> <p>"There's no accountability in these places. The staff are overworked. If somebody's getting strung out over something it's just too easy. In fact if they want to actually get rid of them they've only got to aggravate him and then they've got an excuse to restrain. And that happens, I've seen that." (Brophy et al., 2016a p.6)</p> <p>"You'll go talk to them and they seem run off their feet and angry and stuff, and they take it, then their mood affects everyone else, because they're usually carrying on. Sometimes they're just as bad as people on the ward." (Brophy et al., 2016a p.8)</p> <p>"Staff are frightened, police officers are probably frightened too, like people don't necessarily have those connections, like staff in hospitals don't always have connections with people that are like deep enough to, or like genuine enough to talk to people when they're in really bad distress, and I think it's not necessarily that the staff are really bad, it's just that there's not the money for them to spend the time that they would need to spend... I think there's all that stuff, there's a culture of fear in Australia like fear of difference, I think that adds to it." (Brophy et al., 2016a p.8)</p>
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TABLE 5 (Continued)

- "They're overworked and there isn't genuinely enough staff" (Emrich et al., 2021 p.158)
- "The worst I have ever been dealt with by anyone in the whole of my past, that was just wrong" (Emrich et al., 2021 p.158)
- "I was told that I wasn't allowed out. Then [Doctor A] gave me a new medicine card and told me to go to the pharmacy, so I went to pharmacy for my drugs and came back and they were searching for me. [The doctor] has sent me to the pharmacy because she's known me so long, and yet I'm not supposed to be allowed out. So what do you do? You don't know where you stand here." (Bonner et al., 2002 p.468)
- "They didn't want to know much. They should sit and talk to the patient. They should understand that you're in hospital because you're unwell." (Bonner et al., 2002 p.468)
- "I asked [the nurse] to use the phone and he said, 'use the pay phone', and I said to him, 'it's private and not for everyone to hear', and I was basically ignored. He says, 'Sorry, we're too busy' [for you to use the phone in the office] and it's not until I start the screaming and the shouting and losing my temper that anything is done." (Bonner et al., 2002 p.468)
- "It was unfair, males restraining me. I didn't like that. Males are stronger than females and hurt more when they're restraining you." (Bonner et al., 2002 p.468)
- "Disgusted that a male nurse was present... it was bad enough having the injection without the embarrassment of having a male nurse present. Only female nurses should be present when restraint or injections are given to female patients." (Bonner et al., 2002 p.468)
- "don't know why they didn't sit down and talk to me. I'd been in a mute state. I thought that they'd try to come and speak to me. After [the incident] a student nurse came and spoke to me. It was the first conversation I had in days. I found that helpful. The ward staff involved were unapproachable." (Bonner et al., 2002 p.469)
- "Crying on [Nurse B's] shoulder was helpful. The fact that he just let me cry on his shoulder." (Bonner et al., 2002 p.469)
- "I've seen some of my records. It's helped to look at the impression that they had of me at the time. It's helped to build a better picture. The nurses have sat down with me and gone through my records with me. It feels better to look back with a better insight. You can see where you were going wrong. You can see where to make changes or where you've made changes. The nurses talking to me [subsequently] had helped. [Nurse C] just talking through incidents with me helps you feel calmer about it. It was good to talk it through afterwards especially if there has been awkwardness during the restraint." (Bonner et al., 2002 p.469)
- "They never talked about it to me. That would have helped. If somebody had sat down and talked it through with me." (Bonner et al., 2002 p.469)
- "They haven't discussed it with me, they haven't asked me how I felt or why I did it." (Bonner et al., 2002 p.469)
- "caring people" (Felicity) (Hughes et al., 2009 p.156)
- "really high standard of care" (Cherie) (Hughes et al., 2009 p.156)
- "gadlers" (Ben) (Hughes et al., 2009 p.156)
- "just doing their job" (Ian) (Hughes et al., 2009 p.156)
- "I used to plead with them and plead with them (tearful), please don't give me that [medication]. And of course that used to make me more crazy, because I didn't know where to turn, I didn't know what to do (crying) [...] the more bad I was, the more I knew I was going to be medicated, so the more crazy I got, because I was terrified." (Annie) (Hughes et al., 2009 p.157)
- "How the nurses talk to them up there, it very, very, very rude. They can have just a question and they get a bad response back. A real bad response like 'don't mess with us coz I work here', you know?" (Peter) (Sambrano & Cox, 2013 p. 527)
- "That was the only thing: I just got wild how I was treated. They took my, they sort of like, broke my spirit" (Peter) (Sambrano & Cox, 2013 p. 527)
- "They were pumping me up with most all the drugs they were giving me. When I was first locked, they sort of like took me from my reality, into a person that was dopey, not worried about how they were thinking about me and how they were treating me, like rubbish." (Peter) (Sambrano & Cox, 2013 p. 527)
- "Well they put me in isolation and I needed to go to the toilet. I'm knocking, knock, knock, knock. [Calling] '[Come on, I need to go toilet. Can someone open up please?]' Nothing, nothing, nothing. So, [calling again] 'I need to go the toilet can someone open up please?' I thought oh stuff this ok. Pee my pants. Then I laid down and I was wet laid down and wait till they come in to let me out. Then I had to clean the mess up then I could get back into the ward ... [I thought] Oh, just smart arseholes, fine I'll clean the mess up kind of attitude." (Ani) (Sambrano & Cox, 2013 p. 527)
- "I blacked out, when they pinned me down. I blanked out from that stab wound in the head ... it wasn't even treated! It wasn't even treated! They just locked me up with my stab wound in the head! I had headaches for about 3 days, no medic ... no aspirins, or no Panadol or anything to stop the headaches; I thought I would have had a blood clot in my head or anything like that. I could have been dead!" (Peter) (Sambrano & Cox, 2013 p. 528)
- "I cannot get things that I want to do or get out ... Nobody was listening ... Uh ... I mean ... The doors are shut behind you ... And you are there alone ..." (John) (Ezebebe et al., 2014 p.307)
- "I felt violated.. I felt everything had been stripped from me.. I felt ashamed because I wanted to cooperate with the staff, you know" (Mary) (Ezebebe et al., 2014 p.307)
- "The nurse told me to take my medicines ... the nurse did not explain the situation to me ... rather ... uh ... the nurse called four big guys and they held me ... the nurse refused to listen to me ... uh ... I was ... um ... I was afraid and powerless ... I did not know what they were going to do to me ... I did not have any family at this hospital and uh ... you know ... they outnumbered me ... I was not able to concentrate ... I felt I was going to die" (Latasha) (Ezebebe et al., 2014 p.307)

(Continues)

TABLE 5 (Continued)

"The nurse should use a calm tone of voice to talk to me ... answer my questions ... have compassion ... don't be violent towards the patient no matter how frustrated the nurse gets ... uh ... I mean ... the nurse should just walk away." [Jose] (Ezeobebe et al., 2014 p.307)

"I was kicking the door and screaming because somebody was pumping gas through a tube inside the room ... the staff was instigating and inciting my behavior ... ah.... I feel that the staff do not care ... uh ... I am angry at them and feel like hurting staff." [Jim] (Ezeobebe et al., 2014 p.308)

"I would rather go without asking a technician for help ... they only want to sit on their chair relaxed ... they have too much pride, uh ... no ... humility ... uh ... I think ... they need to choose if they want to be a servant or a King ... um ... to be a servant is the most humble thing to do ... uh ... I felt violated ... by the way they treated me." [Jake] (Ezeobebe et al., 2014 p.308)

"The nurses hollered at me ... spoke to me in a derogatory tone ... and made jokes ... the nurse should have ... ah ... listened to me ... uh ... before responding and not ... uh ... reacting to my verbiage of calling them stupid, ignorant and belligerent" [Ricky] (Ezeobebe et al., 2014 p.308)

"Seclusion could have been avoided if the nurses were empathetic ... uh ... spoke to me in a positive way and acted as if ... ah ... um ... their supervisor was present ... " [Ricky] (Ezeobebe et al., 2014 p.308)

"I did not know why I was secluded ... I was angry and told staff to get out of my room ... staff said I was yelling too long ... the nurses got some guys and I was escorted to the seclusion room ... the nurse did not tell me why I was being secluded" [Rebecca] (Ezeobebe et al., 2014 p.308)

"Staff should use one person that the patient knows and trusts to talk to them ... if staff would have talked to me and say ah ... you are not supposed to do that ... instead of yelling at me like a child ... the staff should listen before responding ... they need to learn how to talk to patients with respect ... learn how to communicate with us all over again." [Bill] (Ezeobebe et al., 2014 p.308)

"Staff said I would be restrained if I didn't calm down" (Wynn, 2004 p130)

"If they had asked "what is this?" then I could have responded that I was terribly anxious and needed to get the aggression out of my system ... then we could get into a dialogue that could make the use of restraint completely unnecessary" (Wynn, 2004 p131)

"I think things would have turned out better ... if they had just left me alone in my room" (Wynn, 2004 p131)

"I had only one thought in my head ... and that was to defend myself against them ... and they were five men." (Wynn, 2004 p131)

"I think they treated me badly" (Wynn, 2004 p133)

"I had just received a Dear John letter.... I was very upset; I started banging my head and hitting my head with my hands, and all of a sudden there were five or six people around me and they picked me up and carried me with my face to the floor." (Gallop et al., 1999 p.406)

"I was feeling really bad being in the hospital.... At lunch ... a nurse, she was a patient from another hospital, ... started blasting me how she didn't understand how women who had children could be suicidal. I just lost it.... I threw my tray ... went to my room and right away they called the doctor, didn't want to talk to me to find out what was wrong. I had to have an injection and I didn't want it ... locked myself in the bathroom ... eight people dragged me into isolation ... and my family were in the hall and they pulled me in front of my daughter." (Gallop et al., 1999 p.407)

"We were never allowed to talk about it in the hospital, and they [staff] used to say we were just behaving the way we did to get attention" (Gallop et al., 1999 p.408)

"They helped me a little bit.... They could handle it. But we weren't allowed to talk to anyone else about abuse.... At interaction groups we weren't allowed to say we were abused, because they told us it would upset other patients too much." (Gallop et al., 1999 p.408)

"But they didn't talk to you about it or express concern or relate it to what was happening with you" (Gallop et al., 1999 p.408)

"They didn't talk to me at all about my past, just what brought you in this time.... I don't really get to talk to people" (Gallop et al., 1999 p.408)

"The worse thing they can do is treat us like a child and punish us.... It seems like a control issue.... It was very demeaning" (Gallop et al., 1999 p.409)

"They would talk about me like I wasn't there, but they wouldn't talk to me, they seemed hostile" (Gallop et al., 1999 p.409)

"At night shift, I could hear them reading my file and laughing at me, reading about, you know, things from my past.... I felt like I was an object" (Gallop et al., 1999 p.409)

"Treating me like a child, locking me up ... punishing me" (Gallop et al., 1999 p.409)

"It's all these guys," (Gallop et al., 1999 p.410)

"It's usually male, too, usually so huge." (Gallop et al., 1999 p.410)

"They were all bigger than I was." (Gallop et al., 1999 p.410)

"They would just drug me and eventually I'll lose my will to fight." (Gallop et al., 1999 p.410)

"They're allowed to do whatever they want." (Gallop et al., 1999 p.410)

"I was so incapacitated with these restraints ... couldn't do anything ... couldn't move." (Gallop et al., 1999 p.410)

"They overpowered me ... completely subdued ... couldn't cry out." (Gallop et al., 1999 p.410)

TABLE 5 (Continued)

- "He really had a grip on me. And they took me to my room.... They had me spread-eagle again, and that's terrible. If only when they restrain you your legs could be together.... It's like you're ready to be raped. It really is a violent vulnerability." (Gallop et al., 1999 p.411)
- "While they're [names] ripping my clothes off ... I was nude.... They pulled my pants down and my underwear went down with it, and that was very embarrassing" (Gallop et al., 1999 p.411)
- "They do everything, and they shine on the ward. Then there are the others who have been around long enough and stereotype everyone" (Gallop et al., 1999 p.411)
- "More into paperwork" (Gallop et al., 1999 p.412)
- "Not being involved with patients." (Gallop et al., 1999 p.412)
- "She'd come round and make herself known, you know, in the morning. She'd say, 'I'm [name], I'm your nurse for the day,' put her number on the board then. But it's actually written on the board from my place out in the corridor, but I never really look at it. She could kind of make herself more known." (Skelly et al., 2013 p.1676)
- "Here in my experience, I find, with the exception of a few nurses, an awful lot of the nurses never approach you, never sp—. You could go five days without even having any interaction with any of the nurses. There's nobody taking active interest." (Skelly et al., 2013 p.1676)
- "I didn't get to see a doctor for five nights. Now, I have shaken hands with my doctor now and we've gotten over that, but I had to write a comment card and highlight what they're saying in the comment card: "Mental health matters." And I said, "This is ludicrous." I'd go see a doctor in the middle of the night to get me off the Rivotril in the morning and then I saw my doctor to get Valium during the day. Now, that's not being looked after. Five whole days." (Skelly et al., 2013 p.1676)
- "He walked out in front of me and said, "If you aren't feeling better, come back." Like, he didn't listen and walked out the door in front of me. He wrote something down, just took the pile [of medical charts] up and walked out." (Skelly et al., 2013 p.1676)
- "She's thorough. She tries to get to the bottom of the problem. And she goes into it, detail with you." (Skelly et al., 2013 p.1677)
- "One issue I brought up a couple of nights ago, the nurse poo-hooped it and put it down to something which it's not. I said it to the doctor today and he said he'll look into it, as to why this is happening—a problem in my body as a result, I believe, of the tablets." (Skelly et al., 2013 p.1677)
- "I was put on Largactil one time and one morning the nurse said, "Ah, I don't think you need that Serenace," which was to counteract the side effects. And then following that I got this lockjaw, my knees were shaking. I said it to the nurse the following morning and she said I don't—, you know, she wouldn't give me the Serenace again. And I asked her, "Well then, to what would you attribute these problems that I'm having?" Anyway, she called the doctor and it was the registrar came in, and when I held out my hands for her she said, "Oh." She gave it away. "Oh, you are shaking." (Skelly et al., 2013 p.1677)
- "You tell them something, they don't believe what you're telling them, and it's often a, one hundred percent true.... I think it lengthens your stay." (Skelly et al., 2013 p.1677)
- "I don't know if it's because I'm unwell and I'm getting a little bit paranoid or something, they really kind of have to dismiss you a lot and it's kind of like they don't want to feed into your behavior at all because you might get a little bit higher, but it drove me mad.... When you do get sick you come into hospital because you really need to be taken care of, but it's just a bit—, doesn't feel nice when you are an adult and people are treating you like that." (Skelly et al., 2013 p.1677)
- "He just he wrote me off, basically, because I was diagnosed with paranoid schizophrenia." (Skelly et al., 2013 p.1677)
- "When you get to the inevitable sad bits, he sort of said, "Awh." And that really sounded so insincere. I could almost see the textbook page there in front of me: "At this point, one should sympathize or empathize with the patient, perhaps say, "Awh." (Skelly et al., 2013 p.1677)
- "I find even though they're very busy doing their work, the nurses, they'll smile to you as they go along." (Skelly et al., 2013 p.1677)
- "It was a lot of noise in the corridor.... I was in the chair looking up to him and he opened the door and he shouted vulgarities at the patients, shut the door, and continued to talk to me for about two minutes before he said, "You're not allowed out again" or whatever. But I thought it was so unfair to me for him to open the door and use the f-word on somebody that wasn't well.... It was a very traumatic experience because I was in a bad state when I got there" (Skelly et al., 2013 p.1677)
- "I tried to change doctors and I sent letters and letters. And I got nothing back. And this time, I sent letters and I got responses back for each one with a reference code. And then [names staff member], I don't know if you've heard of her, very nice lady, she runs all the comments maybe. So she came down and said that my comments would be looked at." (Skelly et al., 2013 p.1678)
- "I was in for three months. I wrote and wrote letters to say that I wanted to move to a lady female doctor or somebody who would understand me. And nobody could do that. So I had to lie to get out. Unfortunately." (Skelly et al., 2013 p.1678)
- "I had a very negative impression of them until this time. There's been a positive change on both sides in terms of I'm more approachable, in terms of giving out information, telling them the truth. All that sort of stuff about how I feel." (Skelly et al., 2013 p.1678)
- "They've definitely come towards giving me what I need which is, you know, more responsibility for my tablets. And they give me more choice in what I'm taking. They've been very quick in changing my medication to what I would like it to be, so there's been a definite improvement." (Skelly et al., 2013 p.1678)
- "I asked him, in case I get sick—I always had that from my other doctor—that if I got sick he'd tell you when he was going on his holidays and who his registrars were, they were good, they were bad. Or if you didn't want to see a registrar, some other consultant would see you. And I asked this particular doctor. "Oh that. I'm going away for a few weeks. That will all be taken care of while I'm away." And didn't tell me anything. I was sorry that I asked." (Skelly et al., 2013 p.1678)

(Continues)

TABLE 5 (Continued)

- "My family aren't being involved in the issues I don't want them to be involved in and they are involved in the issues that I'm comfortable with them being involved in. And there's a really open dialogue with me and the consultant and also the psychologist about what's being discussed and what isn't being discussed." (Skelly et al., 2013 p.1678)
- "It was the art of persuasion that introduced me to Olanzapine. Whereas, in the public system, I was forced, physically forced to take it.... There wasn't, oh there wasn't even a question of the nurse saying, "Oh listen, just take it tonight and talk to the consultant in the morning," or "Yeah, that's okay, you can discuss it with your consultant." It was just one-way dialogue. It was just getting—, forcing me to take it." (Skelly et al., 2013 p.1678)
- "Even though they say you're the expert on your own care, you don't have the medical know-all so therefore you have to trust that they are working in the best interest for you." (Skelly et al., 2013 p.1678)
- "Sometimes you're asked to do things and you don't feel up to it or you don't feel you're ready for it, but I suppose without that push when would you ever be ready for it? So I suppose sometimes you just have to trust that they know what they're doing and go with their experience." (Skelly et al., 2013 p.1678)
- "I felt like I was back at school, cause they were administering the drugs, I was to take the drugs. If I didn't take the drugs it was my problem that I was coming back in. There was no sense of, you know, you have to have some part in what we're giving you? Why aren't you happy?" (Skelly et al., 2013 p.1678)
- "There'd be four or five different doctors and nurses and they'd be all sitting around you, all talking to you and telling you what this is and that is. And you just felt like, I don't know, like you're a school kid that was sitting on a little chair being told, "Now you've been doing this and now you should be doing this." ... It just seemed really kind of impersonal. I didn't feel like I had a chance to somehow put my input into it or maybe even have any design in my own treatment. I know I was particularly unwell but it just felt like all the power was completely taken away from me." (Skelly et al., 2013 p.1678)
- "I think we should slowly or quickly try get away from putting psychiatrists and their ilk high up on pedestals, where they almost become little gods in their own area. At the end of the day they're doctors. And I think that they've— across the whole system, private or public—far too much power.... They need to be more hands on and getting away from the old fashioned, "The doctor knows best." Sometimes I know best, and I want that to be heard and I want to feel that I'm being heard." (Skelly et al., 2013 p.1679)
- "got a kick out of hurting others." (Skelly et al., 2013 p.1679)
- "This is what we're witnessing every day and it's quite alarming.... It's only when ... one particular nurse is in, then I feel safe." (Skelly et al., 2013 p.1680)
- "[Staff member] said to me today, "Do you want to fill in one of those depression forms?" And I had filled in one for [staff member] when I was due for CBT [cognitive behavioral therapy], and I was erring on the side of caution and sort of giving myself marks and suddenly she said to me, "Oh, you're not ready for CBT." And I said, "Bloody hell! I've been waiting fecking eight weeks to get some sort of therapy here and now because I've filled this form in—." Whereas when you're chatting one on one with a patient like that, who has a similar condition to yourself, you have none of those concerns, you know?" (Skelly et al., 2013 p.1680)
- "My key worker has no dealings with me whatsoever and I may even pass her in the corridor and she doesn't even say hello, never mind actually to discuss your care. you know.... You're supposed to see your key worker within seventy two hours and I presume I did because I've vague recollections of her talking to me, but lately when I've been well, in inverted commas, she has shown no interest whatsoever. At the point where I'm ready to sort of communicate." (Skelly et al., 2013 p.1680)
- "Participant 1 (P1): I've never met my key work nurse outside of the seventy-two hours, which—, the window is really difficult because that window is where you're at your worst. P2: When you are at your most vulnerable. P1: You don't tend to say what you want to say or you can't really function properly in those seventy-two hours." (Skelly et al., 2013 p.1680)
- "It's so easy to kid ourselves that we're in compliance when we haven't really sat down and thought carefully enough about, What is the role of this key nurse? What things should we expect from her? So that if she's not doing those things we can be able to measure that.... We've best practices and procedures and then we like to tell ourselves that we're complying with them. Whereas, in the back of our mind, we're thinking, "They're not really that important anyway," or "You couldn't possibly do all that," you know? And certainly I got that feeling from my key worker that she felt, "Well, with everything else I'm expected to do on the ward, I couldn't possibly have time and energy to fulfill the role of the key worker as well." (Skelly et al., 2013 p.1680)
- "Having peer workers available and on the spot definitely does I guess make people feel a bit more secure, that number one they're being listened to, and obviously if the consumer consultant is sitting there, you know, the nurses are not going to come up and start saying something really terrible to that person at that point right then and there" (Brophy et al., 2016b p.603)
- "So I think carers play a really important role in making sure that you're safe. Just because you've got that level of trust with someone who can actually, you can actually sort of feel like they can carry that burden for you." (Consumer) (Brophy et al., 2016b p.603)
- "I came into the hospital voluntarily, I trusted the staff would be there to help me, not hurt me" (Smith, 1995, p.24)
- "I just totally lost it this time. Psychologically, I couldn't take any more. I became that abused 12-year-old again. I fought with every ounce of strength I had left in me, but it was a lost battle. No one cared, no one helped me" (Smith, 1995, p.25)
- "I did whatever they wanted, I answered the way I knew they wanted me to answer. The staff terrified me. I would never have told them the truth about how I felt: surely they would only "rape" me again. I feel betrayed, victimised, dehumanised. When they told me to take my clothes off for a strip search, I simply complied. They had already taken away all sense of self, all dignity. I could no longer defend myself. There was nothing left to defend myself. I did exactly what I was told to do, when to do it, how to do it. I lied about how I felt in order to get out of that prison. It took a week, but I was finally set free, my hands still swollen, my right thumb painfully numb at all times." (Smith, 1995, p.25)

TABLE 5 (Continued)

<p>"People I trusted to help me when I reached out for help punished me for becoming manic. They may not have raped me vaginally, but they most certainly raped me emotionally, psychologically and spiritually." (Smith, 1995, p.25)</p>	<p>"My bipolar illness can be controlled with medications. The trauma I experienced in hospital with staff and family is not so easy to resolve" (Smith, 1995, p.25)</p> <p>"Now I have intense flashbacks of being attacked at the hospital, as well as flashbacks of being raped. They are one and the same to me." (Smith, 1995, p.25)</p> <p>"All the nurses do is come in to torture you, stick needles in you. I cried, I screamed for help. I begged for mercy. No one ever responded to me. No one cared if I was dead or alive. I will never allow myself to be taken to a psychiatric institution again; I will kill myself first. Death is far preferable to life in such a place where torture is accepted as the norm. How can anyone working in such places think they are 'helping' anyone?" (Smith, 1995 p.25)</p> <p>"Oh, I figured out that if I could just get released from the restraints, I could take my way into being discharged." (Smith, 1995 p.25)</p> <p>"I guess the absolute worst part of it for me was I was totally at their mercy; I had no control over anything. They could do whatever they wanted to, whenever they wanted to. It was no different than being abused while growing up" (Smith, 1995 p.26)</p> <p>"I finally checked myself into an open psychiatric unit at a local hospital. There nurses greeted me friendly enough, assuring me I could tell them anything or if I needed help. I didn't feel like meeting other patients; I guess I was afraid of them" (Smith, 1995 p.26)</p> <p>"I just wanted to get rid of the panic attacks and the flashbacks. He noticed my writings and asked to see them. I agreed- I trusted him. I quickly learned I had made a terrible error in. He had shared part of my writings, the part about wanting to hurt myself, with the nursing staff. Before I had the chance to explain anything, a large group of nursing staff rushed into my room, grabbed me and dragged me to lock me up. I had trusted them; I had trusted my uncle. I will never trust another nurse or doctor ever again. They did not listen to me; they did not even bother to read all that I had written. They 'helped' by hurting me all over again. I will never forget what they did to me. I will never again ask for help" (Smith, 1995 p.26)</p>
<p>2. Specific interventions</p>	<p>"I spent many years very depressed and lithium was completely ineffective. I decided to start a psychotherapy thanks to my parents who supported me financially. I could not afford it alone and the psychologist of the mental health center could only see me once a month, or sometimes once every two months." (Vallarino et al., 2019 p.132)</p> <p>"In the mental health center where I went for my routine visits, I asked my psychiatrist if I could have some psychological support, but I felt like I was asking for a pot of gold. I would like to know if there were some treatments that could help me to recover in addition to medication" (Vallarino et al., 2019 p.132)</p> <p>"I began to realize that there is life beyond the illness. I was more than just "bipolar". I am a good cook, I can speak three languages, I am an aunt, I am a good friend when I am not ill... and other many things. I worked hard with my therapist. Now when I speak with other people I choose to say that "I have a bipolar disorder because it reminds me that I am not limited to the label, I am definitely more than this!" (Vallarino et al., 2019 p.132)</p> <p>"Looking at the other group participants, I saw myself where I was before the psychotherapy...angry, chaotic, confuse and deeply alone. On the other side, some members of the group helped me in determining what kind of person I would become in the future. One of the best parts of this group was the interaction with other participants... sharing experiences, as most people cannot understand in everyday life" (Vallarino et al., 2019 p.132)</p> <p>"It was nice to be around people who know how you feel and what you have been through, I felt like I was being "protected". I am still in contact with a couple of people, for my birthday they sent me a pretty birthday card: I was really touched! (Vallarino et al., 2019 p.132)</p> <p>"We were eight people and everyone had their own story. I felt lucky listening to other stories. I have a family that emotionally supports and loves me, but some people were completely alone. I felt bad for them, especially for a young woman who lived in a residential facility, she could not even take her cats there! I felt very miserable and touched by her story, although she had a very hard life, she always had a word of comfort and kindness for all of us." (Vallarino et al., 2019 p.132)</p> <p>"I had prolixin injection, could not sit or stand still after injection." (Lu et al., 2017 p.5)</p> <p>"Medicines make me fat and destroyed my beauty." (Lu et al., 2017 p.5)</p> <p>"Taking bad medications with side effects [was really traumatic]. The psychiatrist gave me a lot of milligrams of medications. After taking them, I could not walk. I felt like I was drunk. It felt like I was being poisoned by the medications." (Lu et al., 2017 p.6)</p> <p>"...put you in a cell that has no toilet and no air and leave you there for 10 hours and then you'll be cured, and it's not...you go in there seeking help and surviving the traumas in your life, but you end up having to cope with even more trauma. It's pointless." (Brophy et al., 2016a p.4)</p> <p>"Deny people their freedom, for example if it's restraint of freedom of movement, or the freedom to ask questions, the freedom to be able to interact with other people, I mean isolation basically is almost another form of punishment, you've been bad, you've done something wrong. I mean that's how I see somebody being isolated. And takes that confidence away, because you must be bad so you are in isolation." (Brophy et al., 2016a p.5)</p> <p>"Seclusion and restraint, the very practices themselves, are sort of very anti-recovery...[Recovery is] all about self-responsibility, self-direction, and then seclusion and restraint is all about someone else's control, so it doesn't actually sit with recovery at all." (Brophy et al., 2016a p.6)</p>

(Continues)

TABLE 5 (Continued)

- "So it's not the best, it's not the nicest, yeah it's pretty horrible...you start to lose your mind." (Brophy et al., 2016a p.6)
- "It's pretty hard because you can't even use like some of your strategies you'd use at home because you're just in these four walls." (Brophy et al., 2016a p.6)
- "That undue use of power which is sometimes invoked with trying to seclude or restrain people, it comes right down to even when they start that aggressive behaviour management training" (Brophy et al., 2016a p.6)
- "To me the restraint is about bringing you into line with a way of thinking about doing what's best for you...Seclusion and restraint is about compliance." (Brophy et al., 2016a p.6)
- "They literally took me, 5 of them, I didn't resist if you like but I didn't help, they took me round there and jabbed me in my ass ... and when I actually walked out of that room I turned to[name], the ward manager and to others who are with him and said I'm just going to leave this in here, that was morally corrupt, deal with that ... I never ever had anything like that happen to me before, you know I wasn't bawling my eyes out but I actually felt that I'd literally had a kind of human right there denied me." (Sebastian) (Emrich et al., 2021 p.160)
- "you are laid flat, like you are dead or something. And then you are gradually, with medication and various things, you are built up [...]. But] you don't have any relationship with yourself, you don't know what you were like before, you don't know what you're going to be like. (Sandra)" (Hughes et al., 2009 p.155)
- "they [mental health professionals] are looking for. I had little plans to work my way through the day ... I used to clean my room, and make my bed, and try to, to occupy myself with activities, that were per se, done by everybody else in the community in their normal lives. (Ben)" (Hughes et al., 2009 p.156)
- "talking to my mum [...] convinced me that I needed help" (Jake). (Hughes et al., 2009 p.156)
- "They used to take away my furniture, so I was left with a mattress on the floor. And, no sheets, no bedding [...] So those were the ways that they used to punish me." (Annie) (Hughes et al., 2009 p.156)
- "without the medication I wouldn't have become well again" (Cherie) (Hughes et al., 2009 p.157)
- "I couldn't talk, my mouth was locking, my mouth was like twisting, it really hurt [...] And I couldn't talk to let them know what was wrong." (Ian) (Hughes et al., 2009 p.157)
- "they gave me medication where I couldn't breathe [...] I couldn't sit down [...] and I felt drowsy, tired. Not the kind of drowsy where you think, oh, I'll have a good night's sleep. It's the kind of drowsy where you think, oh, I'm going to die in a minute." (Ian) (Hughes et al., 2009 p.157)
- "They took me back to the room, they put me face down on the bed, actually holding my face into the cushions, so that I couldn't breathe. I was fighting and fighting. And they were saying, um, go on, pull her trousers down and stick it in her arse. I thought they were raping me." (Sarah) (Hughes et al., 2009 p.157)
- "I'd get forced! I'd get forced! They would just take me to seclusion and just give me the injection! And they just leave me for the night let me out in the morning. You know? And when I'm there, and, Ahhh!!!" (Peter) (Sambrano & Cox, 2013 p. 525)
- "I came back to the ward and I started getting noisy and that. I wasn't violent, I was just angry. So they put me in seclusion and gave me a needle" [Daniel] (Sambrano & Cox, 2013 p. 525)
- "Or something just to show, don't mess with them. Don't mess with their standards and all that kind of stuff coz you get locked up" [Peter] (Sambrano & Cox, 2013 p. 526)
- "Oh! Just getting your head shoved into the ground, being aroused by security. Having your arms tied behind your back. Not being able to move, yelling, trying to yell to get them off you ... Oh Jesus, let me go please! Just leave me alone!" [Ani] (Sambrano & Cox, 2013 p. 526)
- "And there was one time they hog-tied me. They got me on the ground and put my legs and arms up behind me and held me down. It was kind of like being hog-tied. That was very distressing coz I couldn't breathe normally when I was under a lot of pressure ... I think the nurses, when it comes to seclusion, they are very heavy handed. When it comes to putting someone in seclusion ... the nurses hold you, you've got your arms behind your back or they hold your clothes. It feels like you want to break free but you can't. And the nurses won't let you go. That's why it feels heavy handed. Coz you're trying to break out of it but they won't let you go." [Daniel] (Sambrano & Cox, 2013 p. 526)
- "They could a strung me up with my socks or something like that. Said I got access to my socks and hung myself. They would cover it all up, the fucking white pricks ... it makes me angry. They do that to, you know, all the Murriss [Murriss is the term that some Indigenous people in southeast Queensland and the border regions of New South Wales use as a cultural identifier]." [Peter] (Sambrano & Cox, 2013 p. 526)
- "Told a nurse at hospital 'here's your fucking medication, now get fucked I'm not having it'. She put four to six nurses on me, throw me into the room. So I sang Amazing Grace for about 3 hours that day. Three or 4 hours till they let me out" [Ani] (Sambrano & Cox, 2013 p. 527)
- "In isolation they drug you up. So you're just going around like this ... [shows the researcher a zombie-like expression]. And then you can't even talk properly and the talk is all blah, blah, blah, frothing at the mouth, dribbles all that." [Ani] (Sambrano & Cox, 2013 p. 527)
- "Seclusion calmed me down ... I guess it is a 'cool down' room.... Um ... hm ... I felt good ... and ... I had good communication with God ... and ... I was praying to God to forgive my actions." [Mike] (Ezebebe et al., 2014 p.308)
- "That one in some cases may have to use restraint ... that's certain" (Wynn, 2004 p131)
- "Being in restraint made me scared and aggressive" (Wynn, 2004 p132)
- "One reported flashbacks while in restraint and said it reminded her of 'awful things that happened to me as a child' (Wynn, 2004 p132)
- "Being in restraint calmed me down" (Wynn, 2004 p132)
- "The worst part was not being able to move my body ... I was completely helpless" (Wynn, 2004 p132)

TABLE 5 (Continued)

- "Spending so much time in restraint was not a positive experience" (Wynn, 2004 p.133)
- "it was completely unnecessary ... it was an abusive act" (Wynn, 2004 p.133)
- "it wasn't such a big deal ... I've been in restraint before" (Wynn, 2004 p.133)
- "These four attendants or nurses ... all male ... about six feet tall but I just kicked and screamed ... and I kicked them in the shins ... and they threw down on the bed, on my face, and they restrained me and they injected me." (Gallop et al., 1999 p.407)
- "For some reason I was fighting with the nurse and it wasn't physical and then it got physical. I was pushing on her shoulder and she was pushing on my shoulder, but we weren't really violent fighting.... She wanted me to go to bed and I didn't.... Next thing I know I'm waking up, ... my arms are tied and my legs are spread apart, lying on my back.... Maybe the nurse ... was part of my psychosis." (Gallop et al., 1999 p.407)
- "That whole experience ... wasn't for my own good. I feel it was more like punishment" (Gallop et al., 1999 p.409)
- "Oh no. Oh no! If they'd asked me, "Well, do you want restraints or do you want someone like me to spend the rest of the evening with," I'd say, "I'd rather spend the evening talking.... I don't want to be tied down and left.... My earliest memories in my childhood, either I was totally ignored or abused, physically and sexually." (Gallop et al., 1999 p.409)
- "It was the most terrifying experience ... absolutely terrifying.... Like this was something from the Dark Ages ... having these straps around my hands and legs and having them yanked against cold steel bars.... It's terrifying.... All it did was make me scream to get it off.... It's like being staked out; it's like torture." (Gallop et al., 1999 p.410)
- "I was scared to death being locked up. I had experience as a child of being locked up in a very, very dark room and there were no windows." (Gallop et al., 1999 p.410)
- "Sometimes I go away because I can't handle what they're doing.... My mind just shuts off" (Gallop et al., 1999 p.410)
- "Then you're not human anymore." (Gallop et al., 1999 p.411)
- "I never felt so degraded in my life." (Gallop et al., 1999 p.411)
- "When I was tied to the chair ... it seemed to me like I was back in my childhood ... and being terrified that it was going to happen to me again" (Gallop et al., 1999 p.411)
- "The fear of being tied up was extreme and it just made me sick" (Gallop et al., 1999 p.411)
- "It brought it all back. I felt I actually physically felt like I was being raped that whole night long." (Gallop et al., 1999 p.411)
- "Like one time I felt as if I was being raped. Because they pulled the pants down and it's—it's—like you're being undressed." (Gallop et al., 1999 p.412)
- "Hot milk" (Gallop et al., 1999 p.412)
- "Talking with other patients" (Gallop et al., 1999 p.412)
- "Supportive messages" (Gallop et al., 1999 p.412)
- "Deny people their freedom, for example if it's restraint freedom of movement, or the freedom to ask questions, the freedom to be able to interact with other people, I mean isolation basically is almost another form of punishment, you've been bad, you've done something wrong. I mean that's how I see somebody being isolated. And takes that confidence away, because you must be bad so you are in isolation." (Consumer) (Brophy et al., 2016b p.602)
- "So what I've seen with people who've felt, when they've had even a single 24 h experience of seclusion and restraint under the mental health system, which is the door, the police, the medication, down into the whatever, the taking of the clothes, the whole lot - that person's changed forever in their feeling and their relationship to the society around them. To every other state agency they're changed, and that allows, that's again that learned helplessness." (Consumer) (Brophy et al., 2016b p.602)
- "Yeah I think it does, I think it encourages the people doing the restraining or taking action to be careful, because this person is loved by somebody." (Consumer) (Brophy et al., 2016b p.603)
- "I will die before I ever seek help from a psychiatric hospital again!" Case 1 (Smith, 1995, p.24)
- "I was caught unexpectedly as I attempted to hang myself in the restroom. Without warning. I was grabbed by the staff I had trusted, thrown to the floor, dragged to a cot, placed face down, and placed in five-point restraints. I felt sheer terror as the leather restraints tightened painfully around my wrists and ankles. I couldn't see who had grabbed me, who had touched my arms, my legs, my chest, my thighs; I couldn't see anything. Hands grabbed at my body, pulling my pants down, exposing my buttocks. I only felt terror, humiliation and pain. The staff left without a word as I screamed for help, begged for mercy" (Smith, 1995, p.24)
- "Surely my husband will help me. He won't let them keep hurting me" He came; he saw my pain, my terror, my swollen hands. He walked away saying "I'm not going to help you get out of here. This is for your own good" He left. I was totally, completely abandoned and betrayed. I wanted to die worse than ever before." (Smith, 1995, p.24-25)
- "Suddenly I wasn't in the hospital any more. I wasn't 45; I was 12. My terror increased unmercifully, with my heart pounding as though to burst through my chest wall, my head feeling as if it was about to explode. The pain in my wrists and ankles increased steadily. A neighbour, a trusted family friend had offered to help me fix my bike, if I would just go into the garage with him to get the tools he needed. Without warning, he grabbed me from behind and threw me to the ground. His hands were all over my body, hurting me with his body thrown on top of mine. 'Get off me! Please, please, let me go! Get off me! Please don't hurt me! Please! There was no response from staff. My heart was pounding painfully. I tried to turn my head, but I couldn't get my face away from the mattress. I felt I was suffocating. The mattress muffled my screams of terror" (Smith, 1995, p.24)
- "Finally, I was able to turn my head to the side far enough to see the door; it was closed tightly. I was alone, isolated, terrified, tied down in a spread eagle position. 'I can't breathe! Get off me! Why are you doing this to me? Why? Please stop hurting me!' My screams for help went unheard; no one came to my aid. My hands were forced over my head, my legs spread apart." (Smith, 1995, p.24)

(Continues)



TABLE 5 (Continued)

2(A) Nature of symptoms	<p>"Despite dark times of mood instability, of many ups and downs [...] I've always considered my work an important part of who I am, through the years having a job helped me to monitor my mood [...] when I am down it gives me a reason to wake me up and go out." (Vallarino et al., 2019 p.133)</p> <p>"Two years ago I had one of the worst weekends of my life. In 48 hours, I spent more money than during the rest of the year. On the internet, I bought many items I cannot even remember! The day after I realized everything and I felt so desperate about what I had done... I went to the front door of the mental health center very early in the morning waiting for it to open." (Vallarino et al., 2019 p.134)</p> <p>"I spent weeks trying to repair all of the damage I had done in that terrible weekend; maybe if the mental health center had been open, it wouldn't have happened." (Vallarino et al., 2019 p.134)</p> <p>"Voices telling me something bad is going to happen to you."</p> <p>"Hearing voices that say 'you are gay.'"</p> <p>"I wanted to die no girl-friend, took a lot of pills that could kill 20 people."</p> <p>"I heard things. I heard devil telling me to do it I did it before when I was sad, he begged me that I could not do it and survive it and I did it again."</p> <p>"I tried to hang myself."</p> <p>"I was obsessed with killing people."</p> <p>"I wanted to kill everyone who give me harm, like my abusive grandmother."</p> <p>"I had a suspicion that my aunt who is a psychologist want to hurt me. She knows black magic."</p> <p>"Going to jail, [there I was feeling that] people trying to poison me."</p> <p>"One afternoon, I took my clothes off, I was crazy, ran in the street for 2 miles, people were laughing at me, police took me to hospital."</p> <p>"I was catatonic, I could not walk or talk, that was traumatic." (Lu et al., 2017 p.4)</p> <p>"[The most traumatic part is] hearing voices telling me where to move. Three years ago I started to hear voices on TV and radio, telling me to move. I moved non-stop in the past two years, not finding a place to live. People on radio and TV suggest places for me to go." (Lu et al., 2017 p.4)</p> <p>"One afternoon, I took my clothes off, and ran in the street for two miles. People were laughing at me. The police took me to hospital." (Lu et al., 2017 p.5)</p> <p>"I was catatonic, I could not walk or talk, that was traumatic." (Lu et al., 2017 p.5)</p> <p>"Very angry, I wanted to hurt her."</p> <p>"Upset, should not happen to me."</p> <p>"I cried a lot, depressed."</p> <p>"[I felt] sad, confused, inconsolable."</p> <p>"I felt sad and angry."</p> <p>"It feels a little down, angry."</p> <p>"I felt angry, clumsy, and confused. I can't break the spell."</p> <p>"I felt emotionless." "I felt no emotions." "I don't know [how I felt]."</p> <p>"Nervous, out of control, felt pressured."</p> <p>"I knew I was in serious trouble police were almost ready to shoot me."</p> <p>"I was horrified."</p> <p>"I felt shocked and betrayed." (Lu et al., 2017 p.5)</p> <p>"I used to always want to be stoned and I think well that's beyond panic attacks, that's like I want to be in a coma, that's how stressed out I am, I want to be like partially conscious...that's not like something that we should just reject these people, and say... they've got these drug problems...they brought it on themselves...that's the feeling I get when people talk about dual diagnosis." (Brophy et al., 2016a p.8)</p> <p>"My future is just being ripped out in front of me" (Emrich et al., 2021 p.158)</p> <p>"I find it hard to cope so I do draw back to the drugs and alcohol" (Emrich et al., 2021 p.158)</p> <p>"I tried really hard for my dissertation but all throughout that period it manifested as something in my head that was telling me you're not worth it, you're not intelligent enough, that sort of things ... and you know it would sort of manifest in me sort of still trying to improve my fitness, improve myself, but not really inside having the self-worth and not being able to cope with the things going on." (Ben) (Emrich et al., 2021 p.159)</p> <p>"I did cocaine for a while and yes that may have been me to be honest trying to deal with depression at certain points. When I was younger, I had a lot of anxiety and I would say depression as kind of bedfellows, naughty bedfellows. You know I didn't enjoy myself when I was out there I drank quite a lot." (Sebastian) (Emrich et al., 2021 p.160)</p>
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TABLE 5 (Continued)

<p>"Erm and everything had some kind of connection, erm everything was being related in some way to everything else, you know the levels, the channels, the sections, the dimensions and everything all merging into one big state of mind. Erm and yeah, I was having a lot of delusional beliefs, but also was realising a lot of things in reality, all at the same time." (Richard) (Emrich et al., 2021 p.161)</p>	
<p>"a hedgehog because hedgehogs hibernate and being mentally ill is like being asleep, but when you're awake you know why you were ill and all those little prickly experiences when you were mentally ill." (Alex) (Emrich et al., 2021 p.162)</p>	
<p>"I was ill ... I was very distressed ... I was manic and high at the time." (Bonner et al., 2002 p.468)</p>	
<p>"[I was feeling]... Desperate. Just wanted to kill myself...suicidal." (Bonner et al., 2002 p.468)</p>	
<p>"I got angry because they wouldn't listen to what I was trying to tell them. Telling them that I needed help, wanted to hurt myself ... it was horrible, I never want it to happen again." (Bonner et al., 2002 p.468)</p>	
<p>"I didn't feel like I was a human being. I felt I was just a number. I thought they were going to kill me." (Bonner et al., 2002 p.468)</p>	
<p>"I was still angry, distressed." (Bonner et al., 2002 p.469)</p>	
<p>"Disgusted ... Disheartened that I had stooped so low. I was upset that the nurses felt it was necessary to restrain me." (Bonner et al., 2002 p.469)</p>	
<p>"Embarrassed ... Forlorn at reaching that point." (Bonner et al., 2002 p.469)</p>	
<p>"Low, anxious, scared. I was in a side-room and they shut the door." (Bonner et al., 2002 p.469)</p>	
<p>"My illness has affected me, but I wouldn't say being sectioned has affected me. (Cherie)" (Hughes et al., 2009 p.155)</p>	
<p>"I knew I was evil before I went into hospital, because of what happened in my childhood. But ... but, they sort of, what do you say, they sort of exemplified it [...] they sort of made it double that. (Annie)" (Hughes et al., 2009 p.155)</p>	
<p>"whole social life had fallen apart" (Sarah) (Hughes et al., 2009 p.156)</p>	
<p>"I don't know ... um ... hm ... I don't remember ... I must have been out of it and ... um ... well I may be um ... really bad ... what happened on the day I was secluded ... I do not even remember what you asking me ... the seclusion ... are you kidding me." [Justin] (Ezebele et al., 2014 p.308)</p>	
<p>"I think I was hysterical ... I was in my own world, I had fantasies" (Wynn, 2004 p.130)</p>	
<p>"The previous time I was restrained I had tried to injure myself ... this time I was aggressive and psychotic" (Wynn, 2004 p.130)</p>	
<p>"There was a tremendous amount of pain going on inside me.... I woke up one day feeling so desperate.... I started hitting my head against the wall.... When I was hitting my head I wasn't feeling quite so terrible inside.... In the afternoon I was on constant observation.... This new person came on whom I knew and she said: "Stop it," so I got off the bed ... raced down the hall ... banging my head into the wall at the end.... The doctor roared, "get up." ... I ran back to my room and he said I was going into restraints.... There was something about change of shift that made me frantic." (Gallop et al., 1999 p.406-407)</p>	
<p>"I did have flashbacks as well. The nightmares were similar to the flashbacks" (Gallop et al., 1999 p.412)</p>	
<p>"I could only think about my illness and what my future might be." (Smith, 1995, p.24)</p>	
<p>"I was hurting so intensely, I really believed that death was the only way to end the emotional pain I was experiencing." (Smith, 1995, p.24)</p>	
<p>"I am chronically depressed, crying over nothing, over everything." (Smith, 1995, p.25)</p>	

(Continues)



TABLE 5 (Continued)

3. Nature of the environment	<p>"The fact that my friend and cops should have been more civil to me rather than forcing me to come to the hospital." (Involuntary hospitalization) (Lu et al., 2017 p.5)</p> <p>"The fact that I was restrained, three guys restrained me [and] gave me a med." (Restraints) (Lu et al., 2017 p.5)</p> <p>"Several times, I was physically restrained to take meds; I was held down to take injection." (Forced medication) (Lu et al., 2017 p.5)</p> <p>"Being in the hospital for 1 year and 3 months is the most traumatic; the cops thought I was living in my car. I was driving from VA to NJ to be with aunt and uncle. Had a lot of stuff in the car. Got arrested for making a call. The cops took me to hospital and I have been here since." (Lu et al., 2017 p.5)</p> <p>"Since 2001 only released for 4 months and in the hospital for over 6years." (Lu et al., 2017 p.5)</p> <p>"I don't understand why I am here; they say I should be here for at least 21 days, but I've been here for 12 years; the psychologists say I'll be here permanently." (Lu et al., 2017 p.6)</p> <p>"Since 2001, [I was] only released for 4 months and [I have been] in the hospital for over 6years." (Lu et al., 2017 p.6)</p> <p>"The fact that my friend and cops should have been more civil to me rather than forcing me. My friend called cops who hand-cuffed me, and brought me to the ER. Then they shifted me to psych ward." (Lu et al., 2017 p.6)</p> <p>"So, and then for me to have the arrival of these people [admission team] at your door to take you off is very hard. [...] Like you can't even control your own house anymore." (Female, 41, ID3) (Murphy et al., 2017 p.22)</p> <p>It's [being detained] very bizarre. It's very frightening. [...] You're very confused and you want to sort of stand up and try to defend yourself, but you know that it's pointless, because you're surrounded. They [admission team] had me ambushed, surrounded [in own home]." (Female, 46 years, ID44) (Murphy et al., 2017 p.22)</p> <p>"I went to the door with the phone still to me ear, opened the door. [NAME] was standing there, my ex and there was, I don't know, maybe three men and a lady, maybe four. I don't know [...]. So, I said to my mother on the phone, oh my God, I said, the cavalry is here." (Male, 47, ID14) (Murphy et al., 2017 p.22)</p> <p>"He [the GP] was basically telling me to go to hospital. He didn't give me any choice. He didn't say anything about medication, about counselling. He just said "I think you should go to hospital". I just went along with that. I don't know why I did. I was in shock. I'm still in shock in a way." (Female, 36, ID41) (Murphy et al., 2017 p.22)</p> <p>"They [admission team] came into my garden where I was working. I heard my dog barking. I came in, three of them and this woman and I didn't know were they politicians or what they wanted and they showed me the cards [ID] and said they were from [the National Admission Team] whatever and they had to bring me into the unit [hospital] and I said to them I had responsibilities, that I couldn't just go like that, but they didn't... they weren't interested." (Male, 56, ID23) (Murphy et al., 2017 p.22)</p> <p>"There was one who came into the restaurant but there was another two accompanying him and then they brought me in the car back to the station. (Police) INT: And what did they say to you? Can you remember? RESP: Just that I had to come with them and I knew if I didn't they were going to get assertive. So, I left with them and when they got me in the car they kind of put their two hands on both my arms so I was kind of held down so I knew I had to go with them (Police)." (Female, 46, ID44) (Murphy et al., 2017 p.22)</p> <p>"I came in by the Guards [Irish police], yes. They came into the pub and took me out. [...]" (Male, 49, ID2) (Murphy et al., 2017 p.22)</p> <p>"Suddenly a woman called [NAME] came into my room and then a few men followed her and they just dragged me. Like, they took my wrists and ankles and just pulled me down." (Female, 30, ID19) (Murphy et al., 2017 p.23)</p> <p>"At that stage I almost felt like I was violated. I think that was one of the words I used, that I was basically like taken. Someone [admission team] came to my house, came into the house and then said "you're coming with us. We want you to come", but [participant pauses] it's always that 'but' and that sort of silent threat, that sort of coercion." (Male, 47, ID14) (Murphy et al., 2017 p.23)</p> <p>"They [admission team] come in and say "if you don't come with us we'll get the Guards [Irish police] involved and we'll put handcuffs on you and bring you". This kind of thing and they actually did that once." (Female, 41, ID3) (Murphy et al., 2017 p.23)</p> <p>"I suppose when you're involuntary, having that sort of label on you and knowing that you're trapped there [in hospital], [...] feel very much like you've had your human rights taken away, you feel imprisoned and you kind of feel, as I said before, a second-class citizen" (Female, 33, ID24) (Murphy et al., 2017 p.23)</p> <p>"I just wasn't respected and I was in prison and I was forced to do whatever they asked me to do and if I don't, then they would take my light away or they would take my mobile phone away." (Female, 26, ID48) (Murphy et al., 2017 p.23)</p> <p>"I just felt I hadn't any control of what was going to happen with me, how long I was going to stay in [hospital] or anything. I think they [treatment team] had the decision made up already beforehand and that was it. Even if I was progressing in my health as the days went on, they wouldn't release me." (Female, 24, ID9) (Murphy et al., 2017 p.23)</p> <p>"Well, I preferred the [names a drug] over two weeks but then when it was changed I went through every drug on the market and now we finally found [names another drug] which Dr. [NAME] wanted me on in the first place and wouldn't let me leave hospital without me going on it. So, I was beaten into it in the end." (Female, 41, ID3) (Murphy et al., 2017 p.23)</p> <p>"Hospitals grind you down. You're just ground down into nothing until the doctor feels that you're supplicant or whatever the word is. [...] Until you're nothing, until you agree with them. So, the doctors will keep you here until you agree with them. They break you down like that" (Male, 32, ID12) (Murphy et al., 2017 p.23)</p> <p>"I was given no notice of anything and told nothing. Not prepared [for Tribunal], didn't even know the solicitor was coming. [...] I was just sitting down on the chair beside the bed relaxing, when in comes this man and he said 'I'm your solicitor, I'm going to represent you at the tribunal' and I said fine. He introduced himself. Sure I didn't know what was happening, [NAME] about tribunals. [...] the day that the independent psychiatrist arrived, I never knew he was coming either. Never told, had no time to prepare. Went inside to this doctor, never saw him in my life before. He told me he was from Dublin and that he was the independent psychiatrist and I asked him would he be present at my tribunal and he said he didn't know" (Female, 60, ID30) (Murphy et al., 2017 p.24)</p>
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TABLE 5 (Continued)

- "I don't know. I think I was told what it [tribunal] was for. I was never asked to go to the tribunal or whatever. I don't understand what the tribunal was anyway." (Male, 23, ID37) (Murphy et al., 2017 p.24)
- "I kind of got the feeling that you know sort of medics [doctors] stick with medics as it were and in tribunal situations I always, you kind of get the feeling that they would take the medics' view over the patients' view, because they are medics and it's a medical situation. Maybe you know they're not really listening to the patient" (Female, 33, ID24), (Murphy et al., 2017 p.24)
- "So what I've seen with people who've felt, when they've had even a single 24 hour experience of seclusion and restraint under the mental health system, which is the door, the police, the medication, down into the whatever, the taking of the clothes, the whole lot—that person's changed forever in their feeling and their relationship to the society around them. To every other state agency they're changed, and that allows, that's again that learned helplessness." (Brophy et al., 2016a p.5)
- "You literally just get de-humanised and it's sort of that once you have become part of that system you do become almost, well not completely, but treated in a sub-human way. You can do things that you would not normally do. If you had a cancer patient in that same situation the furor would be terrible with the treatment they receive." (Brophy et al., 2016a p.5)
- "Emergency [department] is just the worst place for mental health issues." (Brophy et al., 2016a p.7)
- "the only reason I came into hospital this time was because my dad was out of the country and my wife convinced me to come here as an informal patient but then I ended up getting sectioned because I absconded." (Mohammed) (Emrich et al., 2021 p.160)
- "My sister in law said why don't you lie to the doctor to get yourself a hospital bed otherwise these aren't going to give you a hospital bed, so I said to the doctor yeah I've been killing people in the street, I've been killing doctor and I'm going to stab you as well" (Mohammed) (Emrich et al., 2021 p.160)
- "So, it would be nice to have sort of a little bit of a period of time, like I noticed it has helped me in here having meals cooked for me." (Ben) (Emrich et al., 2021 p.161)
- "My biggest fear before coming into hospital is being restrained. It puts me off seeking help because I'm frightened. I then become ill and end up being admitted and restrained anyway" (Bonner et al., 2002 p.470)
- "there wasn't much to demonstrate your confidence through. Um, you didn't have the opportunity to do anything, so you didn't know if you were competent or not. (Jake)" (Hughes et al., 2009 p.155)
- "Having to wait several days for permission to go outside the ward "Even though you are ready to do it", was seen as having implications for the capability of the self: "I thought I was useless" (Josline)" (Hughes et al., 2009 p.156)
- "I came back drunk and I wasn't allowed to be drinking so they called the coppers ... I was pissed off coz the nurses rang the police; it didn't have nothing to do with them. They psychiatric nurses could have done it. And the nurse thought I was arguing about when they put me in the car. I was saying to the police 'this has nothing to do with you, this is a psychiatric matter, psychiatric nurses should be here to take me back' ... Yeah [the police where he was going into seclusion] said 'take off all your clothes, put the gown on' ... Like I was a prisoner, like I was a prisoner of some sort!" (Sambrano & Cox, 2013 p. 525)
- "I realized that I just had to lay down ... didn't struggle, didn't move." (Gallop et al., 1999 p.410)
- "It's like you're totally helpless and powerless." (Gallop et al., 1999 p.410)
- "I think you can be as you are. If you're feeling strange or acting strange, be as you are without—, no great judgment placed upon you that would be placed upon you if you were in a coffee shop, if you were in a bar, or if you were in, you know, people visiting the house." (Skelly et al., 2013 p.1679)
- "The great thing about [names service] is that you talk about things that you wouldn't talk about outside. Like, you talk about your feelings and you go, you know, 'I was in a bad—, I was low yesterday,' or 'I was high,' or 'I was—' etcetera. And nobody—, everybody's in the same boat, so it's a really good atmosphere." (Skelly et al., 2013 p.1679)
- "I'd say that when I was in [hospital ward] that the socialization, where we'd all just sit around watching TV and having a cup of tea and a sandwich and having the chat. Then, as a result of that, you'd have an empathy with one or two people. Then you'd have a chat with them on your own and you'd go into things in more depth and you become a kind of a support for each other" (Skelly et al., 2013 p.1680)
- "That's something I think still all hospitals should look to ... that in every ward there is some element of interaction and conversation taking place between the patients themselves rather than people going off to their bed or to their room and trying to do it all on their own. You know? And that doesn't cost. There's no resource cost in that, you know?" (Skelly et al., 2013 p.1680)
- "If someone actually is brought into the emergency department either intoxicated or under the influence of drugs, they can't actually start to have a mental health assessment until they're actually sober, and that can take anywhere from 12 to 16 h." (Consumer) (Brophy et al., 2016b p.602)

(Continues)



TABLE 5 (Continued)

- "Everything should be done to avoid hospitalization: the staff there are generally not interested and offer no psychological support. I was forced to take medication...next morning my admission I was getting dressed because I wanted to leave...my cats were waiting for me at home... I spent most of the day in my bed... So it was a terrifying place and my experience was very traumatic...I was thinking 'I was in prison and I asked myself several times for what crime?' (Vallarino et al., 2019 p.133)
- "...when I arrived to the hospital, I knew I was in the right place and I stayed there. I made a lot of friends in the hospital ward... At the beginning, it was a bit frightening with all the strange behaviors going on." (Vallarino et al., 2019 p.134)
- "Being exposed to a whole bunch of very sick people for 2 months." (Lu et al., 2017 p.5)
- "Seeing a patient pulling her hair and throwing up was the most traumatic." (Lu et al., 2017 p.5)
- "I miss my family, I was physically assaulted by two patients, one punched me and the other squeezed my breast." (Lu et al., 2017 p.6)
- "Being exposed to a whole bunch of very sick people for two months was traumatic. At admission, they would scream, cry really loud, there were fights among the patients." (Lu et al., 2017 p.6)
- "If I didn't have those [out-patient appointments & group sessions] I would have been a hell of a lot worse because as I said when I came out of here [hospital], I felt I needed more therapy than when I came in. You know what I mean, I felt there were more issues because it was something that, you know it [experience of detention] was like a nightmare." (Male, 47, ID14) (Murphy et al., 2017 p.25)
- "So, when I came home into my own environment it was like then I had to go through post-traumatic stress of being in the hospital and within a few days I did bring terrible anxiety over me. [...] I just went through a period of horrendous anxiety." (Female, 56, ID20) (Murphy et al., 2017 p.25)
- "It was really traumatic. I have nightmares about it [being restrained]. [...] Then sometimes I wake up in the middle of the night screaming. It was the most traumatic and stressful experience so it's like it left a scar in my past and it's now sometimes I get repeated thoughts about it and then it's like flashbacks." (Female, 26, ID48) (Murphy et al., 2017 p.25)
- "Well, then I started going back to my room trying to sleep and that was this place where people [admissions team] handcuffed me, treated me with so much aggression. I couldn't sleep. I had lots of fear in my own room because of them. [...] I just kept remembering all that happened and all they did to me and I just couldn't feel safe. I couldn't feel safe in my room. I couldn't feel safe in the world. Because you have to feel maybe they can come in again. I mean you just don't feel safe like. Like, if that happened one time, it could happen another one. Like, fear of something could happen." (Female, 30, ID19) (Murphy et al., 2017 p.25)
- "I made it up ... incarcerated, institutionalised, log cabin cobbled hypnagogic fever ... erm it's just how I was feeling erm and so how you start behaving when you become institutionalised. You feel incarcerated, you feel trapped, you feel you have no freedom, you feel these inside walls and the garden is all you have in life, that's all that exists, it exists forever." (Richard) (Emrich et al., 2021 p.160)
- "We had a manic patient harassing and shouting abuse at [the patient]." (Bonner et al., 2002 p.468)
- "the ward was very, very disturbed. At the time we'd had an awful lot of incidents, of different types, not usually involving restraint but things like self-harming, superficially setting fire to the ward." (Bonner et al., 2002 p.468)
- "They should have got him [another patient] out of the ward or got me out until he was gone. You warn them. I was saying, 'I'm gonna smack him when he comes out that room ... It's going to kick off.' I warned [the agency nurse]." (Bonner et al., 2002 p.468)
- "that took me back to my childhood [...] my childhood abuse" (Gloria). (Hughes et al., 2009 p.157)
- "I was very aggressive, I was very abusive. That was probably in this environment that I was in [...] I did say to them, if you treat me like an animal, then I'll act like an animal. Why are you doing this, to me? You know, because I was acting, totally out of character." (Sarah) (Hughes et al., 2009 p.157)
- "I thought I was in the prison cell again ... Uh ... I was unable to get out ... I was left there for 3 hours." [Jim] (Ezeobebe et al., 2014 p.307)
- "The seclusion experience reminded me of the time I was in a jail cell ... the seclusion forced me to revisit the bad experience I had in jail again ... the seclusion room had no 'peep holes' like they have in the jail ... I thought how to get out of the room ... uh ... I mean ... uh ... if there was a ladder I would have climbed out of there ..." [Gerald] (Ezeobebe et al., 2014 p.307)
- "It's great to come in here, let it all out, because you keep that in for so long and it's like a volcano building up, emotional kind of thing. And it's useful to let it out." (Skelly et al., 2013 p.1679)
- "We're faced with rules and regulations and care plans and this plan and everything else, and at the end of the day, it is all just paperwork. Very little of what is on or in those guidelines are actually implemented in a professional manner." (Skelly et al., 2013 p.1680)
- "Because it's so cold when you walk in, just everything is just cold about it. (Consumer)" (Brophy et al., 2016b p.602)
- "You go in there seeking help and surviving the traumas in your life, but you end up having to cope with even more trauma. It's pointless." (Consumer) (Brophy et al., 2016b p.602)
- "I was isolated from other patients, deprived of any outside stimuli, such as music, television, or reading material." (Smith, 1995, p.24)
- "I've been in those leather restraints, locked away in a room all alone for days at a time. There is nothing worse. You become totally unprotected, totally vulnerable." (Smith, 1995 p.25)

They never talked about it to me. That would have helped. If somebody had sat down and talked it through with me.

(Bonner et al., 2002 p.469)

Patient data clearly links poor staff interactions to patients getting frustrated and reacting by either hurting themselves or wanting to hurt the staff:

I think things would have turned out better ... if they had just left me alone in my room

(Wynn, 2004 p131)

Positive relationships reduced re-traumatization greatly, and enhanced patient's experiences of the inpatient setting, being listened to about aspects of their care plan. Kind, caring, down to earth are some of the traits described by participants who had positive engagements with staff:

And then she said "if you ever need to talk, just get the nurses to get me and I'll talk to you" like, you know. She's very down-to-earth. Very civil and everything like, you know. [...] Because she'd talk to you like she was a friend of yours like, you know

(Male, 47, ID33) (Murphy et al., 2017 p.26)

Patients also found that the staff who provided them with information on their detention process and tribunal were very insightful and allowed patients to ask them questions in relation to it:

No, I was given plenty of information [about detention]. I had somebody come to me and talk to me. They gave me the mental health booklet. Somebody talked to me about the tribunal. Nurses came over to me regularly and asked me what was going on. They were very insightful at the time; I found regarding what was happening to me and what would possibly happen next.

(Male, 37, ID5) (Murphy et al., 2017 p.26)

When staff went through patient records to help patients understand and gain insight on where things went wrong for them. Having a nurse talk through incidents contributed to helping calm patients' thoughts about restraint:

I've seen some of my records. It's helped to look at the impression that they had of me at the time. It's helped to build a better picture. The nurses have sat down with me and gone through my records with me. It feels better to look back with a better insight. You can see where you were going wrong. You can see where to make changes or where you've made changes. The nurses talking to me [subsequently] had helped.

[Nurse C] just talking through incidents with me helps you feel calmer about it. It was good to talk it through afterwards especially if there has been awkwardness during the restraint.

(Bonner et al., 2002 p.469)

The data relating to instances where patients had positive interactions with staff, stands in stark contrast. Where patients were able to trust that the staff have their best interests and the medical knowledge to support recovery patients did acknowledge this:

Even though they say you're the expert on your own care, you don't have the medical know-all so therefore you have to trust that they are working in the best interest for you.

(Skelly et al., 2013 p.1678)

3.5.2 | Specific interventions

The theme-specific interventions, (sub-theme nature of symptoms) illustrate how patients are eager to receive interventions based on consultation and choice, but that often these are not offered and that the interplay of their symptoms and re-traumatizing interventions such as forced medication, restraint, and seclusion are often the norm. Indeed interventions such as conversation are often lacking and replaced by isolation or at times abusive interactions with staff. Participants also illustrated how specific interventions hindered their recovery and led to re-traumatization. Lack of psychological support being offered:

In the mental health center where I went for my routine visits, I asked my psychiatrist if I could have some psychological support, but I felt like I was asking for a pot of gold. I would like to know if there were some treatments that could help me to recover in addition to medication

(Vallarino et al., 2019 p.132)

Medication affecting participants physically with difficult side effects:

In isolation they drug you up. So you're just going around like this ... [shows the researcher a zombie-like expression]. And then you can't even talk properly and the talk is all blah, blah, blah, frothing at the mouth, dribbles all that.

[Ani] (Sambrano & Cox, 2013 p. 527)

Physical restraint and seclusion during their stay in a psychiatric ward were particularly traumatic. It led to participants feeling scared and helpless:



...put you in a cell that has no toilet and no air and leave you there for 10 hours and then you'll be cured, and it's not...you go in there seeking help and surviving the traumas in your life, but you end up having to cope with even more trauma. It's pointless.

(Brophy et al., 2016a p.4)

The overwhelming emphasis of the data that contributed to the theme Specific interventions illustrates that far from being in receipt of positive recovery-focused care the participants in these studies received traumatizing or re-traumatizing care. Some of the data though did describe how certain interventions were helpful towards their recovery and overall satisfaction with the mental health services. Psychotherapy and group therapy were in particular noted to be a turning point for participants:

It was nice to be around people who know how you feel and what you have been through, I felt like I was being "protected". I am still in contact with a couple of people, for my birthday they sent me a pretty birthday card: I was really touched!

(Vallarino et al., 2019 p.132)

One participant found seclusion a positive experience as it allowed him to calm down:

Seclusion calmed me down ... I guess it is a 'cool down' room.... Um ... hm ... I felt good ... and ... I had good communication with God ... and ... I was praying to God to forgive my actions.

[Mike] (Ezeobebe et al., 2014 p.308)

Nature of symptoms

The sub-theme nature of symptoms explores the negative effect symptoms could have on their lives:

One afternoon, I took my clothes off, I was crazy, ran in the street for 2 miles, people were laughing at me, police took me to hospital.

(Lu et al., 2017 p.4)

Participants noted that attempting to deal with symptoms by having a purpose such as a job gave them the motivation to keep going and it helped them monitor their moods:

Despite dark times of mood instability, of many ups and downs [...] I've always considered my work an important part of who I am, through the years having a job helped me to monitor my mood [...] when I am down it gives me a reason to wake me up and go out.

(Vallarino et al., 2019 p.133)

But less positively participants spoke about how the lack of access to treatment led to difficulties in their mental health which took weeks to repair. This sub-theme illustrates that participants are aware that the symptoms require interventions and that they are willing to access services if available:

I spent weeks trying to repair all of the damage I had done in that terrible weekend; maybe if the mental health center had been open, it wouldn't have happened.

(Vallarino et al., 2019 p.134)

3.5.3 | Nature of the environment

The themed nature of the environment speaks to the negative nature of acute settings and the impact this had on participants in the included studies. For many participants they found hospital a terrifying place and found it traumatic. This sub-theme illustrates settings where staff were either through lack of personal capacity, training, or resource unable to offer positive recovery-focused care. Many participants compared their experience to being in a prison:

Everything should be done to avoid hospitalization: the staff there are generally not interested and offer no psychological support. I was forced to take medication...next morning my admission I was getting dressed because I wanted to leave...my cats were waiting for me at home... I spent most of the day in my bed... So it was a terrifying place and my experience was very traumatic...I was thinking I was in prison and I asked myself several times for what crime?

(Vallarino et al., 2019 p.133)

Participants describe mostly negative experiences of hospitalization in particular being around other unwell patients:

Being exposed to a whole bunch of very sick people for two months was traumatic. At admission, they would scream, cry really loud, there were fights among the patients.

(Lu et al., 2017 p.6)

The experience of hospitalization resulted in patients reporting symptoms of PTSD following discharge from the hospital such as anxiety, nightmares, difficulty sleeping, and the fear something was going to happen to them:

It was really traumatic. I have nightmares about it [being restrained]. [...] Then sometimes I wake up in the middle of the night screaming. It was the most

traumatic and stressful experience so it's like it left a scar in my past and it's now sometimes I get repeated thoughts about it and then it's like flashbacks.

(Female, 26, ID48) (Murphy et al., 2017 p.25)

However, there was some positive feedback about admission to the hospital as it allowed participants to let out their emotions and even make friends:

It's great to come in here, let it all out, because you keep that in for so long and it's like a volcano building up, emotional kind of thing. And it's useful to let it out.

(Skelly et al., 2013 p.1679)

4 | DISCUSSION

To the best of our knowledge, this is the first systematic review to synthesize qualitative literature that reports on mental ill-health patient's experiences of re-traumatization in acute mental health inpatient settings. Unfortunately, the studies found for this review report predominantly negative re-traumatizing experiences in acute settings. This section will now consider the analytical themes and sub-themes that arose from the analysis considering the extant literature and policy. By presenting the theme and sub-themes; Quality of staff interaction; Specific interventions, nature of symptoms; and Nature of the environment, this review provides some insight into the experience and causes of traumatizing/re-traumatizing staff behaviours and environments adding to the evidence in this area. The 14 included studies crossed a 26-year time span and they provided in-depth narratives from the participants. The findings presented to provide insight into their participant's experiences. Also, analysis indicates that inpatients are likely to have a history of previous trauma with the findings from the review suggesting that this is likely underreported.

This review highlights the number of challenges inpatients experience while accessing mental health services. The findings suggest participants are not asked about their previous trauma histories on admission and it is not taken into consideration during interventions such as seclusion, restraint, and even forced medication. It is highlighted by Department of Health (2020) that trauma-informed care is an approach that acknowledges that many people with mental health difficulties have experienced some form of trauma in their life. The approach aims to provide care in a manner that is neither traumatizing nor re-traumatizing for clinicians and service users. A trauma-informed service requires everyone working in mental health services to have a basic understanding of trauma and be aware of how it can affect individuals, families, and communities. It responds by fully incorporating trauma literature into policies, procedures, and practices and attempts to resist re-traumatization (SAMHSA, 2014).

The theme Quality of staff interaction reveals that participants who have negative interactions with staff in acute inpatient mental health settings are more likely to not engage with the services provided and will avoid speaking openly to their treating teams about their actual mental and physical health needs, even lying to get discharged from hospital sooner. This experience of staff interactions feeds into the understanding of the Specific interventions theme and sub-theme nature of symptoms. This understanding raises the concern that inpatients are not receiving trauma-informed care that is set out in best practice guidance (HSE, 2017; MHCC, 2013; SAMHSA, 2014) and they are not receiving a recovery-orientated service. Participants describe acute inpatient mental health settings as inhumane and are not beneficial to recovery as they felt they had no control or say on their treatment (Care Quality Commission, 2017; Leamy et al., 2011). There are five recovery processes as outlined by Leamy et al. (2011) these include connectedness, hope and optimism, identity, meaning in life, and empowerment. Mental health services should be delivering healthcare that is consumer-centred, this involves promoting choice, autonomy, and self-determination (Cleary, 2004; Muskett, 2014). As a result of being hospitalized, participants often feel restricted with ward rules and policies. Isobel (2015) states that enforcing rules can contribute to trauma and re-traumatization.

When considering the Specific interventions theme and sub-theme nature of symptoms the distance between policy aspiration and reality is highlighted. Policy mandates that each inpatient is entitled to have their human rights respected and protected, right to dignity and respect, and privacy and confidentiality in line with MHCC (2013). The Specific interventions theme illustrates that far from achieving these standards there are a number of shortcomings that highlight the negative aspects of hospitalization. These include vulnerable inpatient's views of not being listened to about medication, forced medication, restraints, and even seclusion in some circumstances. These service-driven actions erode inpatients confidence around active decision-making in their own care and contribute to poor adherence to medication upon discharge. As mental ill-health patients are a vulnerable population, it is of great concern that interpersonal difficulties with clinical staff was cited by participants in 13 of the 14 included studies (Bonner et al., 2002; Brophy et al., 2016a, 2016b; Emrich et al., 2021; Ezeobele et al., 2014; Gallop et al., 1999; Hughes et al., 2009; Lu et al., 2017; Murphy et al., 2017; Sambrano & Cox, 2013; Skelly et al., 2013; Smith, 1995; Wynn, 2004). These interpersonal difficulties compounded underlying power imbalances and had a negative impact on their care. When participant's views were not being heard it led to diminished opportunities to collaborate in their own treatment subsequently reducing the chance of recovery. Consequently, this further aggravated their mental health difficulties and led to difficult relationships with clinicians. It is well known that inpatients have reported ongoing dissatisfaction and poor care experiences in acute mental health inpatient settings (Care Quality Commission, 2017). Wood et al. (2019) highlight

that experiences such as disempowerment, lack of choice and control, and uncollaborative care all conflict with recovery values (Pitt et al., 2007). However, some participants expressed positive staff experiences during hospitalization. They describe being listened to, welcoming staff, kind and caring, providing information, a shoulder to cry on, approachable, having their best interests, the medical knowledge, and being respectful of their wishes. This led to increased satisfaction with services and improved nurse-patient relationships.

The theme Nature of the environment indicates that the nature of clinical settings contributes to reduced staff and patient satisfaction that may be linked with under resourced work environments, excessive workload, and lack of opportunity which lead to staff burnout and increased stress (Björkdahl et al., 2010). Mental health nurses experience time stress and high levels of acuity and demand while working in acute inpatient mental health settings (Cleary, 2004). They report feeling torn between demands for treatment efficiency and humanistic ideals (Björkdahl et al., 2010). Educating clinicians about trauma-informed care may enhance their understanding of how likely it is to re-traumatize inpatients. It may also enable a compassionate and respectful approach to service delivery leading to increased job satisfaction and improved relationships. It is important that clinicians delivering services are able to change their behaviour, language, and policies to consider the experiences of those with trauma histories. Clinicians should be taught how to recognize signs of trauma and understand how organizational practices may cause difficult memories for patients with trauma histories. A trauma-informed approach means that the mental health service is aware of the possibility of trauma histories amongst the clientele. Roberts (2000) posits that narratives add value to what is known and understood about the lived experience. Hence, there is a clear need for further qualitative research in this context, both to inform policy and service provision and to let the voices of mentally ill-health inpatients be heard.

4.1 | Strengths and limitations

This review represented the experiences of 288 people with mental health difficulties being inpatients in acute mental health settings. They were from various backgrounds and geographic locations, yet it found similarities in their experiences in the hospital and their concerns related to mental healthcare. However, the review needs to be read in the context of the following limitations. There was a significant lack of recent qualitative studies conducted on this topic that has impacted not only the findings of the review. Given the lack of diversity represented in the combined population of participants and the small study sample sizes, the transferability of the findings to all inpatients in acute mental health inpatient settings is not possible.

Although no geographical or language limiters were set, the fact that only studies published in the English language and from

high-income countries were located has potentially introduced a bias. The findings may have been in part shaped by the review team's experiences as practitioners and researchers in mental health, and therefore, what was deemed relevant may be a result of professional training, standards, and perspective. Future research would benefit from further qualitative studies on diverse populations that focus exclusively on inpatient's experiences of acute mental health inpatient care. It may have been beneficial to involve a person with first-hand experience of acute mental healthcare in undertaking the analysis of this review. It would also be beneficial for future research to consider participant status as inpatient's experiences may be shaped according to them being detained under the mental health act or if they voluntary sought treatment.

4.2 | Implications for mental health nursing

There are a number of strategies that can be used to effectively implement trauma-informed care in inpatient mental health settings to reduce the risk of re-traumatization of inpatients. These include having clear leadership within an organization who is committed to strive to prioritize trauma-informed care in the assessment, planning, implementing, and evaluating stages.

The inclusion of mental health nurses in contributing to the collection of data from practice to inform and adapt practices to reduce trauma to inpatients. This relates to data from coercive practices such as seclusion, restraint, forced medication, and involuntary admission. Automatic screening of trauma histories at the point of assessment would assist with creating care plans alongside the patient and individualize treatment and de-escalation plans. By collaboratively involving the patient in their own recovery. Encouraging inpatients to complete patient satisfaction surveys and compliant feedback forms post discharge. By involving patients in policy-making.

Staff induction and training development need to be completed at both the university training level and annually when working in the service. Mental health nurses need to be confident in their approach, competent in their knowledge, and understand the risk of re-traumatization during an inpatient's stay in the hospital. Physical environments need to be welcoming, homely, and have comfortable furnishing. They also require adequate space for inpatients to move around freely and have a quiet space to calm and soothe themselves when required.

Having mental health nurses that are interactive, friendly, interested, and personable all contribute to a more positive experience for inpatients. It is critical that all inpatients receive care from mental health nurses who are emotionally supportive. Staff and inpatients should receive de-briefing following incidents. Staff supervision should also be facilitated to reduce to risk of burnout. Staff support and training should also be cognizant of the fact that staff may also have had traumatic experiences. This may affect their ability to recognize and effectively respond to trauma in patients. Mental health

inpatient units that focused on psychological support such as talk therapies were perceived as helping inpatients build on their own self-determination and autonomy.

5 | CONCLUSION

This systematic review has highlighted an urgent need for the international implementation of trauma-informed care in all acute mental health hospitals as well as a need for further studies that explore the experiences of inpatients using the services. Despite being admitted to the hospital for mental health difficulties, they often have histories of trauma and vulnerabilities. Therefore, acute mental health hospitals should allow inpatients to feel safe, develop coping skills, receive support from staff, and access quality mental health interventions. If acute mental health hospitals are truly recovery orientated, all inpatients need to encounter staff that embodies the humanistic principles of empathy and unconditional positive regard.

AUTHOR CONTRIBUTIONS

All authors listed meet the authorship criteria, according to the latest guidelines of the International Committee of Medical Journal Editors. All authors are in agreement with the manuscript. BH and AMG designed the study with initial design input from AH. BH and AMG performed the database search, screening of abstracts/full text, data analysis, and were responsible for drafting and critical revisions of the manuscript. AH made substantial contributions to conceptualization, methodology, formal analysis, and manuscript writing. All authors contributed to the write-up.

CONFLICT OF INTEREST

None declared.

DATA AVAILABILITY STATEMENT

Data available on request from the authors.

ETHICAL APPROVAL

None.

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