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Implications of Involuntary Psychiatric Admission

Health, Social, and Clinical Effects on Patients

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Abstract: Involuntary psychiatric admission is an increasing, widespread practice adopted throughout the world; however, its legal regulation and practice are still under debate, and it is subject to criticism from the human rights point of view. Only a few studies have strictly focused on the outcomes and subsequent treatment implications of this practice. To perform a scoping review of the literature on involuntary psychiatric admission and systematize and summarize its outcomes and implications for adult psychiatric inpatients.

Four overarching issues emerged from the studies: a) symptomatological repercussions, b) impacts on treatment before discharge, c) impacts on treatment after discharge, and d) implications on patients' attitudes, behavior, and functioning. The overall evidence suggested correlations between involuntary psychiatric admission and several implications: length of stay, aggressive behavior, occurrence of psychopathologies, uses of coercive measures, psychiatric service activations after discharge, emotive reactions, and quality of life. The proposal presented here is the major involvement of the patient and of all the other actors involved during the entire treatment process to promote a shift from a delegation perspective to a negotiation perspective in the management of involuntary psychiatric admission.

Key Words: Involuntary psychiatric admission, mental health, hospitalizations, health care, public health, clinical, treatment

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Despite the shift from institutional care to community-based care in the field of mental health assistance, involuntary psychiatric admission (IPA) or hospitalization is an increasing, widespread practice that is adopted throughout the world, whereby states institutionalize a person with severe mental illness against his or her will (Giacco et al., 2018; Gowda et al., 2017; Seed et al., 2016). The available epidemiological data show that the IPA rates are significantly different across Europe, ranging from 12.4 per 100,000 inhabitants in Italy to 232.5 per 100,000 in Finland (Fiorillo et al., 2011). A Europe-wide comparison of IPA over a period of 8 years detected that Germany had the greatest overall percentage increase (75%), with the United Kingdom having the lowest (5%) (Hoffmann et al., 2017). Although the available epidemiological data show that countries have significantly different admission rates and that admission criteria are different between states, two main models determine national procedures: the legal and medical models (Fiorillo et al., 2011; Hoffmann et al., 2017; Wynn, 2006). The former is underpinned by the idea that deprivation of individual freedom must be decided by judges following the criteria coded by law, whereas the latter considers the procedure from a health perspective (Fiorillo et al., 2011; Wynn, 2006). Four cross-cutting conditions have been identified as typically requiring IPA: a) having a mental illness diagnosis or presenting symptoms of serious mental illness, b) being unable to take care of oneself, c) being unwilling to be voluntarily admitted to/treated in a hospital, and d) being a danger to oneself or others (Crisanti and Love, 2002; Gowda et al., 2017).

Nevertheless, there is also a shared perspective concerning critical issues in IPA's clinical and ethical aspects. For instance, one clinical aspect is the questionable correlation between severe mental illness and IPA (Ritsner, 2018). One of the ethical aspects is that involuntary admission is largely debated for its legal regulation and practice, and it is subject to growing criticism from the human rights point of view, particularly expressed by involuntary patients (IPs) (Gowda et al., 2017; Kallert et al., 2008). In particular, the use of coercive measures during involuntary hospitalization is a common practice that is characterized by seclusion, restraint, and forced medication (McLaughlin et al., 2016). The incidence of seclusion and restraint varied from 35.6% of all admissions in Austria to 2.6% in Norway and around 0% in Iceland and the United Kingdom (Hoffmann et al., 2017). A comparison of studies carried out in different countries indicated that coercive interventions are used in 100% of the wards in Germany, 60% of those in Switzerland, and none in Great Britain (Beghi et al., 2013). Coercive interventions, along with the involuntary placement of the patient, may have a strong impact on specific outcomes, such as quality of life, therapeutic relations, motivation for treatment, likelihood of subsequent involuntary hospitalizations, and satisfaction with treatments (Cornaggia et al., 2011; Fiorillo et al., 2011; Ritsner et al., 2018; Wyder et al., 2015). There is an ongoing debate about what constitutes the right balance between the patient's autonomy and the state's obligation to ensure maximum protection of health and life (Isobel, 2019; Wynn, 2006).

Although the above-mentioned issues are well acknowledged and IPA is widely used regardless, only a few studies have systematized and summarized the treatment implications and outcomes, suggesting a critical role of empirical evidence in the effects of IPA and subsequent treatments (Kortrijk et al. 2010; Priebe et al., 2010). The impacts of IPA on inpatients' care and health are yet to be clarified or are based on traditions rather than evidence to inform practices (Giacco et al., 2018).

To shed light on the aforesaid blurred issues and to track down empirical evidence on the impact of IPA on inpatients' care and health, this study reviews the literature on IPA to systematize and summarize its outcomes and implications in adult psychiatric inpatients. Particularly, investigating the current state of the IPA and related health practices was deemed important to provide general empirical evidence on the outcomes of involuntary admission and thereby inform researchers and health providers on the subject. To this end, the following research questions were formulated:

a) Which issues are involved in the impact of IPA on inpatients' care and health?
b) What are the outcomes and implications of IPA on patients' care and health?

METHODS

Theoretical Background

This study utilizes an interactionist epistemological theoretic framework (Iudici et al., 2020; Salvini, 1998). Especially in the *Discussion*, this

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theoretical perspective is adopted to frame the social interactions between users and psychiatric services, as several actors and practices characterize the IPA process. From this perspective, the thinking processes and meanings are shaped by the social interactions surrounding an individual, and discourses form a structural sequence of intentional acts (Blumer, 1969; Harrè and Gillett 1994; Iudici and Fabbri, 2017; Iudici et al., 2017).

Research Design: The Scoping Literature Review

The current study focuses on exploring the impact of IPA on hospitalized patients and reconstructing a map of the effects of IPA on patient care and health. Accordingly, the scoping review was identified as the most suitable research strategy (Carr et al., 2017; Grant and Booth, 2009; Valaitis et al., 2012) to identify what has already been achieved and systematize the data present to arrive at policy decisions or operational intervention proposals (Arksey and O'Malley, 2005).

Inclusion/Exclusion Criteria

Because of the paucity of studies specifically concerning outcomes and implications of IPA on adult psychiatric inpatients, no preliminary distinction was made regarding the articles' research design, type of psychiatric disorder, and types of process that lead to IPA. Furthermore, cross-national differences in IPA seem to be mostly related to policy making and legal aspects rather than clinical ones; therefore, studies that purely focused on the legal backgrounds of IPA were excluded. Moreover, studies whose outcomes were related to involuntary outpatient commitment or involuntary admission in forensic/addiction units were not considered. Articles that focused on IPA's risk factors and coercive practices but did not mention the involuntary admission process were also excluded. On the other hand, articles were assessed and included based on their internal consistency and relevance to the main research theme and objective. Qualitative, quantitative, and mixed-method studies were considered to assess outcomes of and implications for adult psychiatric inpatients who were hospitalized by IPA. Studies focusing on coercive practices and mandatory psychiatric treatment were included if they considered IPA as integral.

Data Collection and Analysis

A keyword search was performed to identify those most relevant to the current research objective; accordingly, keywords used in recently published articles on the related topics were examined. Scopus, PsycINFO, and Google Scholar databases were searched using the main search inputs “involuntary psychiatric admission,” “involuntary psychiatric hospitalisation,” “compulsory admission,” and “compulsory detention.” In all the databases, the search was circumscribed to articles and reviews published between 2000 and 2019, and the study was restricted to works published in English, Italian, and Spanish. Given the large number of results found in Scopus (1577), the object of inquiry regarding the outcomes, implications, and critical aspects of IPA was narrowed down. To this end, internal searches of the 1577 articles were conducted by inputting the following keywords: “relapse,” “aftermath,” “consequence,” “problematic,” “implication,” “neglect,” “outcome” (search inside: limits), “outcome” (search inside: implication), and “outcome” (search inside: critical). After further screening for input, 845 articles were obtained. The same criteria were followed for PsycINFO as well. Given the number of results found (253), there was no need to input any further keywords for internal searches. In an attempt to widen the search for relevant articles, the Google Scholar database was also examined, and two articles that were consistent with the current objective were retrieved.

The research material found (1093 articles) was scanned by title and abstract by three auditors independently. The articles were assessed for their relevance to the research objective. Duplicate articles (75) and those studies that did not satisfy the above criteria (953) were excluded. Finally, 65 appropriate articles were found. Of these, eight could not be accessed. After the full reading, 57 studies that contained relevant information were included in the synthesis. These are presented in Table 1.

The analysis began by extracting relevant quotes from the articles and continued by coding the text extracts into categories that summarized and systemized the content of the data (Fig. 1).

RESULTS

The categories drawn from the data were grouped into four macro-issues related to implications dealing with the following: a) symptomatologic repercussions, b) impacts on treatment before discharge, c) impacts on treatment after discharge, and d) implications and outcomes on patients' attitudes, behavior, and functioning. The final synthesis is the result of a cross-comparison between all the articles analyzed. This process was conducted by two independent authors, and a third researcher was appointed to supervise the whole procedure and check the results' relevance to the research objective. All of the authors' general agreement was guaranteed throughout the data collection and analysis process.

Symptomatologic Repercussions of IPA

Numerous quantitative studies have reported that there is generally some amount of clinical improvement in involuntarily admitted patients (Pandarakalam, 2015). However, other studies found that IPA has few, if any, impacts on clinical outcomes, but it may adversely affect patients' satisfaction and quality of life (Wynn, 2018). The clinical outcomes of IPA are a highly conflicting and debated topic.

On the one hand, some studies of IPs have not shown a significant influence on the Brief Psychiatric Rating Scale (BPRS). On the other hand, other researchers have proved that IPA can lead to suicide, depression, and posttraumatic stress disorder (PTSD) symptoms (Pandarakalam, 2015; Vannoy et al., 2016). Particularly, Tarrier et al. (2007) discovered an association between suicide attempts and IPA as well as between suicide ideation and IPA. Consistent with these results, Crisanti and Love (2002) revealed a 10% increase in suicides among IPs compared with voluntary patients (VPs). Tarrier et al. (2007) found a significant association between PTSD and IPA.

Other studies have shown that involuntary admission in the past was not associated with current PTSD symptoms and that no significant difference exists between IPs and VPs on the total score of the Impact of Event Scale–Revised in the first week. Regarding the IPA of patients with anorexia nervosa, Douzenis and Michopoulos (2015) mentioned how services could reinforce negative behavioral patterns, such as striving for value, perfectionism, and low self-esteem, through an excessively protective and safe environment that undermines the patients' self-determination processes. Finally, a further impact of IPA on treatment concerns the use of drugs. Some researchers have found that the use of a combination of drugs tended to be more frequent in IPs (Campos et al., 2016). They found that high doses of antipsychotics were also more frequent in patients with previous involuntary admission.

The Impact of IPA on Treatment Before Discharge

Concerning the impact of involuntary hospitalization on psychiatric inpatients, several authors encountered a correlation between the legal status of involuntarily admitted patients and the use of coercive treatments (Abderhalden et al., 2007; Ielmini et al., 2018; Raboch et al., 2010). There is a heated debate over the use of practices such as seclusion, restraint, and forced medication (Khatib et al., 2018; Maiese et al., 2019; Mielau et al., 2016; Stylianidis et al., 2018).

Impacts of IPA on the Use of Coercive Treatments

In a systematic review, Beghi et al. (2013) found a more frequent occurrence of restraint episodes among involuntarily admitted patients: two out of three multivariate analyses and three out of four univariate analyses turned out to be statistically significant. Korkeila et al. (2002)

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TABLE 1. References of Reviewed Studies: Authors, Date, Method/Subjects, Nation, Main Objective, and Results

#	Author(s)	Year	Method(s)/Subjects	Nation(s)	Objective(s)	Results
1	Abderhalden, C., Needham, I., Dassen, T. et al.	2007	Prospective multicenter study on 24 acute admission wards in 12 psychiatric hospitals	Switzerland (German-speaking part of Switzerland)	To describe the frequency and severity of aggressive incidents in acute psychiatric wards in the German-speaking part of Switzerland.	Involuntary admission (OR, 2.2; 1.6–2.9), longer length of stay (OR, 2.7; 2.0–3.8), and a diagnosis of schizophrenia (ICH-10 F2) (OR, 2.1; 1.5–2.9) were associated with a higher risk for aggressive incidents, but no such association was found for age and sex.
2	Balducci, P.M., Bernardini, F., Pauselli, L., Tortorella, A., and Compton, M.T.	2017	Descriptive analysis, bivariate analyses, and binary logistic regression Participants: 848 patients, discharged between June 2011 and June 2014, from an Italian inpatient psychiatric unit	Italy	To develop a better understanding of the current patterns of admission in a psychiatric inpatient unit in Perugia, Umbria, Italy, and to examine the correlates of voluntary or involuntary admission.	Bivariate analyses showed that involuntary status was related to the reason for hospitalization, not being on psychiatric medications at admission, and being admitted from another inpatient ward (in particular, from the emergency department).The final regression model identified four main variables independently associated with legal status: being admitted for psychotic features, suicidal behavior, impulsive behavior, and not being on medication at admission
3	Beghi, M., Peroni, F., Gabola, P., Rossetti, A., and Cornaggia, C.M.	2013	Systematic review	Italy	Not reported.	The variables most frequently associated with the use of coercive measures in the 49 studies included in this review were male sex, young adult age classes, foreign ethnicity, schizophrenia, involuntary admission, aggression or trying to abscond, and the presence of male staff.
4	Bustamante Donoso, J.A., and Cavieres Fernández, A.	2018	Review	Chile	To review the national and international context of involuntary hospitalizations, including the Chilean legislation and administrative rules, the published evidence about patients' outcomes, and clinician attitudes.	The authors conclude that the conflict in this issue is not limited to the respect for autonomy and the obligation to provide care. We are now experiencing a new way of caring patients. The complex local, social, and cultural realities require a renewed knowledge and documentation of experiences.
5	Campos Mendes, J., Azeredo-Lopes, S., and Cardoso, G.	2016	Cross-sectional study Participants: 272 patients	Portugal	To establish the prescribing patterns of antipsychotics in acute psychiatric wards across Portugal, to determine the prevalence of polypharmacy and “high-dose” treatment, and to identify possible predictors.	Age, use of depot antipsychotics, previous psychiatrichospitalization, and involuntary admission were significant predictors of antipsychotic “high doses.”
6	Canova Mosele, P.H., Figueira, G.C., Bertuol Filho, A.A., de Lima, J.A.R.F., and Calegaro, V.C.	2018	Univariate analysis, multivariate analysis, and logistic regression Participants: 137 patients hospitalized in the Psychiatry Service of the Hospital Universitário de Santa Maria (HUSM, University Hospital of Santa Maria)	Brazil	To investigate the relationship between involuntary hospitalization, severity of psychopathology, and aggression.	The variables associated with involuntariness were being brought to hospital by ambulance or police and aggression in the first 24 hr of admission. The dimensions of the BPRS associated with involuntary hospitalization were activation, resistance, and positive symptoms. Involuntary psychiatric hospitalization was associated with agitation, psychosis, and aggression.
7	Cornaggia, C.M., Beghi, M., Pavone, F., and Barale, F.	2011	Systematic review	Italy	Not reported.	The variables that were most frequently associated with aggression or violence in the 66 identified studies of unselected psychiatric populations were the existence of previous episodes, the presence of impulsiveness/hostility, a longer period of hospitalization, nonvoluntary admission, and aggressor and victim of the same sex; weaker evidence indicated alcohol/drug misuse, a diagnosis of psychosis, a younger age, and the risk of suicide.

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8	Crisanti, A.S., and Love, E.J.	2002	Retrospective cohort design Participants: 2142 patients with 1064 involuntary subjects (49.7%) and 1078 voluntary subjects (50.3%)	Canada	Whether individuals requiring involuntary hospitalization are more likely than individuals who enter treatment voluntarily to be arrested after being discharged from hospital and whether there is a high-risk period for arrest.	Involuntary subjects (24.7%) were significantly more likely to be arrested for criminal behavior compared with voluntary subjects (19.0%) [c2(1) = 10.19, $p = 0.001$]. Involuntary subjects were just as likely as voluntary subjects to have been incarcerated for the crime immediately after discharge from their index admission [c2(1) = 2.84, $p = 0.092$]. Among those subjects who subsequently engaged in criminal behavior, 30.4% of involuntary subjects and 23.4% of voluntary subjects were sentenced to custody.
9	Cunningham, G.	2012	Unspecified method Participants: 121 patients having three or more involuntary episodes in a calendar year	Ireland	To examine data relating to patients having repeated involuntary readmission in terms of demographic characteristics, length of episode, and diagnoses.	However, the use of involuntary admission remains constant at around 10% of all admissions. Seven percent ($n = 569$) of involuntary admission orders in this 4-year period relate to 2% ($n = 121$) of all IPs. 54% of involuntary episodes relate to patients who experience repeated involuntary readmission lasting for 21 days or less.
10	Dack, C., Ross, J., Papadopoulos, C., Stewart, D., and Bowers, L.	2013	Systematic review and meta-analysis of empirical articles and reports	United Kingdom	To combine the results of earlier comparison studies of in-patient aggression to quantitatively assess the strength of the association between patient factors and a) aggressive behavior, b) repetitive aggressive behavior.	Factors that were significantly associated with in-patient aggression included being younger, male, involuntary admissions, not being married, a diagnosis of schizophrenia, a greater number of previous admissions, a history of violence, a history of self-destructive behavior, and a history of substance abuse.
11	Douzenis, A., Michopoulos, I.	2015	Literature review	Greece	To report the positive or negative impact of involuntary admission in the treatment of anorexia nervosa, its application and effectiveness, as well as the adverse consequences of coercive treatment in eating disorders.	There are trends and arguments for both sides; for and against involuntary treatment in anorexia nervosa. The scientific literature so far is inconclusive, although in the short term, involuntary hospitalization has benefits. This review has also shown that involuntary hospitalization can have adverse long-term consequences for the patient-therapist allegiance.
12	Emons, B., Haussleiter, I. S., Kalthoff, J., Schramm, A., Hoffmann, K., Jendreyschak, J., Illes, F.	2014	Retrospective analysis	Germany	To identify factors influencing the voluntariness of admissions to psychiatric hospitals.	Especially the range of services provided by the social-psychiatric services in the region such as number of supervised patients and home visits had an influence on the proportion of involuntary admissions to a psychiatric hospital. Some demographic characteristics of the region such as discretionary income showed further influence. Contrary to our expectations, the characteristics of the individual hospital seem to have no influence on the admission rate.

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TABLE 1. *(Continued)*

#	Author(s)	Year	Method(s)/Subjects	Nation(s)	Objective(s)	Results
13	Fiorillo, A., De Rosa, C., Del Vecchio, V., Jurjanz, L., Schnall, K., Onchev, G. et al.	2011	Semistructured discussions, focus groups, written survey, structured and nonstructured questionnaires, discussions in thematic workshops, qualitative content-analytical method EUNOMIA study in 12 European countries	Germany	a) To clinically assess all involuntarily admitted patients living in the 13 catchment areas of the participating centers and a subgroup of voluntarily admitted patients who felt coerced at admission. b) To produce standardized reports on the national legal situations on coercive treatment measures in psychiatry on the basis of the original national legal texts. c) To develop suggestions of good clinical practice on involuntary hospital admission. d) To develop suggestions of good clinical practice on coercive treatment measures.	The need for standardizing the involuntary hospital admission has been highlighted by all centers. In the final recommendations, it has been stressed the need to providing information to patients about the reasons for hospitalization and its presumable duration; protecting patients' rights during hospitalization; encouraging the involvement of family members; improving the communication between community and hospital teams; organizing meetings, seminars, and focus groups with users; and developing training courses for involved professionals on the management of aggressive behaviors, clinical aspects of major mental disorders, and the legal and administrative aspects of involuntary hospital admissions, on communication skills.
14	Gowda, G.S., Kondapuram, N., Kumar, C.N., and Math, S.B.	2017	Prospective observational study, regression analysis Participants: 76 patients	India	To study coercion experiences among patients with schizophrenia who were admitted involuntarily. To assess if demographic factors, clinical factors, and the use of coercive measures had any influence on how patients perceived the necessity of their own involuntary admission.	Mean (SD) score on MacArthur Perceived Coercion Scale at admission was 4.04 (±1.61). This reduced to 2.43 (±1.91) ($p < 0.001$). This reduction correlated significantly with improvements in global functioning ($r = -0.40$, $p < 0.001$), insight level ($r = 0.26$, $p < 0.001$), and symptom severity ($r = 0.36$, $p < 0.001$). At discharge, 70% ($n = 47$) of patients reported that their involuntary admission was justified.
15	Hoffmann, K., Haussleiter, I.S., and Illes, F. et al.	2017	A retrospective, large-scale multicenter comparative study 230.678 treatment cases	Germany	To identify factors influencing the risk for involuntary psychiatric hospital admission.	We found an overrepresentation of involuntary admissions in young men (<21 years) with schizophrenia and in female patients aged more than 60 with a diagnosis of dementia. Most of our results are concordant with the previous literature. In addition, admission in hours out of regular outpatient services elevated the risk.
16	Hopko, D.R., Averill, P.M., Cowan, K., and Shah, N.	2002	Participants: 131 inpatients	USA	To examine the association of patient legal status with self-reported psychiatric symptoms and treatment outcome.	The results showed involuntarily admitted patients endorsed fewer psychiatric symptoms both on the SCL-90-R and on the Beck Depression Inventory. BPRS-A ratings did not differ between the voluntary and involuntary groups, suggesting an inherent difference among patients with regard to willingness and/or ability to endorse psychiatric symptoms. Involuntarily admitted inpatients also remained hospitalized longer and may have shown poorer treatment outcome. The findings highlight the importance of acknowledging patient legal status when using self-report data to guide assessment and treatment among involuntarily admitted patients.

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17	Ielmini, M., Caselli, I., Poloni, N., Gasparini, A., Pagani, R., Vender, S., and Callegari, C.	2018	Observational study Participants: 100 voluntary admitted patients and 100 involuntary admitted patients	Italy	a) To observe the most frequent diagnosis both in compulsory admitted patients and in those with voluntary admission. b) To evaluate the most recurring clinical features in the two groups of patients and to verify the existence of a correlation between the modality of admission and the length of hospitalization.	Schizophrenia, schizotypal personality and delusional disorder (F20–29), and other personality disorders (F60–69) are the most frequent diagnosis among patients compulsorily admitted (55% *vs.* 35%, $p < 0.01$); mood disorder is more frequent among volunteer patients (F30–39: 32% *vs.* 15%, $p < 0.01$). A significant difference between LOS of the volunteer patients (13.033 days; SD, 8.19) and LOS of compulsory admitted patients (26.33 days; SD, 22.4) was observed ($p < 0.003$).
18	Isobel, S.	2019	Mixed inductive-deductive descriptive analytical approach using a purpose designed tool and structured interviews Participants: 67 inpatients	Australia	To gather voluntary and involuntary service users' experiences of care during hospitalization in two acute adult mental health inpatient units, through the collaborative completion of a purpose designed tool. The purposes of the study were to examine broad experiences of care and to identify the utility of proactive approaches to ongoing service evaluation.	Findings highlight the complexity of experiences of care including how an admission can seemingly facilitate clinical recovery while not being recovery oriented. The findings also detail areas for improvement in the way that care is delivered and evaluated. The implications are particularly pertinent for mental health nurses to consider how, within the existing constraints of their roles, they can provide therapeutic care to all service users.
19	Jankovic, J., Yeeles, K., Katsakou, C., Amos, T., Morriss, R. et al.	2011	Qualitative study Participants: 30 family caregivers of 29 patients who had been involuntarily admitted to 12 hospitals across England	United Kingdom (England)	To explore family caregivers' experience of involuntary admission of their relative.	Four major themes of experiences were identified: relief and conflicting emotions in response to the relative's admission; frustration with a delay in getting help; being given the burden of care by services; and difficulties with confidentiality. Relief was a predominant emotion as a response to the relative's admission, and it was accompanied by feelings of guilt and worry. Family caregivers frequently experienced difficulties in obtaining help from services before involuntary admission, and some thought that services responded to crises rather than prevented them. Family caregivers experienced increased burden when services shifted the responsibility of caring for their mentally unwell relatives to them. Confidentiality was a delicate issue with family caregivers wanting more information and a say in decisions when they were responsible for aftercare, and being concerned about confidentiality of information they provided to services.
20	Johansson, I.M., Lundman, B.	2002	Qualitative study Participants: 5 involuntary hospitalized psychiatric	Sweden	To illuminate the experience of being subjected to involuntary psychiatric care.	The result of the analysis gave a complex picture of both support and violation. On the one hand, experiences of not being seen or heard, of loss of liberty, and of violation of integrity were found. On the other hand, there were experiences of respect and caring and opportunities to take responsibility for oneself were offered. Being treated involuntarily in psychiatric care was interpreted as a balancing act between good opportunities and great losses.

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TABLE 1. (Continued)

#	Author(s)	Year	Method(s)/Subjects	Nation(s)	Objective(s)	Results
21	Kallert, T.W., Gloückner, M., and Schuützwohl, M.	2008	A systematic literature review	Germany	To bridge the gap (differences in outcomes of involuntarily admitted patients versus voluntary have not been systematically assessed) answering the question: What is the outcome of general psychiatric inpatient care for patients admitted involuntarily compared with patients admitted voluntarily?	Length of stay, readmission risk, and risk of involuntary readmission were at least equal or greater for IPs. IPs showed no increased mortality but did have higher suicide rates than VPs. Furthermore, IPs demonstrated lower levels of social functioning and equal levels of general psychopathology and treatment compliance; they were more dissatisfied with treatment and more frequently felt that hospitalization was not justified.
22	Katsakou, C., and Priebe, S.	2006	Review	United Kingdom	To explore the evidence on involuntary admissions in general adult psychiatry and addresses the following questions: a) What are the outcomes of involuntary hospital admission and subsequent inpatient treatment in terms of observer-rated clinical change and patient-rated outcomes? b) What sociodemographic and clinical characteristics of patients predict more or less favorable outcomes?	Most involuntarily admitted patients show substantial clinical improvement over time. Retrospectively, between 33% and 81% of patients regard the admission as justified and/or the treatment as beneficial. Data on predictors of outcomes are limited and inconsistent. Patients with more marked clinical improvement tend to have more positive retrospective judgments.
23	Katsakou, C., and Priebe, S.	2007	Review of qualitative studies		To explore psychiatric patients' experiences of involuntary admission and treatment by reviewing qualitative studies.	The main areas that seem to be of importance are patients' perceived autonomy and participation in decisions for themselves, their feeling of whether they are being cared for, and their sense of identity. In these areas, both negative and positive consequences from involuntary admission were mentioned.
24	Katsakou, C., Rose, D., Amos, T., (...), Wykes, T., and Priebe, S.	2012	Qualitative study Participants: 59 patients involuntarily admitted in acute wards in 22 hospitals across England	United Kingdom (England)	To explore IPs' retrospective views on why their hospitalization was right or wrong.	Common experiences, 3 groups of patients with distinct views on their involuntary hospitalization were identi fied: those who believed that it was right, those who thought it was wrong, and those with ambivalent views. Those with retrospectively positive views believed that hospitalization ensured that they received treatment, averted further harm, and offered them the opportunity to recover in a safe place. They felt that coercion was necessary, as they could not recognize that they needed help when acutely unwell. Those who believed that involuntary admission was wrong thought that their problems could have been managed through less coercive interventions and experienced hospitalization as an unjust infringement of their autonomy, posing a permanent threat to their independence. Patients with ambivalent views believed that they needed acute treatment and that hospitalization averted further harm. Nonetheless, they thought that their problems might have been managed through less coercive community interventions or a shorter voluntary hospitalization.

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25	Khatib, A., Ibrahim, M., and Roe, D.	2018	Qualitative study Participants: 15 subjects after hospitalization	Israel	To identify the elements that might best minimize the negative consequences of restriction of inpatients and rebuild therapeutic alliance and trust.	Analysis of the data revealed 3 major themes with regard to trust between restrained patient and restraining staff members during restriction of the patient's freedom. Duration of restriction, contact with a staff member while restrained, supportive interactions, and staff's response to restricted patients' needs were reported by patients as crucial in determining the way restrained is experienced and its later impact. Physical restraint in psychiatric hospitalizations generates many negative feelings and can even be traumatic. The patients interviewed help us learn how to provide more human and therapeutic interactions even in extreme situations of restrain, which can be crucial to rebuild therapeutic alliance and trust.
26	Korkeila, J.A., Tuohimäki, C., Kaltiala-Heino, R., Lehtinen, V., and Joukamaa, M.	2002	Retrospective chart review	Finland	a) To study possible differences in the population-based rates of use of seclusion and restraint, rates of previous admissions or commitments to a psychiatric hospital, and rates of diagnoses among three Finnish centers (Turku, Tampere, and Oulu). b) To study the factors predicting the overall use of seclusion and/or restraints in psychiatric treatment settings in 3 different centers. c) To investigate "heavy use" of seclusion and restraints.	There were significant differences among the studied centers as to the population-based level of use of seclusion and restraints. Oulu used significantly less seclusion but had a significantly higher level of use of restraints than Turku and Tampere. The individual institutions best predicted the overall use of restrictive interventions, whereas previous commitments and involuntary legal status on admission were factors predicting "heavy use" of these.
27	Krieger, E., Moritz, S., Weil, R., and Nagel, M.	2018	Exploratory and naturalistic study Participants: 213 patients who had experienced coercion and 51 patient controls	Germany (Hamburg)	To examine patients' attitudes toward and understanding of previously experienced coercive measures and their preferences related to coercive measures and possible alternatives.	As expected, "noninvasive measures" (*e.g.*, the use of a "soft room," observation in seclusion) were better accepted by patients than "invasive measures" (*e.g.*, mechanical restraint, forced medication). Forced medication and mechanical restraint were less well accepted than involuntary hospitalization, seclusion, or video surveillance. The retrospective understanding of coercive measures increased over the course of treatment. In addition, patients rated a number of options for reducing coercion on the wards, particularly music or exercises. A large subgroup indicated they would like to discuss future admissions with the staff.

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TABLE 1. *(Continued)*

#	Author(s)	Year	Method(s)/Subjects	Nation(s)	Objective(s)	Results
28	Lay, B., Drack, T., Bleiker, M., Lengler, S., Blank, C. and Rössler, W.	2015	Participants: 238 psychiatric inpatients who had had compulsory admission(s) during the past 24 mos	Switzerland (Zurich)	a) To examine changes in the patients' perspective, focusing on perceived coercion, empowerment, and self-reported mental health functioning. We hypothesized that the intervention alters patients' perceived coercion so that they feel less coerced and experience greater empowerment. b) To explore whether altered perceptions are linked to particular patient characteristics. c) In which way the patients' perceptions are related to the experience of compulsory rehospitalization during the 12-mo period.	Study participants reported lower levels of perceived coercion, negative pressures, and process exclusion; a higher level of optimism; and a lesser degree of distress due to symptoms, interpersonal relations, and social role functioning (significant time effects). However, improvements were not confined to the intervention group but seen also in the treatment-as-usual group (no significant group or interaction effects). Altered perceptions were linked to older age, shorter illness duration, female sex, nonpsychotic disorder, and compulsory hospitalization not due to risk of harm to others.
29	Maiese, A., Dell'Aquila, M., Romano, S., Santurro, A., De Matteis, A., Scopetti, M., Arcangeli, M., La Russa, R.	2019	Case study of a 58-year-old White male, under involuntary medical treatment	Italy	To evaluate the suitability of restrictive methods for psychiatric patients to establish specific rules to prevent abuse of restraint techniques and even to help physicians to treat psychiatric patients.	During the IHT, he suffered firstly a pharmacological restraint and then a physical restraint to suppress a slight state of agitation. The patient was completely blocked to the bed for more than 80 hr and died after 3 days of hospitalization
30	McLaughlin, P., Giacco, D., and Priebe, S.	2016	Prospective study Across 10 European countries	United Kingdom	To assess the association between different types of coercive measures (forced medication, seclusion, and restraint) used during IPA.	Use of forced medication was associated with patients being significantly less likely to justify their admission when interviewed after 3 mos. All coercive measures were associated with patients staying longer in hospital. When the influence of other variables was considered in a multivariate analysis, seclusion remained as a significant predictor of longer inpatient stay, adding about 25 days to the average admission. Of the 3 coercive measures, forced medication seems to be unique in its significant impact on patient disapproval of treatment. Whereas all coercive measures are associated with patients staying longer in hospital, only use of seclusion is associated with longer inpatient stays independently of coerced patients' having higher symptom scores at the time of admission.
31	Mielau, J., Altunbay, J., Gallinat, J., Heinz, A., Bermpohl, F., Lehmann, A., and Montag, C.	2016	Comparative study Participants: 90 patients with schizophrenia, schizoaffective, and bipolar disorder according to *ICD-10*, and 60 nonclinical control subjects	Germany	To explore attitudes toward psychiatric coercive interventions in healthy individuals and persons with schizophrenia, schizoaffective, or bipolar disorder.	Patients and nonpsychiatric controls showed no significant difference in their attitudes toward involuntary admission and forced medication. Conversely, patients more than controls significantly disapproved of mechanical restraint. Subjective experience of coercive interventions played an important role for the justification of treatment against an individual's "natural will." Factors influencing judgments on coercion were overall functioning and personal experience of treatment effectiveness and fairness.

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32	Opsal, A., Kristensen, Ø., Vederhus, J. K., and Clausen, T.	2016	Unspecified method Participants: 63 patients involuntarily admitted and 129 patients voluntarily admitted	Norway	To study patients diagnosed with substance use disorders who were involuntarily admitted to hospital, to determine whether these patients perceived coercion differently than patients who were admitted voluntarily.	Scores on the Perceived Coercion Questionnaire showed that patients admitted voluntarily and those admitted involuntarily experienced similar levels of perceived coercion. Those admitted voluntarily reported higher levels of perceived coercion from internal sources, and those admitted involuntarily perceived significantly higher coercion from legal sources. No differences between groups were found with the other tests.
33	Oyffe, I., Kurs, R., Gelkopf, M., Melamed, Y., and Bleich, A.	2009	Cross sectional study Participants: 183 who were admitted to hospital 3 or more times; 1056 non–revolving door patients registered in the computerized hospital database and random sample of 98 non–revolving door patients	Israel	To study social, demographic, clinical, and forensic profiles of frequently rehospitalized (revolving door) psychiatric patient	In the period 1999–2000, 183 revolving door patients accounted for 771 (37.8%, 4.2 admissions per patient) and 1056 non–revolving door patients accounted for 1264 (62.5%, 1.2 admissions per patient) of the 2035 admissions to hospital. Involuntary hospitalizations accounted for 23.9% of revolving door and 76.0% of non–revolving door admissions. Revolving door patients had significantly shorter mean interval between hospitalizations, showed less violence, and were usually discharged contrary to medical advice. We found no differences in sex, marital status, age, ethnicity, diagnoses, illegal drug and alcohol use, or previous suicide attempts between the groups.
34	Pandarakalam, J. P.	2015	Qualitative research	United Kingdom	To enhance the awareness among mental health professionals for the need to upgrade the quality of research on the effects of involuntary admission and find more sophisticated alternatives.	There is a scarcity of research specifically concerned with the identification of the ill effects of compulsory detention and detection of a subset of highly vulnerable patients who are likely to respond negatively to compulsory care.
35	Priebe, S., Katsakou, C., Amos, T., Leese, M., Morriss, R., Rose, D., Til Wykes, T., and Yeeles, K.	2009	Observational prospective study Participants: 1570 involuntarily admitted patients	United Kingdom (England)	To assess involuntary readmissions and patients' retrospective views of the justification of the admission as 1-yr outcomes and to identify factors associated with these outcomes.	At 1 yr, 15% of patients had been readmitted involuntarily, and 40% considered their original admission justified. Lower initial treatment satisfaction, being on benefits, living with others, and being of African and/or Caribbean origin were associated with higher involuntary readmission rates. Higher initial treatment satisfaction, poorer initial global functioning, and living alone were linked with more positive retrospective views of the admission.
36	Priebe, S., Katsakou, C., Glöckner, M., Dembinskas, A., Fiorillo, A., Karastergiou, A., Kiejna, A., Kjellin, L., Nawka, P., Onchev, G., Schuetzwohl, M., Solomon, Z., Torres-Gonzalez, F., Wang, D., Kallert, T. and Raboch, J.	2010	Multicenter prospective cohort study in 11 countries Participants: 2326 consecutive IPs	Bulgaria, Czech Republic, Germany, Greece, Italy, Lithuania, Poland, Slovakia, Spain, Sweden, and United Kingdom	To explore patients' views after involuntary hospitalization in different European countries.	In the different countries, between 39% and 71% felt the admission was right after 1 mo, and between 46% and 86% after 3 mos. Females, those living alone, and those with a diagnosis of schizophrenia had more negative views. Adjusting for confounding factors, differences between countries were significant.

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TABLE 1. (Continued)

#	Author(s)	Year	Method(s)/Subjects	Nation(s)	Objective(s)	Results
37	Raboch, J., Kališová, L., Nawka, A., Kitzlerová, E., Onchev, G., Karastergiou, A., Magliano, L., Dembinskas, Kiejna, A., Torres-Gonzales, F., Priebe, S., Kallert, S., Kjellin, L.	2010	Participants: 2030 involuntarily admitted patients	Bulgaria, Czech Republic, Germany, Greece, Italy, Lithuania, Poland, Spain, Sweden, and United Kingdom	To assess and compare the use of coercive measures in psychiatric inpatient facilities in 10 European countries.	In total, 1462 coercive measures were used with 770 patients (38%). The percentage of patients receiving coercive measures in each country varied between 21% and 59%. The most frequent reason for prescribing coercive measures was patient aggression against others. In 8 of the countries, the most frequent measure used was forced medication, and in 2 of the countries, mechanical restraint was the most frequent measure used. Seclusion was rarely administered and was reported in only 6 countries.
38	Ritsner, M. S., Farkash, H., Rauchberger, B., Amrami-Weizman, A., and Zendjidjian, X. Y.	2018	Cross-sectional study Participants: 125 patients	Israel	To compare the levels of needs, care satisfaction, quality of life, and social support of compulsory admitted patients with severe mental disorders to a comparable group of voluntary admitted patients.	Court observation order (COO) patients were significantly discriminated from the 2 other groups (district psychiatrist order and voluntary) by severe negative symptoms, better satisfaction with both nursing staff, and family support. COO subjects had more nonillness unmet needs, whereas reported better hedonic capacity for social and interpersonal pleasure—compared with VA patients. District psychiatrist order patients were significantly indicated by poorer awareness to illness, but better satisfaction with subjective feelings. Voluntary subjects were significantly discriminated from compulsory admitted patients by higher illness severity scores.
39	Rosenman, S., Korten, A., and Newman, L.	2000	Comparative study Participants: 105 involuntarily hospitalized psychiatric inpatients	Australia (Canberra)	The effectiveness of an experimental model of personal advocacy for involuntarily hospitalized psychiatric patients was examined.	The experimental and control groups were similar in demographic characteristics, diagnosis, and severity of illness. At the start of hospital care, satisfaction with care was similar in both groups; however, it improved significantly in the experimental group, whereas it declined in the control group. Aftercare attendance was significantly better in the experimental group. The experimental subjects' risk of involuntary rehospitalization was less than half the risk of control subjects, and community tenure was significantly increased. Clinical staff reported that the experimental advocacy facilitated management of patients.

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40	Rüsch, N., Müller, M., Lay, B., Corrigan, P. W., Zahn, R., Schönenberger, T., Bleiker, M., Lengler, S., Blank, C., and Rössler, W.	2014	Participants: 186 individuals involuntarily admitted during the past 24 mos	Switzerland (Zurich)	Quantitative studies of stigma-related emotional and cognitive reactions to involuntary hospitalization and their impact on people with mental illness.	In multiple linear regressions, more self-stigma was predicted independently by higher levels of shame, self-contempt, and stigma stress. A greater sense of empowerment was related to lower levels of stigma stress and self-contempt. These findings remained significant after controlling for psychiatric symptoms, diagnosis, age, sex, and the number of lifetime involuntary hospitalizations. Increased self-stigma and reduced empowerment in turn predicted poorer quality of life and reduced self-esteem. The negative effect of emotional reactions and stigma stress on quality of life and self-esteem was largely mediated by increased self-stigma and reduced empowerment. Shame and self-contempt as reactions to involuntary hospitalization as well as stigma stress may lead to self-stigma, reduced empowerment, and poor quality of life. Emotional and cognitive reactions to coercion may determine its impact more than the quantity of coercive experiences.
41	Sampogna, G., Luciano, M., Del Vecchio, V., Pocai, B., Palummo, C., Fico, G. Vincenzo Giallonardo, V., De Rosa, C., and Fiorillo, A.	2019	Participants: 294 patients recruited in 5 Italian psychiatric hospitals	Italy	To identify sociodemographic and clinical predictors of the levels of perceived coercion in a sample of Italian patients with severe mental disorders at hospital admission.	According to the multivariable regression model, being compulsorily admitted (OR, 2.5; 95% CI, 1.3–3.3; $p < 0.000$), being male (OR, 0.7; 95% CI, 0.9–1.4; $p < 0.01$), being older (OR, 0.03; 95% CI, 0.01–0.06), and less satisfied with received treatments (OR, −0.2; 95% CI, −0.3 to −0.1; $p < 0.05$) are all associated with higher levels of perceived coercion, even after controlling for the use of any coercive measure during hospitalization.
42	Seed, T., Fox, J. R., and Berry, K.	2016	A review and synthesis of qualitative studies	United Kingdom	To build on a previous review and updated understanding of how patients experience involuntary detention for their mental health difficulties.	Results: 7 overarching themes emerged. “Sanctuary,” “loss of normality and perceived independence,” “feeling terrified,” and “fluctuating emotions” illustrate the experiences of involuntary detention. The remaining themes reflect the factors that influence these experiences: “a continuum of person-centered practice,” “disempowerment,” and “intrapsychic coping.”
43	Strauss, J. L., Zervakis, J. B., Stechuchak, K. M., Olsen, M. K., Swanson, J., Swartz, M. S., Weinberger, M., Marx, C., Calhoun, P., Bradford, D., Butterfield, M. I., and Oddone, E.Z.	2013	Participants: 240 psychiatric inpatients	United Kingdom (Durham)	To examine associations between objective and subjective indices of coercive treatments and patients' satisfaction with care in a psychiatric inpatient sample ($N = 240$)	Lower satisfaction ratings were independently associated with 3 coercive treatment variables: current involuntary admission, perceived coercion during current admission, and self-reported history of being refused a requested medication. Albeit preliminary, these results document associations between patients' satisfaction ratings and their subjective experiences of coercion during both current and prior hospitalizations.

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TABLE 1. *(Continued)*

#	Author(s)	Year	Method(s)/Subjects	Nation(s)	Objective(s)	Results
44	Stylianidis, S., Peppou, L. E., Drakonakis, N., Iatropoulou, G., Nikolaidi, S., Tsikou, K., and Souliotis, K.	2018	Focus group study Participants: 14 involuntarily admitted patients	Greece	Exploring patients' views about the rightfulness of compulsory admission, their experience of hospitalization, and potential interventions for reducing its effect in Athens.	The themes that emerged include conflicting attitudes toward the rightfulness of admission, the absence of patient participation in any form of decision making, substantial infringement of human rights, and patients' dearth of knowledge about them. Therefore, raising awareness initiatives, adequate training of all involved parties, the integration of psychotherapy in the treatment plan, the creation of a therapeutic milieu, and less coercive alternatives to acute psychiatric care were the course of action suggested by patients.
45	Svindseth, M. F., Dahl, A. A., and Hatling, T.	2007	Participants: 102 patients	Norway	To investigate the experiences of humiliations by patients in the admission process to acute psychiatric wards.	Negative events during the admission process were significantly more common among patients with involuntary admission, but were also observed among those voluntary admitted. Humiliation in connection with negative events during the admission process was reported by 48 patients: 24 involuntary and 24 voluntary admitted. In univariate analyses, humiliation was significantly associated with events where the patients were exposed to verbal or physical force, as well as with the conviction that "the admission was not right." In multivariate analyses, the latter conviction was the only significant one, although "use of physical force" also showed a trend (P/0.06). Negative events are common among the routines, procedures, and situations of the admission process to acute psychiatric wards.
46	Taborda, J. G., Baptista, J. P., Gomes, D. A., Nogueira, L., and Chaves, M. L. F.	2004	Cross-sectional study Participants: 205 hospitalized patients comprising 64 psychiatric patients, 58 surgical patients, and 83 medical patients	Brazil	Assessment of perceptions of coercion among psychiatric and nonpsychiatric (surgical and medical) patients after admission.	Psychiatric patients presented significantly higher scores in all scales than nonpsychiatric ones, and among the mentally ill individuals, those involuntarily hospitalized felt themselves more coerced during admission. This was not observed among nonpsychiatric patients. Surgical and medical patients, independent of status of hospitalization (emergence or elective) presented similar feelings of coercion, pressures, and fairness during admission, suggesting that they were a homogeneous group as far as the restrictions on autonomy they suffered are concerned.

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47	Tarrier, N., Khan, S., Cater, J., and Picken, A.	2007	Qualitative study Participants: 35 patients	United Kingdom (Manchester)	To assess the subjective effect and consequences of experiencing a first episode of psychosis. It was hypothesized that suicide behavior would be associated with the negative consequences of psychosis and comorbid symptomatic PTSD.	A total of 35 patients experiencing their first episode of psychosis were interviewed. As a result of the onset of their illness, 77% indicated they had had loss or disruption to their life, 60% had thwarted future aspirations, 38% had experienced violence or harassment, 53% had experienced stigma, and 50% social exclusion. In total, 80% felt they had been traumatized by their treatment, and 38% were cases for symptomatic PTSD. Symptomatic PTSD was significantly associated with involuntary hospitalization but not psychotic symptoms. Positive psychotic symptoms were associated with harassment, stigma, and social exclusion. Suicidal ideation was reported by 40%, and 31% reported attempting suicide. Suicidal behavior was greater in those with symptomatic PTSD, but this was not significant, suicidal behavior was significantly associated with the experience of trauma, but not the severity of that trauma, before the onset of their psychosis.
48	Terkelsen, T. B., and Larsen, I. B.	2013	Ethnography	Norway	To explore how patients and staff act in the context of involuntary commitment, how interactions are described, and how they might be interpreted.	Two parallel images emerged: a) the ward as a hotel. Several patients wanted a locked ward for rest and safety, even when admission was classified as involuntary. The staff was concerned about using the ward for real treatment of motivated people, rather than merely as a comfortable hotel for the unmotivated. b) The ward as a detention camp. Other patients found involuntary commitment and restrictions in the ward as a kind of punishment, offending them as individuals. Contrary, the staff understood people with dual diagnoses more like a generalized group in need of their control and care.
49	Van der Post, L. F., Beekman, A. T., Peen, J., Zoeteman, J., Twisk, J. W., and Dekker, J. J.	2016	Observational study Participants: 460 involuntarily admitted patients	Netherlands (Amsterdam)	Look at the 5-yr outcome of involuntary admissions after psychiatric emergency consultations in Amsterdam	The ORs for involuntary readmission during the fourth and fifth follow-up years were 0.71 (95% CI 1/4 0.50–1.01; P 1/4 0.059) and 0.64 (95% CI 1/4 0.45–0.92; P 1/4 0.015), respectively. Readmission was associated with low discontinuity of treatment (Chi2 P 0.001) and high total consumption of services (Chi2 P 0.001) during follow-up. It emerged that involuntary readmission could be predicted on the basis of high care consumption 5 yrs before inclusion (OR, 2.61; CI, 1.44–4.73; P 0.002), a history of involuntary admission (OR, 1.56; CI 1/4 1.03–2.35; P 1/4 0.034), being older than 44 yrs at baseline (OR, 0.57; CI 1/4 0.39–0.84; P 1/4 0.007), and living alone (OR, 1.68; CI 1/4 1.22–02.33; P 1/4 0.002). The risk of involuntary readmission declines after 3 yrs.

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TABLE 1. (Continued)

#	Author(s)	Year	Method(s)/Subjects	Nation(s)	Objective(s)	Results
50	Van der Post, L., Mulder, C. L., Bernardt, C. M., Schoevers, R. A., Beekman, A. T., and Dekker, J.	2009	Prospective cohort study	Netherlands (Amsterdam)	Presents initial data from the Amsterdam Study of Acute Psychiatry (ASAP-I) about factors associated with the decision to admit patients compulsorily (involuntarily) to emergency psychiatric services in the Amsterdam region of the Netherlands.	A history of more than 14 outpatient contacts the previous year was associated with a low risk of compulsory admission (OR, 0.3). An involuntary admission in the previous 5 yrs was associated with a higher risk (OR, 3.7). Referral by a general practitioner was associated with a low risk compared with referral by police (OR, 2.4) or by mental health services (OR, 2.3).
51	Vannoy, S.D., Andrews, B.K. and Srebnik, D.	2016	Observational, descriptive study	USA	To analyze data on 10,082 suicides from 2000 to 2011 to examine demographics related to evaluation for detention and the association between demographics and evaluation dispositions on survival time.	Evaluation preceded 11% of suicides; 53.8% of deaths occurred within 365 days, 6.5 times the expected rate. Males and older individuals were least likely to have been evaluated. Minority status and referral disposition influence 30-day survival time. Risk is highly concentrated in the first year after evaluation.
52	Wyder, M., Bland, R., Blythe, A., Matarasso, B., and Crompton, D.	2015	Qualitative research Participants: 25 involuntary inpatients	Australia	To capture the experience of people receiving involuntary treatment.	Participants described the following themes: a) the ITO admission was a daunting and frightening experience; b) staff behaviors and attitudes shaped their experiences in hospital; c) importance of staff listening to their concerns; d) importance of having a space to make sense of their experiences; e) importance of staff ability to look beyond their illness and diagnosis; and f) importance of staff working in partnership.
53	Wynn, R.	2018	Systematic review	Norway	Identifying the current state of knowledge and areas in need of further research.	Seventy-four articles were included and grouped into 6 categories based on their main topics: Patients' experiences, satisfaction and perceived coercion (21 articles), the referral and admission process (11 articles), rates of admission (8 articles), characteristics of the patients (17 articles), staff attitudes (9 articles), and outcomes (8 articles). The findings were largely in line with the international literature, but the particularities of Norwegian legislation and the Norwegian health services were reflected in the literature. The 4 intervention studies explored interventions for reducing rates of involuntary admission, such as modifying referring routines, improving patient information procedures, and increasing patients' say in the admission process, and represent an important avenue for future research on involuntary admission in Norway.

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No.	Authors	Year	Method	Country	Aim	Findings
54	Wynn, R.	2006	Unspecified method	Norway	To present types and rates of coercion and discuss competency, ethics, and the reasons given for the use of coercion.	Although legislation in all Western countries allows for the coercion of patients with a mental disorder, when they pose a danger to themselves or others, most countries also accept the use of coercive measures when this is considered necessary for treatment. Whereas some see all use of coercion as unethical, most seem to agree that the use of coercion is ethically acceptable when the benefits with regard to protection or treatment outweigh the negative effects on patients' autonomy, integrity and comfort. Research is still scarce regarding the clinical outcomes of the use of coercion, and more studies are needed that examine the clinical outcomes of involuntary admission and involuntary medication.
55	Xu, Z., Lay, B., Oexle, N., Drack, T., Bleiker, M., Lengler, S., Blank, C., Müller, M., Mayer, B., Rössler, W., and Rüsch, N.	2019	Participants: 186 individuals with serious mental illness and a history of recent involuntary hospitalization	Switzerland (Zürich)	To examine the impact of stigma-related emotional reactions and stigma stress on recovery over a 2-yr period.	More shame, self-contempt, and stigma stress at baseline were correlated with increased self-stigma and reduced empowerment after 1 yr. More stigma stress at baseline was associated with poor recovery after 2 yrs. In a longitudinal path analysis, more stigma stress at baseline predicted poorer recovery after 2 yrs, mediated by decreased empowerment after 1 yr, controlling for age, sex, symptoms, and recovery at baseline.
56	Zanardo, G. L. D. P., Moro, L. M., Ferreira, G. S., and Rocha, K. B.	2018	Systematic review	Brazil	To analyze the criteria of FPR and associated factors	The most consistent results indicate that young, single people, with less social support and involuntary admissions have higher chances of FPR, while community interventions seem to reduce FPR.
57	Zervakis, J., Stechuchak, K. M., Olsen, M. K., Swanson, J. W., Oddone, E. Z., Weinberger, M., Bryce, E. R., Butterfield, M. I., Swartz, M. S., and Strauss, J. L.	2007	Participants: 205 voluntarily hospitalized veterans	USA (North Carolina)	Whether history of involuntary commitment was associated with current perceptions of coercion in a sample of voluntarily hospitalized veterans ($N = 205$).	In adjusted analyses, perceived coercion during the voluntary admission was significantly associated with prior history of involuntary commitment (rate ratio, 1.60; $p = 0.05$). Perceived coercion was also higher among participants who were married/cohabiting (rate ratio, 1.83; $p = 0.01$) and among those with greater functional impairment (rate ratio, 0.97; $p = 0.04$). Although frequently unavoidable, the current results underscore the potential negative effects of coercive practices such as involuntary commitment and support the importance of policies that aim to minimize coercive treatment experiences among psychiatric patients.

FPR, frequent psychiatric readmission; IHT, involuntary health treatment; ITO, involuntary treatment order; LOS, length of hospitalization; SCL-90-R, symptom checklist-90 revised.

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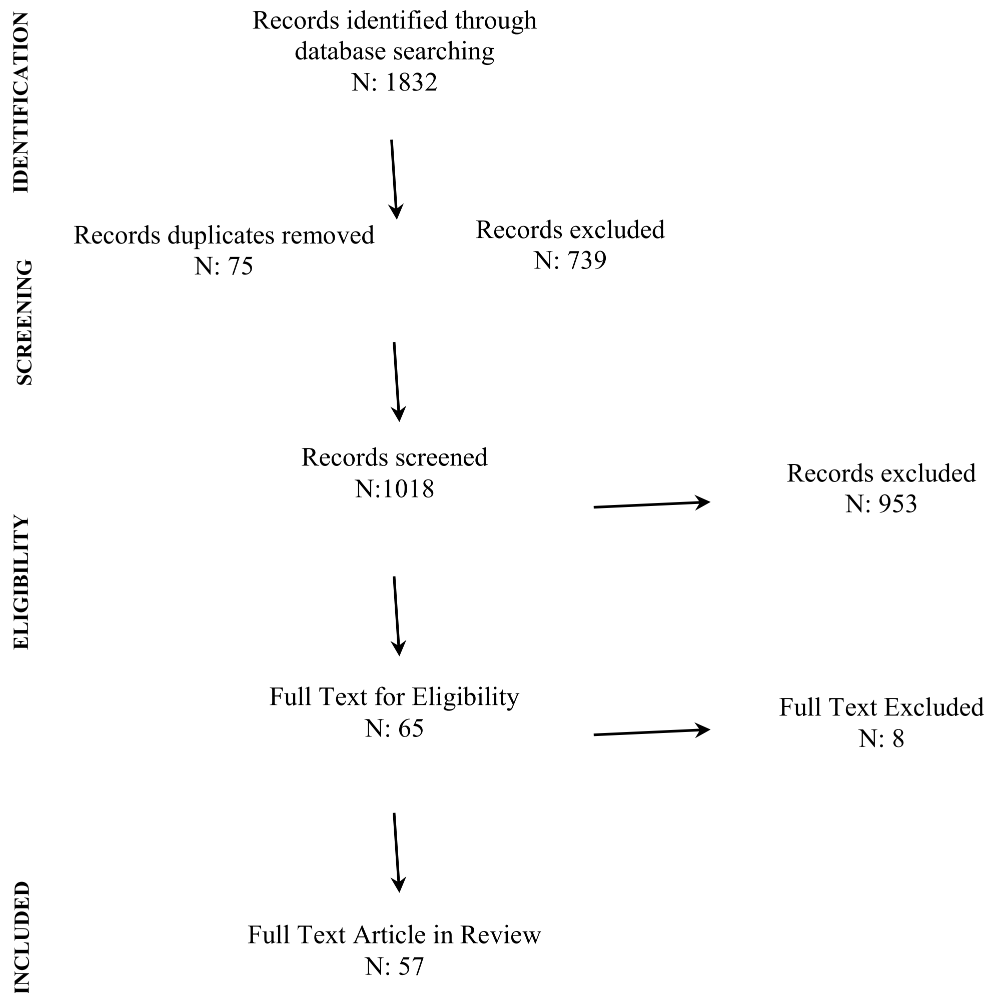

FIGURE 1. Preferred reporting items for systematic reviews and meta-analyses flow diagram illustrating the processes of literature searches and screening.

found that involuntary legal status on admission predicted the use of restraints (odds ratio [OR], 5.6; 95% confidence interval [CI], 3.0–10.4; probability [p] < 0.001). Furthermore, involuntary legal status on admission (OR, 9.8; 95% CI, 6.3–15.3; $p < 0.001$) and previous commitments (OR, 2.3; 95% CI, 1.5–3.6; $p < 0.001$) were significant predictive factors for either seclusion or restraints when using a stepwise logistic regression model. By drawing upon previously gathered data from the European Evaluation of Coercion in Psychiatry and Harmonization of Best Clinical Practice and involving 2030 involuntarily admitted patients from 10 countries (Bulgaria, Czech Republic, Greece, Germany, Italy, Lithuania, Poland, Spain, Sweden, and the United Kingdom), McLaughlin et al. (2016) found that 37.9% of the patients were subjected to coercive measures in the first month of their admission or less, if discharged within 1 month.

In an exploratory and naturalistic study on 213 IPs, Krieger et al. (2018) detected (4 of 5 days after the coercion intervention was finished) frequent use of these interventions on IPs overall, compared with the group of VPs. In fact, after admission, IPs had experienced mechanical restraint (36.6%), seclusion (15%), forced medication (14.1%), and video monitoring (9.4%). Of all the IPs, 21.1% experienced one coercive measure, 19.7% experienced two, and 3.8% experienced three coercive interventions (Krieger et al., 2018). In addition, in a systematic review, Beghi et al. (2013) presented a cross-sectional prospective study in which authors highlighted how, of the 1214 IPs, 35% had been secluded, 10% had been restrained, and 9% had received involuntary depot medication at discharge.

Furthermore, to assess the frequency of coercion in IPA, it was deemed useful to consider a prospective study that dealt with this issue among 10 European countries with different legislations and practices regarding IPA and which had no statistically significant influences of the technical features of countries overall (Raboch et al., 2010). The authors used the same methods across each location's object of inquiry, revealing that coercion had been used with 770 involuntarily admitted patients (Raboch et al., 2010). Consistent with other previous studies (Abderhalden et al., 2007), Raboch et al. (2010) identified involuntarily admitted status as a predictor of coercive interventions. In fact, they noticed a frequency of 38% of coercive measures in their sample of participants, a rate that is higher than that retrieved from other similar studies in several other European countries (Raboch et al., 2010). Statistically speaking, Korkeila et al. (2002) found previous commitments (OR, 2.2; 95% CI, 1.3–3.8; $p < 0.01$) and involuntary legal status on admission (OR, 14.0; 95% CI, 7.7–25.0; $p < 0.001$) as predictors of the overall risk of seclusion.

Impacts of IPA on Patients' Perceptions of Coercive Treatments

Ambivalent positions concerning inpatients' reactions to IPA have been traced down in the literature, regarding patients' perceptions of coercion (Krieger et al., 2018; Wynn, 2006, 2018). In the current research, only one study was found to report a negative and independent

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correlation between IPA and perceived coercion and between past experience of coercion and satisfaction with care (Strauss et al., 2013). Several studies reported higher levels of perceived coercion in IPs than in VPs (Katsakou et al., 2012; Terkelsen and Larsen, 2013; Wynn, 2018) or nonpsychiatric patients (Taborda et al., 2004). Furthermore, one study found that the occurrence of IPA impacted the perceived coercion more than the nonoccurrence. Concurrently, other studies highlighted that both IPs and VPs revealed perceived coercion during the admission, and in some cases, VPs reported significantly higher scores in a self-subscale concerning the internal sources of perceived coercion (Opsal et al., 2016). On the other hand, Zervakis et al. (2007) showed that a history of past involuntary admission and patients' perception of coercion were positively associated. Research on IPA and perceived coercion has found a degree of agreement among patients for their involuntary hospitalization before (Sampogna et al., 2019) and during (Mielau et al., 2016) admission. This degree of agreement was justified by the patients' idea of having protected themselves and others (Gowda et al., 2017; Mielau et al., 2016) and the sense of care, protection, and safety (Krieger et al., 2018; Stylianidis et al., 2018). Nevertheless, other authors ascertained how dissatisfaction and negative feelings, such as frustration, low self-esteem, anger, sadness, infringement of the autonomy, and feeling out of control during the admission, are associated with IPA and coercive practices (Katsakou et al., 2012; Krieger et al., 2018; Taborda et al., 2004). Furthermore, Stylianidis et al. (2018) found that when IPA is combined with systematic police involvement and mechanical restraints, a severe loss of dignity is experienced by inpatients. When IPA is accompanied by coercive measures, the impacts also include a sense of dissatisfaction toward services (Isobel, 2019; Lay et al., 2015). Concerning the extent to which the degree of perceived coercion impacts the treatment of IPs, one study remarked that IPA does not influence improvement in the Global Assessment Scale, whereas the conditions of those IPs that felt coerced improved during hospitalization (Wynn, 2006). Along with studies concerning the relationships between IPA and perceived coercion, there is evidence that the legal status on the admission of IPs has a direct impact on the uses of restrictive admission (Beghi et al., 2013; Wynn, 2018).

Another issue related to IPA concerns the sense of humiliation and loss of freedom on the side of IPs (Svindseth et al., 2007; Wynn, 2018), which strengthens the stigma felt by people with mental disorders and ends up being a factor that prevents reintegration, decreases adherence to treatment, and worsens prognosis (Bustamante et al., 2018; Khatib et al., 2018). Wyder et al. (2015) explained that IPs often do not understand what it means to be in a hospital under an IPA, and they are not allowed to take part in decisions about treatment and care (Johansson and Lundman, 2002; Katsakou and Priebe, 2007). Moreover, other authors pointed out that the rules are seen as tough and inflexible because of how they are imposed (Seed et al., 2016). Nevertheless, some other studies found that IPA has been described as a protection from danger and a useful experience at the time of the discharge (Johansson and Lundman, 2002; Katsakou et al., 2012; Wyder et al., 2015). Rosenman et al. (2000) noted that IPs, because of their disease and their status, are often silenced, and many of them tend to be unaware of their legal rights, maybe even giving them up. The restrictions are generally considered negative, harmful, and traumatic, as they entail the suspension of fundamental human rights (Khatib et al., 2018). In addition, Khatib et al. (2018) found that the negative effects of these procedures were long-standing and were not limited to the period of hospitalization.

Impacts of IPA on Therapeutic Relationship

Rosenman et al. (2000) revealed that there are no mechanisms that ensure the involvement of patients in the decision-making process about their treatment during an IPA, highlighting that usually there is no procedure in place to ensure that patients' needs are recognized. Other authors have found that IPs are often not informed about their rights, and this lack of information makes patients more prone to submissive behavior toward medical staff (Stylianidis et al., 2018). In fact, Wyder (2015) reported that IPA may undermine the therapeutic relationship between medical staff and the patients' perception. Other authors found that the staff's interactions with patients play a central role from the point of view of IPs (Khatib et al., 2018; Ritsner et al., 2018). Khatib et al. (2018) noted that replacement of bedding, the extent of comfort when a patient is tied or restrained, and the suitability of the room (*e.g.*, temperature and ventilation) emerged as themes about the extent to which staff impact IPs' freedom. Svindseth et al. (2007) revealed that IPs experience a lower degree of humiliation if doctors and health workers listen and respond to them in a rational, explanatory manner. Regarding the relationship between the staff and IPs, Beghi et al.'s (2013) review showed that IPA is likely to make the staff have a more negative view of IPs than VPs, which is a significant result. Some research have shown that IPs consider the restraints as nontherapeutic and as a violation of human rights and that they felt victimized, offended, and confused by the restriction itself (Khatib et al., 2018; Rosenman et al., 2000; Terkelsen and Larsen, 2013).

Impacts of IPA on Patients' Aggressiveness

Some authors have found that when IPs are not involved in decisions about their treatment and believe that hospitalization is not necessary, they tend to engage in aggressive behavior and put up barriers against those who want to help them (Seed et al., 2016). Canova Mosele et al. (2018) found that the presence of aggression in the first 24 hours of admission is statistically associated with IPs; in addition, they showed that IPs are 4.75 times more likely to behave violently than VPs. In agreement with these results, the occurrence of one or more aggressive incidents was found to be significantly associated with the age of the patient, the admission status of the patient, and length of stay (Abderhalden et al., 2007; Dack, 2013; Lorine et al., 2015).

Impacts of IPA on Length of Stay

Furthermore, several studies providing evidence of a relationship between the involuntarily admitted status and a longer length of stay, compared with voluntarily admitted patients, were found (Hoffmann et al., 2017; Hopko et al., 2002). Hopko et al. (2002) compared the length of stay between IPs and VPs, revealing a longer length for IPs (mean, 10.8 days; SD, 8.0) than for VPs (mean, 7.5 days; SD, 3.9) ($F[1,129] = 10.02$, $p < 0.01$), emphasizing that it would not imply a more positive treatment outcome. In their systematic review, Kallert et al. (2008) retrieved six studies highlighting a statistically significant longer length of stay in IPs, whereas two studies revealed a similar statistical significance for voluntarily admitted patients (Balducci et al., 2017; Kallert et al., 2008).

Consistent with this relationship between length of stay and IPs, Balducci et al. (2017) found a highly significant correlation between involuntarily admitted patients and length of stay: 14.3 ± 10.6 days for the IPs and 10.3 ± 10.0 days for the VPs. Along with these results, in the latest study, a significant difference ($p < 0.003$) was also observed between length of stay of VPs (13.033 days; SD, 8.19) and IPs (26.33 days; SD, 22.4) (Ielmini et al., 2018).

Nevertheless, Hoffmann et al.'s (2017) results differed, namely, there was a generally shorter median duration of stay of 22.6 days (SD, 23.80) for VPs (*vs.* 24.84 days for IPs; SD, 28.48; $p < 0.001$), whereas for a longer period of stay (more than 7 weeks), the proportion of days was higher for IPs (18.2 *vs.* 15.1 for VPs) (Hoffmann et al., 2017).

The Impact of IPA After Discharge

Regarding the impact of IPA after discharge, it was found that IPs are more likely to be readmitted compulsorily than VPs (Cunningham, 2012; Kallert et al., 2008; Seed et al., 2016; Van Der Post et al., 2009). For instance, Crisanti and Love (2002) reported that IPs are significantly more likely to be readmitted (hazard ratio, 1.95; 95% CI, 1.70–2.23), regardless of the

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distribution of other variables (*e.g.*, sex, age, diagnosis). Furthermore, a study that aimed to assess involuntary readmissions and patients' retrospective views of their IPA experience found that 15% (234 IPs) of the total sample had been involuntarily admitted within the 1-year follow-up period (Priebe et al., 2009). Consistent with two previous studies, Oyffe et al. (2009) also found that the readmitted patients were not hospitalized for long periods and did not have more days of hospitalization or more involuntary admissions than the nonreadmitted patients (Oyffe et al., 2009). Along with these results, Van der Post et al. (2016) reported that 68 of 113 patients (within a cohort of 460 involuntarily admitted patients) experienced involuntary readmission, a risk that significantly, even if slowly, diminishes after the third/fourth follow-up year. Moreover, higher levels of total care consumption and lower treatment interruptions for those IPs who underwent IPA (compared with VPs) were found (Van der Post et al., 2016). The same study also confirmed involuntary admission and a history of high service utilization as independent variables that are able to predict involuntary readmission (Van der Post et al., 2016). Furthermore, Zanardo et al. (2018) systematically reviewed the factors associated with psychiatric readmission and reported a larger number of involuntary hospitalizations among frequently admitted patients (13% *vs.* 2% of other patients), a higher number of patients with frequent readmission being involuntarily admitted, and an increased risk (53%) of being readmitted for those psychiatric patients compulsorily hospitalized. Besides, the same authors found that IPs had 3.5 times longer subsequent hospitalizations than VPs when readmitted and that there was only one study in which the relationship between IPA and a higher frequency of readmission or late readmission seemed to have lapsed (Zanardo et al., 2018).

In terms of relations with other services, we found one article that shows a correlation between the IPA index and activities of community psychiatric cooperation, social-psychiatric services, and complementary facilities, emphasizing a trend of low usage of social psychiatric services in those regions with high IPA indices (Emons et al., 2014).

Implications and Outcomes on Patients' Attitudes, Behavior, and Functioning

Many studies have found IPA to have negative impacts in certain domains, such as treatment satisfaction and quality of life (Fiorillo et al., 2011; Katsakou et al., 2012). In a more recent research, it was observed that IPA was perceived by IPs as injustice and that IPs described themselves as victims of the mental health care system (Katsakou et al., 2012). More specifically, 42% of IPs were convinced that their lives might be irreparably disrupted by a long period of hospitalization with a greater impact on their independence (*ibidem*).

Conversely, in their review, Katsakou and Priebe (2006, 2010) stated that IPs seemed to have more positive views of their hospitalization, especially after longer periods. Notwithstanding this, a significant proportion of interviewees (up to 48%) reported negative perceptions of self-reported outcomes (Katsakou and Priebe, 2006). Jankovic et al. (2011) discovered some problems related to privacy and lack of information during IPA, which were revealed by family members. Particularly, family caregivers stated that they were not fully involved in treatment decisions and that the staff expected them to take responsibility for future care; they also stated that health services improperly relied on them to care for patients when they were very sick (*ibidem*). Finally, a further qualitative study reported that family caregivers felt guilty after IPA and felt little support in dealing with these situations of crisis (Bustamante Donoso and Cavieres Fernandez, 2018).

In a qualitative study by Rüsch et al. (2014) that dealt with the emotional reactions to IPA in subjects after recent discharges, the authors found that patients experienced more frequent episodes of discrimination after the involuntary hospitalization. Positive correlation between stigma-related stress, shame, and self-esteem, as reactions to involuntary hospitalization and involuntary hospitalization itself, was detected as well (*ibidem*). Other research on this theme has stated that higher levels of shame, self-conformism, and stigma-related stress at the starting point, as a response to involuntary admission, are predictors of a poor recovery after 2 years (Xu et al., 2019).

DISCUSSION

The review of evidence in this study is indicative of correlations between IPA outcomes/implications and several variables such as length of stay, aggressive behavior, occurrence of psychopathologies, use of coercive measures, psychiatric service activations after discharge, and emotive reactions (concerning self-esteem and the stigma of stress). Furthermore, most of the studies referred to IPs' perspectives on the implications of IPA, especially when dealing with themes such as coercive measures, quality of life, stigma-related stress, and therapeutic relationship, as confirmed by several qualitative studies focusing on the patients' perspective. Before discussing our results, we should point out that correlations do not imply causation between IPA and the variables analyzed.

With regard to implications on clinical treatment for IPs, a discrepancy was observed in the results. On the one hand, some studies uphold an overall clinical improvement for IPs; on the other hand, others state few impacts of compulsory admission on clinical outcomes. Particularly, depression, PTDS, anorexia nervosa, suicidal ideation, suicide attempts, and suicide were found as diagnostic elements related to IPs but not VPs. Furthermore, higher doses of medications were found to be stated as implications of compulsory admission, with there being high doses of antipsychotic medication in patients who had been previously involuntarily admitted. This evidence gains significance when related to the full-blown phenomenon of coercive measures as an outcome of IPA: forced medication and pharmacological restraint have been identified as some of the clinical strategies used in compulsory admissions. This finding is consistent with the higher dosage of antipsychotics or other medication in IPs. The implications also reveal significant correlations between coercive measures and IPA, as stated by eight studies and one systematic review. Therefore, what happens during the compulsory admission and consequent treatment stages seems to have a crucial impact on how patients and staff experience and face the recovery and care processes, especially when observing these results through the theoretical framework used in the current study.

In this respect, most of the studies stated a correlation between perception of coercion and involuntary hospitalization, whereas only one study disconfirming this conclusion was retrieved. This study reported patients' perception of coercion as a way of having protected themselves and others from harm, or as a feeling of care, protection, respect, relief, and safety. Instead, the other studies found an idea of coercion as feeling dissatisfied, having low self-esteem, being angry or sad, feeling an infringement of autonomy, or feeling out of control during the admission. Regarding the negative perception of coercion among IPs, two studies noted the use of justification modalities as a way to agree with compulsory hospitalization after discharge. On the other hand, negative feelings experienced about involuntary admission seem to accompany coercive practices and the presence of police, with implications for the clinical relationship, whereby patients reported an overriding of their will or objections. In addition, to feel prevented from taking part in decisions about treatment and care seems to be related to IPA as well, with outcomes regarding the perception of being stigmatized by being mentally ill. The stigmatization process could end up being a factor preventing reintegration, decreasing compliance, and impacting prognosis. However, one study dealing with patients' negative perceptions revealed an impact of IPA on the improvement in the Global Assessment Scale and, indeed, an improvement during hospitalization. Therefore, a comparison between how someone perceives and reports his or her own experience as an IP and his or her Global Assessment Scale score, or other clinical observations, should be considered in future research conducted on this topic.

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The management of IPA's implications should take into account the patients' perceptions about the health care procedures and the policies of the mental health service to which they are subjected. In fact, their involuntary admission experience could affect the use of coercion, medications, and mental health care services overall as well as the experience of future hospitalization.

The observations in the present study enabled the interpretation of phenomena related to IPA, such as the length of stay, readmission, and a higher probability of being arrested after being discharged. Notably, according to the current theoretical framework, it is important to explore how IPs configure the experience of IPA. This is because the way they talk about their experiences contributes to the construction of a negative or positive perception about their treatment and the service system overall, with implications on future uses of a mental health service. In this respect, several studies have explored patients' views on the IPA experience. Generally, the narratives of IPs can be traced back to two main themes: "justification," wherein the IPA is recognized as being useful and necessary, and "negative experience," wherein the IPA is considered a deprivation of an individual's freedom and autonomy as well as a humiliating and stigmatizing experience. These findings are more significant if they are linked to evidence that the patients who have a negative view of their hospitalization have shown little improvement during the period of involuntary hospitalization.

Moreover, there is also evidence that, after discharge, the negative experiences associated with IPA negatively impact IPs' reintegration, treatment adherence, and prognosis. For instance, when patients evaluate IPA as unnecessary, they display a tendency to exhibit aggressive behavior and refuse any outside help. This particular tendency has been explained by some authors as being a consequence of coercion, whereas others explain the coercive procedures as just a method to address the aggressive behavior shown by IPs in the first place. In the first case, the aggressiveness phenomenon can be described as a circular system, where the aggressiveness is amplified by the coercive measures.

As a matter of fact, a major role during involuntary hospitalization is played by the doctor-patient interactions. The reviewed studies have shown that IPs consider contact with clinicians and staff after being involuntarily admitted to be fundamental. In addition, outside the medical environment, caregivers are actors involved in the IPA perception configuration process. In one study, families reported that medical staff do not involve them enough in treatment decisions, which tends to delegate future patients' care to family members.

These days, as is widely demonstrated in this research, there are risks of increasing user dissatisfaction concerning the services' effectiveness and of fostering the negative effects of the IPA. However, with the scoping review in the present study, it is possible to highlight the importance of intervening in all the social roles that contribute to the construction of the IPA phenomenon and thus pursue care objectives based on user needs, rather than applying standardized practices.

CONCLUSIONS

Reported figures regarding IPA reveal a still debated and rather controversial practice. On the one hand, a degree of convergence was found among articles dealing with coercive measures as a recurring implication of IPA. On the other, studies focusing on the impact of compulsory admission on treatment and the quality of life for IPs revealed a higher degree of ambiguity. The fragmented literature on this topic seems to reflect the fragmented clinical practices adopted to deal with IPs, as it has been found that a crucial role is played by joint medical management, encompassing several actors that comprise the overall IPA framework. In this regard, communication between clinicians, staff, patients, caregivers, and families seems to be in a cross-sectional topic in our main outcomes, especially where patients reported a lack of information about aspects of their admission or treatment by clinicians and staff.

Consistent with the United Nations Convention on the Rights of Persons with Disabilities (2014), patients should be more involved in the whole decision-making process to gain more control over their lives (Burn et al., 2019; Giacco et al., 2018; Hamann et al., 2020; Shay and Lafata, 2015; Wallace et al., 2012). A shift in perspective from that of delegation to negotiation in the management of IPA is required. Focusing on the relationship between clinicians, staff, patients, and caregivers seems to be fundamental to consider patient needs as well as prevent and manage the outlined critical outcomes that characterize IPA (Sharac et al., 2010; Wyder et al., 2018).

The negotiation approach, other than stressing the importance of the involvement of other actors, such as patients and caregivers during the decision-making process, requires the presence of a consistent dialogue to improve treatment quality and guarantee the fulfillment of patients' rights (Mattner et al., 2017; Olasoji et al. 2017; Wyder, 2018). An example is the shared decision-making (SDM): a process facilitating patients' involvement in their treatment, working together with clinicians to explore and to choose the therapeutic offering, from the first day of admission (Burn et al., 2019; Giacco et al., 2018; Hamann et al., 2020; Shay and Lafata, 2015). Some of the main clinical benefits of SDM are the following: a better long-term clinical outcomes of the treatment, a reduction in power asymmetry between care providers and patients, an improvement of the empowerment, and the patient satisfaction with care and health (Burn et al., 2019; Faccio et al., 2013; Faccio et al., 2019; Giacco et al., 2018; Hamann et al., 2020; Iudici, 2015; Turchi et al., 2019). Some authors (Giacco et al., 2018; Olasoji et al., 2017; Wyder et al., 2018) also suggest including patients' family members and carers in the full care team to improve communication with clinicians. Family well-being is improved if they feel part of the care team (Burn et al., 2019).

Thus, we propose the following:

a) To promote the involvement of patients and all other significant actors involved in the entire treatment process, which entails jointly working, where all the combined efforts are directed toward the patient's recovery.
b) The need for clinicians and medical staff to undertake training courses, as well as the need for the inclusion of professional figures such as psychologists, to promote communication skills.

LIMITATIONS AND STRENGTHS

As only three sources of information were considered—Scopus, PsycINFO, and Google Scholar—future research could be extended to other scientific databases.

Regarding the inclusion/exclusion criteria, neither the impacts of the type of psychiatric disorder and the type of process leading to compulsory admission nor those studies focusing on policy-making and legal aspects related to IPA were considered. Moreover, the studies whose outcomes were related to involuntary outpatient commitment or involuntary admission in forensic/addiction units were excluded. Thus, future studies should take into account how the relationship between mental illnesses and IPA influences the treatment outcomes; new research might focus on comparing interventions in both the community and hospital. Furthermore, because the differences between voluntary and IP populations have been ascertained in several studies, future research should consider their impact on IPA, focusing on different diagnoses, clinical needs, or levels of risks of these populations. Besides, no ethnic and cultural influences on the outcomes of IPA were considered in this study, and they remain uncovered fields of research.

The main strength of this work is intended to be that it is the latest exploratory overview of this phenomenon and is consistent with previous research. Accordingly, the present study may be useful to not only clinicians, staff, and patients but also caregivers or significant others

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in terms of information and awareness in dealing with IPA and its implications.

DISCLOSURE

The authors declare no conflict of interest.

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