Supplementary Table 1

Meta-aggregation results: synthesised findings and categories

Synthesised findings	References	Categories	Original findings
1. Patients perceived the hospitalisation and its restrictions either as a necessary form of protection or as a violation of their autonomy	20	Being violated and losing control (16)	Experiences of compulsory admission (U) Medication (U) Being restricted in autonomy (U) Feeling out of control during hospitalisation (U) Unjust infringement of autonomy (U) Patients' feelings about deprivation of their liberty (U) Professionals remove service user's liberty (U) Regaining liberty (U) Appeal to patient rights (U) Excessive or unnecessary use of force (U) Feeling violated (U) Being confined (U) Feeling trapped and coerced (U) An unnecessary overreaction (U) Getting help (U) The need for involuntary admission (U) Ambivalence on justification (U) Negative emotions (U) Therapy versus oppression (U) The ward as a detention camp (U) Lack of control about decision making in the hospital – freedom (U) ITO was experienced as an intrusion into their liberty and physical integrity (U)
		Being protected and cared for (13)	Medication (U) Being protected and cared for (U) Mentally unwell - at risk before admission (U) Need for coercive intervention - not recognising problems when unwell (U) Averting risk and feeling safe in hospital (U) Coercion seen as help and care (U) Gaining perspective (U) Coercion was necessary as protection (U) A necessary emergency brake (U) Getting help (U) Perception of the impact of admission and diagnosis (U) Ambivalence on justification (U)

			The ward as a hotel (U) Benefits of involuntary hospitalisation in terms of risk reduction – safety (U) The ITO protects from harm (U)
		Feeling ambivalent (4)	Ambivalent group (U) Moving on? (U) The need for involuntary admission (U) The mixed group (U)
		Feeling unwell (4)	Mentally unwell - at risk before admission (U) Deteriorating mental health of service users (U) Diminishing self-mastery (U) Convergence between the parties' understanding of mental disorder (U)
		Type of coercion (4)	Coercive measures (U) Treatment pressures (U) Informal coercion (U) Restrictions on leaving the ward (U) Restrictions on communication (U) Confiscation of property (U) Regulation and informal coercion (U) Pressure to improve adherence to recommended treatment (U) Pressure to improve adherence to social norms (U) Explicit statements (U) Things that go unsaid (U) The material surroundings (U)
2. Patients perceived coercion when they lacked involvement in the decision-making process	20	Being informed (16)	Receiving help with understanding (U) Information and advice following compulsory admission (U) Being outside and not seen or heard (U) Feeling out of control during hospitalisation (U) Lack of information or good reason (U) The early days (U) Lack of informational and emotional support (U) Person-centered encounters (U) Not being involved in one's own care (U) Being involved in one's own care (U) Things that go unsaid (U) A practice in need of improvement (U) Information about the detention process (U) Humanising care (U) Dearth of knowledge and advocacy (U) Captured in silence (U)

			Staff potential to impact on ITO and hospital experiences (U) Provision of information about the ward rules (U) Provision of information about ITO conditions (U) Understanding their ITO conditions and the ward expectations (U)
		Participating in care (11)	To participate (U) Inclusion (U) Being respected as an individual (U) Not participating sufficiently in the admission and treatment process (U) Participating in the admission and treatment process (U) Not being heard or no option (U) Experience of treatment (U) Encountering humanising care (U) Not being involved in one's own care (U) Being involved in one's own care (U) Lack of control about decision making in the hospital – freedom (U) Relationships based on partnerships (U) Having input into their treatment (U)
		Preserving autonomy (6)	To be independent (U) Being protected and cared for (U) Physical resistance (U) Encountering humanising care (U) Lack of control about decision making in the hospital – freedom (U) Us and them (U)
3. Patients perceived coercion when they experienced unsupportive, disrespectful and unreliable relationships	18	Feeling respected and treated fairly (14)	Acknowledgment as a human being (U) Beneficent motivation (U) Respect (U) Being violated by intrusion on physical integrity and human value (U) Not feeling respected - cared for (U) Feeling respected - cared for (U) Experience of treatment (U) Encountering humanising care (U) Person-centered encounters (U) Being an inferior kind of human being (U) Being a human being like other people (U) Nonverbal communication (U) The quality of the personal relationship (U) A practice in need of improvement (U)

			Human devaluation (U) Considering, listening and care in personal regard – respect (U) Exclusively seen as a patient (U) Us and them (U) De-subjectivation – Patients (U) Positive encounters (U) Staff potential to impact on ITO and hospital experiences (U) Being able to look beyond the illness (U)
		Being in contact with staff and getting support (14)	Receiving good care (U) Receiving needed shelter (U) Experience of relationships and interactions (U) Being outside and not seen or heard (U) Being protected and cared for (U) Experience of treatment (U) Encountering humanising care (U) Lack of informational and emotional support (U) Person-centered encounters (U) Receiving care perceived as meaningless and not good (U) Receiving good care (U) The quality of the personal relationship (U) A practice in need of improvement (U) The need for therapeutic care (U) Relationship with the staff (U) Humanising care (U) De-subjectivation – Staff (U) Broken contact (U) Captured in silence (U) Positive encounters (U) Staff potential to impact on ITO and hospital experiences (U) Feeling connected (U) Finding time despite the busyness of the ward (U)
		Trusting the other (5)	Beneficent motivation (U) Qualifications – formal and informal (U) Deceit (U) Trust in health personnel (U) The quality of the personal relationship (U) Positive encounters (U) Staff potential to impact on ITO and hospital experiences (U)

		Interacting with family, friends and other patients (4)	Experience of relationships and interactions (U) The quality of the personal relationship (U) Relationship with families (U) Being protected and cared for (U)
4. Patients perceived coercion when they experienced hospital treatment as ineffective and unsafe	10	Hospital perceived as effective (10)	Receiving care in a healing setting (U) Hospital treatment not effective/Need for alternative treatment (U) Need for coercive intervention - not recognising problems when unwell (U) Managing mental health (on the psychiatric ward) (U) Gaining perspective (U) Receiving care perceived as meaningless and not good (U) The institutional setting (U) Perception of the impact of admission and diagnosis (U) The necessity of treatment (U) Benefits (U) Having a safe space to reflect on their experience (U)
		Hospital perceived as a safe place (6)	Need for hospital treatment and safety (U) Need for coercive intervention - not recognising problems when unwell (U) Managing mental health (on the psychiatric ward) (U) Gaining perspective (U) The institutional setting (U) Having a safe space to reflect on their experience (U)
5. When they felt coerced, patients resorted to various coping strategies to deal with the situation	8	Acknowledging and agreeing (2)	Reasons for deprivation of liberty as perceived by patients (U) Agreeing and accepting (U)
		Conforming (4)	Moving on? (U) Playing ball (U) Emotional state (U) Conforming (U)
		Resisting (3)	Fighting or resisting (U) Resisting the system (U) Emotional state (U)
		Resigning (3)	Resignation (U) Respecting the staff (U) The necessity of treatment (U)
		Moving on (2)	Moving on? (U) Over, not to be recalled (U)
6. When perceived as coercive, the experience of hospitalisation negatively affected several areas of patients' identity and life	8	Well-being and mental health (4)	Recovery in the community (U) Living with the consequences of involuntary hospitalisation (U)

			Admission-induced trauma (U) Impact on health (U) Positive changes (U)
		Relationships and social life (6)	Experience of relationships and interactions (U) Unjust infringement of autonomy (U) Recovery in the community (U) Living with the consequences of involuntary hospitalisation (U) Preserving sense of self (U) Impact on relationships and community life (U) Motivation for political engagement (U) Signing the application and the perceived impact on relationship (U)
		View of self (5)	Views of self (U) Living with the consequences of involuntary hospitalisation (U) Admission-induced trauma (U) Impact on self-esteem and sense of self (U) Emotional state (U)
		Activities and daily life (2)	Unjust infringement of autonomy (U) Impact on relationships and community life (U)
7. Patients called for less coercive and more effective alternative interventions when in a crisis	5	Outpatient services and mobile teams (5)	Need for non-coercive treatment (U) Managing mental health (U) Outpatient care (U) A practice in need of improvement (U) Interventions and alternative suggestions (U)
		Human contact with professionals and other patients (3)	Human contact and handling problems better (U) A practice in need of improvement (U) Interventions and alternative suggestions (U)
		Voluntary admission and shorter coercive measures (3)	Need for non-coercive treatment (U) Preventing coercion lasting too long (U) Voluntary admittance (U) Interventions and alternative suggestions (U)
		Personal strategies (2)	Need for non-coercive treatment (U) Managing mental health (U)

Note: U=unequivocal; E=equivocal; UN=unsupported.