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Servicer user experiences of mental health assessments: a systematic review and thematic synthesis of qualitative literature

Abstract

Background: Successive governments have placed service users’ experiences at the heart of mental health services delivery and development. However, little is known about service users’ experiences of assessments and there is some evidence that assessments can cause harm.

Aims: To synthesise the qualitative literature on service users’ experiences of undergoing mental health service assessments.

Methods: Literature was systematically searched, screened and extracted, following PRISMA guidelines. Several search strategies were employed, including electronic database searches, handsearching, and forward and backward citation tracking, to identify literature which contained data on service users’ experiences of mental health assessments. Thematic synthesis was used to derive a set of themes underpinning these experiences.

Results: Of the 10,137 references screened, 38 were identified as relevant to the review. Two main themes were identified: the importance of humanising assessment processes and experiences of service user agency, with each theme containing four sub-themes.

Conclusions: Findings highlight key factors determining service user experience. We identify key practice implications, contextualised within the literature on trauma-informed approaches and conclude that trauma-informed approaches may aid understanding and improvement of people’s assessment experiences. Further research into the experiences of people from Black and minority ethnic communities is indicated.

Keywords

Assessments; service user experience; qualitative; systematic review; thematic synthesis.

Introduction

In accessing mental health services, people typically undergo detailed assessments to identify individual difficulties and needs, leading to treatment or referral decisions. Assessments are typically based on standardised history and experience gathering interviews that focus on multiple aspects of a person’s life, such as mental health symptoms and experiences, relationships, drug and alcohol use, and risk and safety. This enables services to assess a person’s eligibility for that service, potentially make a diagnosis, and decide on a course of action.

Healthcare systems across the world have produced service guidelines on conducting mental health assessments (Australian Government, Department of Health, 2019; American Psychological Association, APA Task Force on Psychological Assessment and Evaluation Guidelines. (2020).

Within the UK, successive governments have placed service users’ experiences at the heart of mental health service development and provision (Commission for Healthcare Audit and Inspection, 2009). NICE (2011) clinical guidance (136) on service users’ experiences of adult mental health services outlined clear standards for assessments, summarised as: “People using mental health services understand the assessment process, their diagnosis and treatment options, and receive emotional support for any sensitive issues” (quality standard seven). The guidance further stated that on arrival at a mental health service, people are greeted by warm, empathic, and respectful staff who anticipate possible distress. Before an assessment begins, assessors ensure that service users understand the process, the content of the assessment, and principles of confidentiality and shared decision-making. During the assessment, there is sufficient time to discuss all issues, summarise conclusions and ask and answer questions. After the assessment, support is offered, ‘particularly if sensitive issues, such as childhood trauma, have been discussed’. Finally, there is openness and clarity around key processes such as complaints and communications between professionals. The NICE guidance also identified the need for further work to ensure that service users’ have positive experiences. This has since been updated to “people being assessed by mental health services are given information and have their care explained so they understand the assessment process, their diagnosis and treatment options” (Quality Standard 14, National Institute for Health and Clinical Excellence, 2011b, pp 10).

In survivor-led research on service users’ experiences of the UK’s Care Programme Approach, Gould (2012) identified that, whilst service users had experienced some good practice, they also thought that some major improvements were needed in the following areas if assessment (and care planning) were to help them recover: use of service users' own concepts of recovery; catering adequately for African and Caribbean men and women, women in general, service users of diverse ages and disabled service users; mental health professionals' interpersonal skills; a whole person approach as opposed to one drawing mainly on diagnoses and psychiatric medication; a risk focus which helps service users to stay safe, but is balanced and proportionate; recognition of damage caused by the use of compulsion and conflicts between that and service users' exercising choice, control and their rights as citizens; and full service user involvement.

As Gould's research indicates, standardised mental health service assessments are typically based on deficit models which focus on symptoms and struggles, rather than strengths-based approaches which incorporate a holistic understanding of people's unique resources and strategies for living (e.g. Francis, 2014). However, research has shown that strengths-based assessments improve outcomes compared to standard assessment models (e.g. Cox, 2006).

Crawford and colleagues (2013) have described a shift in the UK National Health Service (NHS) from centralised care to management bureaucracies, undermining practitioners' ability to convey compassion and potentially creating a "production-line mentality". Todres, Galvin and Holloway (2009) further argue that the human aspects of healthcare can be obscured through overly mechanised, specialised, positivist approaches to service delivery and research. Within assessments, this could occur, for instance, where the focus is on extracting information to test people's eligibility for services, rather than creating a healing encounter. Following standardised, technical protocols without providing space for story-telling and meaning making can mean that people's experiences become reinterpreted through the prism of diagnosis and illness (Morgan et al, 2016).

Despite published guidance, there continues to be a lack of understanding of servicer user perspectives on and experiences of mental health assessments. For example, a potential risk for causing harm if trauma is not entirely understood in its context during assessment has been identified, where a trauma informed approach seeks to understand service users experiences by shifting thinking from 'what is wrong with you' to a relational approach asking 'what happened to you' (Sweeney *at al*, 2018).

A recent systematic review found that mental health practitioners rarely ask people about their experiences of trauma and abuse during assessments (Author, 2018). This is despite a significant body of evidence that links trauma, particularly in childhood, to adult mental distress (e.g. Dillon et al, 2012; Felitti et al, 1998; Greeson et al, 2011) coupled with estimates that around half of all mental health service users have experienced physical abuse, and one third have experienced sexual abuse (Mauritz et al, 2013). This suggests a potential disconnect between the frame of reference that practitioners employ in assessment encounters and the experiences that many service users bring to the assessment. The systematic review by Read and colleagues (Read *et al, 2007)* identified trauma-informed assessments as a key method for improving rates of enquiry and, ultimately, people's experiences of assessments and services. The authors concluded that the "failure of our research community to show sufficient interest in the self-evidently crucial issue of how abused people are treated by mental health services is troubling" (Author, 2018 pp. 13).

While NICE guidance 136 (2011) provides clear standards for service users experiences of assessments, and isolated studies have explored service user experiences, no review has synthesised the research findings. In the current review, we aim to systematically synthesise the qualitative research evidence on service users' experiences of undergoing mental health service assessments in order to explore subjective, lived experiences of undergoing assessment and identify key themes underpinning those experiences at broader levels. As suggested by Read and colleagues, we go on to situate our findings within the literature on trauma-informed approaches in order both to contextualise our understanding of the potential difficulties service users experience within assessment encounters and to consider practice-based implications.

Materials and Methods

The systematic review was conducted across several phases following Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Moher et al, 2009).

Advisory Groups and protocol development

The study was guided by a Service User Advisory Group (SUAG) and a Clinician Advisory Group (CAG) who met regularly. CAG members were predominantly (but not only) practising therapists with research experience and some personal experiences of undergoing talking therapy assessments. Around half of the SUAG were service user researchers and around half used mental health services in the area local to the university in which the study was based. Although the SUAG was predominantly female, around half of the group were from racially minoritised groups, and there was some diversity in terms of sexual orientation and experiences of talking therapy services. A small working group was established (*authors initials)*, drawn from the wider Service User Advisory Group. The small working group developed a systematic review protocol which was then reviewed by the main Advisory Groups, piloted and revised. The final study protocol was registered on PROSPERO (2015 CRD42015017843, http://www.crd.york.ac.uk/PROSPERO/display_record.php?ID=CRD42015017843).

Selection criteria

The following criteria were used to include studies in the review: any analysed qualitative account of adults' (aged 16 and above) experiences of assessment for any form of care for their mental health. Studies were excluded where: participants were aged 15 or below; it was not possible to separate service user experiences from others' experiences (e.g. carers); assessments were cognitive (e.g. the Mini-Mental State Examination); the assessment was conducted under the Mental Health Act; or the publication was not in English.

Searching, screening and data extraction

Four electronic databases (CINAHL [Cumulative Index to Nursing and Allied Health Literature], Embase, PsycINFO and Medline) were searched in January 2015, updated 2017 and December 2019; these gaps were due to capacity issues within the team but a commitment to undertaking this work nonetheless. No date limits were applied. Search terms used free text and subject headings and were piloted and revised, in consultation with a research librarian and Advisory Groups (see Supplementary Table 1 for an example). We generated multiple search terms within four broad categories: 1) service user experiences (e.g. patient experience), 2) qualitative research (e.g. focus groups), 3) assessments (e.g. first consultation) and 4) mental health (e.g. depression). Additionally, as qualitative research can be notoriously difficult to find through standard search methods (Thomas and Harden, 2008), we undertook several additional steps including forward and backward citation tracking and contact with Advisory Group members and key experts for recommendations. To identify grey literature, two electronic databases were searched (Worldcat Dissertations and Theses, and Opengrey) alongside expert consultation.

Two reviewers double screened 358 records (4%). Where there was disagreement a third member of the team reviewed those records. There was strong agreement between the third and first reviewers. For this reason, the first reviewer then screened all remaining records. Following this, two reviewers screened the full texts of all studies identified as potentially relevant (*initials and initials).* For the updated searches, one reviewer screened all titles and abstracts (*initials)* with two reviewers assessing studies for potential inclusion (*initials and initials)*.

A data extraction form was discussed with the Service User Advisory Group, piloted, revised and applied to the final included literature.

Data synthesis

Thematic synthesis (Thomas & Harden, 2008) was used to explore findings. The thematic analysis was predominantly undertaken by the first author, a postgraduate researcher with developing qualitative skills, and supported by the last author, an experienced qualitative survivor researcher.

In the first stage, the first author read all included literature to achieve familiarisation with the dataset. Following discussion between the first and last authors, the first author then generated early themes by identifying and categorising the ways in which service users were experiencing assessment processes. To do this, the entire paper was considered data, but with a particular focus on results reported in the abstract and findings sections. After carefully considering the early findings, we elected to continue analysing inductively with a focus on understanding how service users experienced assessments, rather than deductively analysing papers for the ways in which trauma-informed assessment criteria were experienced.

In the second stage, the first and last authors organised the emerging findings into an initial set of inductive themes and sub-themes. This formed the basis of the first coding frame.

In the third stage, the coding frame was applied to the entire dataset by the first author. Microsoft Excel was used to manage the synthesis, capturing themes, sub-themes and relevant findings from all included papers, as well as noting connections between themes.

During the final stages the coding frame evolved as the synthesis progressed, with themes and sub-themes gradually becoming less descriptive and more analytical as themes and sub-themes were collapsed, expanded and relabelled.

Synthesis aimed to capture the diversity of service user experience, including negative instances, in order to expand thematic depth (Lincoln & Guba, 1985). The validity of the synthesis was increased through regular meetings with the last author and by centralising service users' experiences through a focus on direct and illustrative quotes. It is important to note, however, that qualitative research is an inherently subjective endeavour meaning that others may have arrived at different results. Our findings are inevitably influenced by our positions as survivors, clinicians and researchers with knowledge of trauma-informed approaches.

Quality appraisal

The 10-item Critical Appraisal Skills Programme (CASP) systematic review checklist was employed to consider the quality of evidence. The three broad areas considered within the CASP are validity, findings and helpfulness of results. Quality appraisal aimed to assess the strength of the evidence base, rather than eliminate studies. To assess the quality of included studies we applied the CASP

(2017), modified to include three additional appraisal areas: service user involvement; intersectionalities and relevance. Key questions for additional areas, adapted from the literature (Brunton et al, 2011; Harden et al, 2006; Rees et al, 2014; Thomas et al, 2003), were: Have service users been appropriately involved in the research? Have issues relating to intersectionalities been fully considered? How relevant is the research to the review question? Using Microsoft Excel, papers were systematically scored against each appraisal area by one author (*initials* for the original papers, *initials* for the updated searches) (Supplementary Table 2).

Our aim in assessing the quality of studies was to gain a broad understanding of the strength of the evidence on service users' experiences of assessments, rather than to provide a definitive quality assessment score for each paper. Given the wide range of aims, methods and approaches to reporting in the included studies, individual study scores based on a single quality tool did not make a meaningful addition to the review.

Results

Overview of included studies

Thirty-eight studies were included (see Table 1), predominately peer reviewed research articles (29) but also published reports (6) and PhD research theses (3). The majority of the studies were based in the UK (23), with four each from USA and Australia, and one each from Sweden, the Netherlands, New Zealand, Israel, Ireland and Poland. Studies considered assessments that took place in primary care mental health and crisis response services, assessments with different groups (e.g. veterans, people with specific diagnoses) as well as assessments for access to psychological therapies through secondary or community-based services. Of the 38 studies, 19 of the papers included elements of trauma informed approaches, which included informed communication with service users, understanding service user experiences, providing choice and using trauma informed therapeutic interventions. 19 studies were based around medical diagnostic approach which focused on the symptoms and diagnosis of individuals. Of the 38 studies, 19 of the papers included elements of trauma informed approaches, which included informed communication with service users, understanding service user experiences, providing choice and using trauma informed therapeutic interventions. 19 studies were based around medical diagnostic approach with the function of the assessment to determine and/ or work with any specific diagnosis which focused on the symptoms and diagnosis of individuals.

- Table 1 about here -

Quality appraisal of studies

There was wide variation in the quality of included studies, with scores ranging from three to 12 (with a maximum of 13 possible). The mean score was 7.7. Across CASP domains, quality was particularly high in reporting of aims; appropriateness of qualitative methods; data collection; and research value (more than 29 studies scored positively in these domains). Quality scores were low for research relationships, ethics, data analysis, intersectionalities and user involvement (between five and 14 studies scored positively). This suggests that the evidence base may not reflect the priorities of service users and is limited in what it can tell us about the role of intersectionalities in how service users' experience assessments, limiting the conclusions that can be drawn.

Thematic synthesis findings

Two major themes were identified which underpin service users' experiences of mental health service assessments: the importance of humanising encounters and experiences of service user agency and service user experience of agency. We report illustrative quotes from people who participated in the reviewed studies in italics.

The importance of humanising encounters

Interpersonal qualities, skills and holistic approaches

The skills, interpersonal qualities and holistic approaches employed by assessors helped to facilitate informative, collaborative dialogues with service users, enabling discussion of the underlying cause of people's difficulties and facilitating progress. Positive experiences and feelings were associated with a humanising experience: *'It was nice to be recognized as an individual and not just another case number'* (Asch et al, 1991).

Several studies highlighted how distressing undergoing assessment can be i.e. Crawford and colleagues (2007) found that lengthy and in-depth assessment processes were often experienced as traumatic. Assessor skills and training around recognising and understanding service users' psychological needs in assessments was beneficial (Craig et al., 2000; Sands et al, 2016).

Assessors that demonstrated warmth, respect and non-judgemental attitudes and a flexible approach tailored to individual needs were experienced positively (Boscarato et al, 2014; Dahlöf et al, 2014; Hamilton et al, 2011; Meehan et al, 2012). Additionally, assessments that were person-centred, dynamic and receptive to modification as service users provided further information or as their needs changed were experienced more positively allowing individuals to feel more relaxed, comfortable, involved and empowered (Danna, 2011; McDonagh, 1997). A checklist or protocolised enquiry lacking empathy and understanding led some service users to become defensive and potentially to disengage (Sands et al, 2016; Bilderbeck et al, 2014). Rather than focusing on symptoms, when assessors paid attention to who a person is and the things they had experienced, they were felt by service users to have gained a better understanding of the function of symptoms (De Saeger et al, 2016).

Trinh and colleagues (2014)highlighted the importance of staff training and awareness regarding conducting culturally appropriate assessments. This can help assessors understand the individual and their experience in relation to their cultural heritage and religion: *'I would have preferred my cultural needs about food, religion and cultural aspects of Hinduism to be met'* (Bhui et al, 2002).

Experiences of stigma

Stigma prevented some people from undergoing assessments and could cause negative experiences: "[*I] felt very stigmatized. [There was] no empathy*" (Sands et al, 2016). Bilderbeck and colleagues (2014), highlighted how perceived stigma caused anxieties surrounding diagnosis leading to service users thinking that mental distress is their fault: '*It [a diagnosis of BPD] makes it sound like it's my fault, it's my personality … [like] I was born wrong so it was never going to be good*' (Bilderbeck et al, 2014). Morgan (1999) found that individuals seemed apprehensive about being treated as a `psychiatric case' and were at pains to distance themselves from common stereotypes of 'the mentally ill'. These experiences of stigma could lead to anxiety, feelings of vulnerability and frustration (Bilderbeck et al, 2014; Sands et al, 2016; Hird, 2007; Horrocks et al, 2005; Morgan et al, 1999) leading individuals to avoid mental health services or disengage from the assessment process.

Enabling disclosures

Strong interpersonal qualities and skills helped build connections between assessors and service users, facilitating disclosures (McDonagh 1997; Morgan 1999; Marshall et al, 2016; Sands et al, 2016). Assessor recognition of the service user as an individual and not just another case was clearly important: *'I was quite pleased that I was being taken notice of and that I was believed in what I was actually saying to people'* (Hann et al, 2015). Continuity of care and familiarity with the assessor was linked with more personal and meaningful discussions during the assessment, reducing anxiety and increasing ease in discussing sensitive life histories (Bilderbeck et al, 2014). For instance, an experience where an assessor telephoned a service user before their initial appointment helped build a positive relationship (Marshall et al, 2016). Reducing unequal power dynamics also facilitated positive relationships: reports of collaboration, equality, and validation were sometimes in notable contrast to people's previous experiences of assessments (De Saeger et al, 2016).

The environment in which the assessment is conducted can also impact on the amount of information service users disclose (Daholf et al, 2014; Lothian & Read, 2002). People report needing a private area where they feel safe enough to open up about their emotions and experiences (Horrocks et al, 2005). Where people feel vulnerable, they may not be able to give their full story (Daholf et al, 2014).

Listening and validating

Assessors who judge people's situations or interrupt them are experienced far less positively (Coakes et al, 2007; Crawford et al, 2007; Hann et al, 2015; Nakash et al, 2009). Listening to service users – their story, experiences and difficulties – creates a sense of validation, recognition, and confirmation that they are allowed to feel that way (Bilderbeck et al, 2014; De Saeger et a., 2016; Sands et al, 2016). When assessors pay full attention to service users, allowing them to talk, and are patient, sensitive, empathic and understanding of people's histories and contexts, service users experience the assessment more therapeutically (Hamilton et al, 2011; Daholf et al, 2014; De Saeger et al, 2016; Lavie-Ajayi & Nakash, 2017) and feel accepted for who they are (Daholf et al, 2014).

If the service user is not acknowledged, but rather dismissed or discredited, this can lead to anger upset, frustration, isolation, anxiety, fear, invalidation and feelings of abandonment (Bilderbeck et al, 2014; Bryant et al, 2007; Hunter et al, 2013). In cases of trauma, such as sexual abuse, this can reinforce the idea that people are responsible for what has happened to them, that it is or was their fault (McDonagh, 1997).

Experiences of service user agency

Expectations and misconceptions

Across a range of settings and services, service users often had unmet expectations and/or misconceptions of services, stemming from a lack of prior knowledge or awareness of services coupled with poor quality and inaccurate information provision (Hann et al, 2015; Hird et al, 2007; Hunter et al, 2012; Morgan 1999; Marshall et al, 2016). Without good quality information, service users were unsure of what their role at the assessment was, and how much they ought to be sharing, impacting on experiences of service user agency. This could lead to fear of judgement and withholding information: "*Am I going to be locked up in a cage, key thrown away*" (Hann et al, 2015).

Hird (2007) found experiences of high levels of anxiety and feelings of vulnerability before and during assessments, linked to misconceptions about what would happen (Hird, 2007). Hann and colleagues, however, found a positive experience where service users were provided with an information pack: *'There was a nice pack actually that came through, to do with things like that. I did have a good look through it.'* (2015).

Information, clarity and communication

Information, clearly communicated, is a core prerequisite for service user agency. Communication between assessors and service users is disrupted when assessors provide minimal information, or service users hold back relevant information (Crawford et al, 2007; Quirk, 2007). Hird (2007), for instance, found that service users who were informed about the assessment process before attending were better able to prepare and make use of the assessment, allowing assessors to gain a greater understanding and direct people to the right support. Marshall and colleagues (2016) found negative experiences included uncertainty about treatment: *'they didn't say how many you would get or anything . . . I felt a bit uncertain about it, I didn't know what would happen and all'*. Conversely, communicating a clear, understandable formulation facilitated self-care and supported people to maintain their wellbeing (Hird, 2007; Williams et al, 2011). The lack of an informed relationship between the service user and assessor sometimes meant that service users left the assessment feeling confused (Marshall et al, 2016).

Culture, context and communication

The presence of family or friends during assessments could impede or facilitate communication and agency. For some, it was helpful to have others present to help explain their experiences and understand what the assessor said (Bilderbeck et al, 2014), whilst others were reluctant to have family members accompany them: *'I would have felt uncomfortable in their presence' (*Bhui et al, 2002). People from different cultures sometimes struggled to articulate their experiences in ways that assessors of different backgrounds could understand. This could hamper communications and understanding, causing frustration. Daholf and colleagues (2014) found that some service users who do not speak the native language experienced significant barriers to engaging with the assessment: *'she explained in a way I did not always understand… and I often had to ask – I'm not sure what you mean […] well, it was a bit complicated for me'*. When assessors communicated clearly, service users felt more confident, and had a sense of containment, validation and recognition (De Saeger et al, 2016; Sands et al, 2016).

Collaboration and communication

The extent to which assessments were experienced as collaborative depended on three critical factors: service user's being able to make choices, having the information needed to inform those choices (the previous sub-theme) and being able to access help when in crisis. Being able to engage in decision making around support created feelings of empowerment, satisfaction, engagement and improvements in mental health (Coakes et al, 2007; Fornells-Ambrojo et al, 2017; Horrocks et al, 2005; Sands et al, 2016). However, 'A common experience was of staff carrying out procedures without offering choices or with little explanation' (Horrocks et al, 2005).

Some service users entered services with particular goals in mind, such as increasing confidence. (Hamilton et al, 2011). Connected to this, people resisted services where a single option was provided that did not align with their goals (Bilderbeck et al, 2014; Hamilton et al, 2011; Coakes et al,2007). Individuals valued approaches that allowed for negotiation, self-determination, and choice, and which led to a balance in the power dynamic, allowing for service users to be heard (McDonagh, 1997; Danna, 2011).

Being offered choices while in crisis was not experienced as helpful by several participants, especially in periods of crisis where the ability to make decisions was impaired or difficult: *'By the time (I) called, I don't know which way is up' and 'I wanted help…not choices'* (Sands et al, 2016).

Discussion

This review synthesised qualitative research on service users' experiences of undergoing mental health service assessments. Three broad themes were identified from 36 studies, focusing on service users' expectations and misconceptions, the importance of humanising encounters and service user agency. Humanisation is created through, for instance, the assessors' interpersonal qualities, skills and holistic approaches and the ability to listen carefully to people's stories and convey acceptance and empathy. Depending on the ways in which these three themes are enacted, assessments can be experienced by service users as therapeutic and validating and linked to positive therapy outcomes, or as distressing and frightening, at times causing people to disengage from services.

Consistent with this, we found mixed evidence on the extent to which NICE guidance (2011) on service users' experiences of undergoing adult mental health service assessments is being applied in practice. For instance, whilst we found many positive experiences, we also found that at times, service users did not have the information they needed to understand the process and content of assessments and to participate in shared decision making. Among the most negative experiences were those where there was a reliance on protocolised enquiries, a lack of empathy and a failure to locate people's difficulties in their individual experiences and contexts. Worryingly, feeling dismissed or discredited during assessments reinforced for some people the belief that they were responsible for the trauma (childhood sexual abuse) they had experienced, a finding echoed in a user-led study of service users' experiences of violence and abuse and associated service responses (Author 2019).

Given the high rates of trauma histories amongst people undergoing mental health service assessments, it is possible that the difficult or damaging aspects of assessment encounters are connected to a broader lack of trauma-informed services and processes (and vice versa). Consequently, and as indicated by Read and colleagues (2018), we situate our findings within the literature on trauma-informed approaches in order to contextualise service users' assessment experiences and consider associated practice implications.

Humanising assessment processes

The most striking finding of our review – and one that is often repeated in the research literature (e.g. Author, 2014) - is the centrality of humanising assessments, broadly understood as the quality of the relationship between an individual and an assessor, in determining service user experience. Indeed, research suggests that developing therapeutic relationships within mental health services is so impactful that it can be considered a form of therapy (Priebe & McCabe, 2008). The literature on trauma-informed approaches also emphasises the importance of relational encounters in facilitating healing and minimising harm (e.g. Author, 2018). For instance, in a reflection on trauma-informed practitioner-service user relationships on inpatient wards, author and colleagues write that:

> "Service users … described forming better relationships with staff members who communicated their basic humanity to them and demonstrated basic levels of interest in and engagement with them. Forming relationships with service users that are rooted in these qualities can build trust, connection and hope, the foundation for positive relationships and trauma-informed practice. This can transform service user experience" (2018).

The current review suggests that the importance of therapeutic, trauma-informed relationships extends to the assessment process. Humanising assessments means recruiting assessors with strong interpersonal skills including warmth, an ability to convey respect and good active listening skills.

Adequate supervision may be needed to ensure assessors remain able to convey their humanity. Our review also indicates that simple steps, such as a phone call before the initial appointment may help put people at ease and begin the process of building trauma-informed, therapeutic alliance.

Our review also found that some people feared the dehumanisation of being treated as a ‘psychiatric case’. The stigma that people experience in relation to acknowledging a struggle with mental distress may in part be related to the ‘medicalisation of misery’ (Pilgrim & Bentall, 1999) where diagnosis labels someone as having something wrong with them rather than ‘symptoms’ being understood as an adaptation to a context. Within trauma-informed approaches, this is often described as the shift from *what is wrong with you?* to *what happened to you?*. In the UK (as elsewhere), as mental health services become more stretched, conversations around its core business become preoccupied with demand management and the efficiency of the care pathway and allocating people to pathways are increasing, rather than on the basis of what might best support that person as an individual. Meeting individual needs requires a workforce able to humanise assessment encounters and with access to alternatives to diagnostically driven approaches, such as the Power Threat Meaning Framework (Johnstone & Boyle, 2018). A trauma-informed narrative about mental health, when translated to assessments, would recognise people in their context, create openness and collaboration around needs and facilitate access to help that is matched to need. Implementing this requires a highly skilled and agile workforce.

Understanding people in their contexts

Our review found that a critical aspect of creating humanising encounters was recognising service users as individuals, and not simply another case, enabling disclosures and creating feelings of safety, validation and hope. In achieving this, assessors drew on interpersonal skills, adopted holistic approaches and were able to adapt assessments as more information was revealed.

We also found that people’s individual contexts, including their cultural backgrounds, were not always considered in assessments. Incorporating people’s identities and contexts into assessments is a key principle of trauma-informed approaches (Author, 2016). However, as in our review, research has consistently found that service users from Black, Asian and minority ethnic communities do not always feel that their cultural identity is incorporated into assessments and planning (Gould, 2012) and can experience widespread cultural and institutional exclusion from mental health services, compromising racial equity (Bowl, 2007). There is a clear need for creative thinking around embedding racial equity and cultural competence into mental health service provision (Bowl, 2007) – a core principle of trauma-informed approaches (e.g. Author, 2016).

Our review also found that situating people within their holistic contexts meant carefully attending to and validating people's stories, particularly relating to trauma, rather than imposing standardised, technical protocols on to their experiences. This connects to trauma-informed approaches which seek to recognise and understand people's unique life experiences and needs in order to deliver effective support (Menschner & Maul, 2016). Achieving this requires flexible, trauma-informed assessments that allow people to be heard from their personal perspective and to raise areas of importance to them, with time for meaningful discussion (Ferentz, 2017). It also suggests the need for national commitments to narrative-based understandings of mental distress. The Scottish ambition to be a trauma-informed nation is a good example of this (e.g. NHS Education for Scotland, 2017). Further, in order to begin understanding people in their contexts, routine enquiries about trauma should be embedded into mental health assessments (e.g. Menschner & Maul, 2016; Author, 2018); indeed this is considered standard good practice in mental health services (Rose et al, 2012).

Fostering agency and collaboration

Our review found that people typically valued approaches that promote agency and collaboration through negotiation, self-determination, and choice, and that this enables people to feel heard and communicates that they matter. The ability to retain agency within relationships and service encounters is vital where people have experienced betrayal trauma (Freyd, 1998). We also found that the ability to enact agency and engage in collaborative approaches depends on service users having clear information; this is consistent with NICE guidance on service users' experiences of assessments in adult mental health services (2011). In communicating clearly, assessors should ensure that lay terms are used; check that they have been understood; adapt communication to suit the needs of individuals; provide the information needed to make wise choices about what happens next; and write follow-up letters, creating opportunities to ensure or reassure that the service user was understood correctly.

Our review also found that identifying and working with people's strengths and goals increased engagement. This is consistent with trauma-informed strengths-based approaches (Ferentz, 2017) as well as person-centred approaches, which can be defined as:

> holistic, biopsychosocial or integrative care that is responsive to people's needs and values and that treats people with dignity, respect and compassion; that empowers them and offers choice, involvement and a partnership approach (Royal College of Psychiatrists, 2018).

We further found that collaborative assessments that enabled shared decision-making increased service users' sense of empowerment and engagement with services. However, a recent review found that uptake of person-centred approaches in psychiatry is low, largely because service users are typically not empowered through their contacts with practitioners (Smith & Williams, 2016). Empowerment has also been identified as a critical element of trauma-informed approaches (e.g. Elliott et al, 2005; Menschner & Maul, 2016), “essential to recovery from the overwhelming fear and helplessness that is the legacy of victimization” (Elliott et al, 2005). Our review suggests that empowerment is compromised where service users do not have the information or scope to enact agency.

Quality appraisal found that few studies adequately considered ethics, research relationships, data analysis, user involvement and intersectionalities. Future research should focus on the experiences of diverse populations, and in particular people from Black, Asian and minority ethnic communities given differential experiences of mental health services (Bhui & O’Hara, 2014).

Strengths and limitations

The review question and protocol were developed with a Service User Advisory Group, enhancing quality and relevance to service users. Our search strategy was comprehensive, with a large number of records screened. We identified a substantial number of papers investigating service users’ experiences of mental health service assessments across a broad range of contexts and nations, increasing the transferability of findings. While research into service users’ experiences in mental health is increasing, such research, particularly when service user led, is often located outside of the peer reviewed literature. This means that including grey literature strengthened our ability to locate relevant data.

Limitations include that some of the review work was conducted by one reviewer (e.g. only 4% of papers were double screened in the initial stages) and this may have introduced bias into the review. However, the evolving synthesis was regularly discussed with a senior service user researcher, enhancing validity. Due to resource limitations, we only included literature written in the English language, limiting the generalisability and relevance of our findings. Studies rarely provided detailed information on the assessment process under study, making it difficult to connect experiences to specific processes.

Conclusions

This review synthesised the qualitative literature on service users’ experiences of undergoing assessment for mental health services. Findings highlighted mixed experiences, dependent on the extent to which the assessment process was humanised, people were engaged in the process with clarity of communication and agency fostered. Through discussing our findings we identified key practice implications that impact on service user experience: the need to ensure humanised assessment processes through relational practice, the importance of understanding people in their contexts and fostering agency and collaboration. Given the connections between our findings trauma-informed approaches, these may be a fruitful means of understanding and improving people's experiences of assessments. Given differential experiences within services and a lack of cultural inclusion (Bowl, 2007), future research should explore the experiences of people from Black, Asian and minority ethnic communities.

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Declaration of interest statement

The authors have no competing interests to declare.

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