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Hannah Prytherch, BSc (Hons)

MAJOR RESEARCH PROJECT

RESIDENTIAL SUICIDE CRISIS CARE: STOPPING PEOPLE FROM DYING
OR SUPPORTING PEOPLE TO LIVE

Section A:

Experiences of residential suicide crisis services: what themes emerge from
first-person accounts?

Word Count: 7,999

Section B:

The power of ideas: women's experiences of a trauma-informed crisis house
and hospital when feeling suicidal

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Doctor of Clinical Psychology

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SALOMONS
CANTERBURY CHRIST CHURCH UNIVERSITY

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Most importantly, I would like to thank the eight women who gave their time in the hope that sharing their experiences might help to improve services for others. I would also like to thank staff at Drayton Park who enabled the research to take place and my supervisors, Anne Cooke & Ian Marsh, who were so patient and supportive. Finally, thanks to Carlos for cooking for me, my mum for always reminding me to keep a reflective journal, Abi and Becca for proof-reading and Sofia and Mags for enticing me to the library!

Summary page

Section A: Systematic Literature Review

This review aimed to answer the question: what themes emerge from first-person accounts of experiences of residential services during a time of suicidal crisis? 20 studies were identified, from peer-reviewed and non-academic literature. Themes relating to hospital services were: 'therapeutic engagement is fundamental', 'barriers created by staff attitudes, fears and availability', 'the fear of coercion' and 'diagnosis overshadowing the person'. Themes relating to alternative services were: 'healing through relationships', 'promoting involvement and autonomy', 'living a "normal" life in a "normal" environment' and 'transformation'. Further qualitative research into experiences of alternative services during suicidal crisis was recommended, focusing particularly on theoretical assumptions underlying services.

Section B: Empirical Paper

Eight women participated in this study exploring experiences of a Trauma-Informed (TI) women's crisis house compared to experiences of hospital during suicidal distress. Seven themes were developed: the power of talking, the limitations of medication, managing emotional safety through trusting relationships, managing physical safety through coercion, a home rather than a hospital, fostering compassion and the benefits of gender sensitivity. Participants said that the medical and custodial model which they experienced in hospital, could undermine therapeutic engagement and exacerbate distress, whereas the TI approach enabled them to safely work through their suicidal feelings, whilst maintaining freedom and control.

Table of Contents

1. Introduction	9
1.1. Grey-Literature.....	11
1.2. Aims.....	12
2. Method.....	12
2.1. Literature Search.....	12
3. Results	16
3.1. Literature Characteristics.....	16
3.2. Literature Appraisal	16
4. Thematic summary: ward experiences	24
4.1. Overview	24
4.2. Therapeutic engagement is fundamental.....	24
4.3. Barriers created by staff attitudes, fears and availability.....	26
4.4. The fear of coercion	28
4.5. Diagnosis overshadowing the person	30
5. Thematic summary: Experiences of alternative residential services	31
5.1. Overview	31
5.2. Healing through relationships.....	32
5.3. Promoting involvement and autonomy.....	34
5.4. Living a 'normal' life in a 'normal' environment.....	34
5.5. Transformation	35
6. Discussion.....	37
6.1. Methodological considerations	41
6.2. Recommendations	43
7. Conclusions	45
References	46
SECTION B	58
1. Introduction	60
1.1. Aims.....	63
2. Method.....	63
2.1. Design.....	63
2.2. Personal positioning.....	64
2.3. Participants	65
2.4. Procedure.....	66
2.5. Data analysis	68

2.6. Quality assurance.....	69
3. Results.....	70
3.1. The power of talking.....	70
3.2. The limitations of medication.....	72
3.3. Managing emotional safety through trusting relationships.....	73
3.4. Managing physical safety through coercion.....	75
3.5. A home rather than a hospital.....	78
3.6. Fostering compassion.....	78
3.7. The benefits of gender sensitivity.....	79
4. Discussion.....	81
4.1. Limitations of Trauma Informed Approaches.....	84
4.2. Research Limitations.....	86
4.3. Clinical implications.....	87
4.4. Research implications.....	88
5. Conclusion.....	88
References.....	90
Appendices of supporting material.....	99

List of Tables

Section A

Table 1. Inclusion and exclusion criteria

Table 2. Literature Characteristics of studies including first-person accounts of hospital services during a time of suicidal crisis

Table 3. Literature Characteristics of studies including first-person accounts of alternative services

Table 4. Themes from studies exploring first-person accounts of ward experiences during a time of suicidal crisis

Table 5. Themes from studies looking at experiences of alternative services

Section B.

Table 1. Inclusion and exclusion criteria

Table 2. Six stages of thematic analysis (Braun & Clarke, 2006)

List of Figures

Section A

Figure 1. Search strategy

List of Appendices

Appendix A: CASP Qualitative Checklist Quality Ratings

Appendix B: Letter of Ethical Approval

Appendix C: Feedback Summary for Ethics Panel

Appendix D: Feedback Summary for Participants

Appendix E: Research Flyer

Appendix F: Participant Information Sheet

Appendix G: Consent Form

Appendix H: Interview Schedule

Appendix I: Excerpts from Research Diary

Hannah Prytherch, BSc (Hons)

SECTION A

Section Title:

Experiences of residential suicide crisis services: what themes
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Abstract

Background and aims. Improving services for those in suicidal crisis remains high on the UK government agenda. Alternative residential services have been created to address service-users' concerns with psychiatric hospital services. This paper systematically reviews qualitative peer-reviewed literature and grey-literature to explore what themes emerge from first-person accounts of experiences of hospital-based and alternative residential services during a time of suicidal crisis.

Methods. A systematic search elicited 20 eligible studies. Findings are synthesised thematically, and theoretical implications are discussed.

Synthesis and discussion. Themes relating to hospital services were: 'therapeutic engagement is fundamental', 'barriers created by staff attitudes, fears and availability', 'the fear of coercion' and 'diagnosis overshadowing the person'. Themes relating to alternative services were: 'healing through relationships', 'promoting involvement and autonomy', 'living a "normal" life in a "normal" environment' and 'transformation'. Hospital services, which were characterised as being more dominated by medical approaches and making more use of coercive practices were more often described negatively than alternative services. However, authors gave little attention to how the model of care adopted by services might influence practice. The theoretical implications of these tentative findings are explored, in light of methodological limitations. Implications for future research and practice are discussed.

Key words: Suicide; crisis; crisis house; alternative residential service; acute care; hospital

Experiences of residential suicide crisis services: what themes emerge from first-person accounts?

1. Introduction

Suicide is one of the leading causes of death worldwide (WHO, 2016), with 5,668 suicides recorded in Great Britain in 2016 (ONS, 2017). The UK government has recently invested an additional £25 million for suicide prevention from 2018 to 2021 (DOH, 2017). Mental health services are a fundamental part of the prevention strategy, particularly inpatient psychiatric services that offer residential care to people in acute crisis (DOH, 2012). However, given the practical and ethical difficulties involved in measuring the effectiveness of hospitalisation, as yet there is no clear evidence that hospitalisation actually prevents suicide (De Leo & Svetlicic, 2010).

Official statistics show that between 2003 and 2013, 1,295 people in England took their lives whilst they were inpatients in psychiatric facilities (HQIP, 2015). During this same period, 19% of the community service-users who completed suicide did so within three months of discharge from hospital and 15% of these did so within the first week (HQIP, 2015). These statistics suggest that hospital is not currently meeting the needs of all those who are admitted in suicidal crisis. Some have even argued that the experience of hospitalisation, particularly involuntary hospitalisation, might actually increase the risk of suicide for some people, through the stigma, trauma, isolation and discrimination that they may face either during or as a consequence of admission (Large & Ryan, 2014; Wang & Colucci, 2017).

More generally, research has highlighted that hospital interventions for mental distress are frequently experienced as coercive and dehumanising (Newton-Howes &

Mullen, 2011). Service-users have reported dissatisfaction, describing wards as frightening (Rose, Evans, Laker & Wykes, 2015; Mind, 2011) and at times infringing their human rights (Katsakou & Priebe, 2006). A lack of therapeutic engagement has been reported (Stenhouse, 2011; Cleary, Hunt, Horsfall & Deacon, 2012; Weich et al., 2012) as well as a lack of information and involvement in treatment decisions (Katsakou & Priebe, 2006). In 2012, a report by the Schizophrenia Commission (2012) found that the highest priority for service-users in England was the reform of acute care.

Residential alternatives, often called crisis houses, have been developed to address some of these concerns (Sweeney et al., 2014). The government has not issued any clear guidance regarding what alternative residential service should look like and indeed, the term seems to be used to cover a range of different theories and practices, as outlined below. However, Sweeney and colleagues (2014) have characterised crisis houses as serving a similar population to hospital wards but generally smaller with a more domestic atmosphere, and as rarely using force, restraint and compulsory detention.

Preliminary quantitative research suggests that alternative residential crisis services involve shorter stays than hospital, are cheaper and are preferred by service-users (Killaspy et al., 2000; Lloyd-Evans, Slade, Jagielska & Johnson, 2009; Slade et al., 2010), who report feeling safer, less coerced (Gilburt, Slade, Rose, Lloyd-Evans, Johnson & Osborn, 2010) and experiencing better therapeutic relationships (Sweeney et al., 2014). This preference is particularly evident for women, and even more so in relation to women-only services (Howard, Rigon, Cole, Lawlor & Johnson, 2008). However, thus far, research into these services has been limited and there have been calls for more (Beaton, 2012; Paton et al., 2016).

Whilst quantitative methodologies are useful in measuring the outcomes of particular interventions according to pre-defined variables, they cannot be used to explore the “quality and texture of experience” or to answer questions about “what it is like” to experience particular interventions (Willig, 2008, p.8). Given the drive to improve services for people in suicidal crisis (DOH, 2017), the aforementioned difficulties with hospital services and the potential for alternative services to offer a different experience, such questions surely need to be explored specifically in relation to suicide crisis interventions. There has been one published systematic review exploring experiences of safety whilst in hospital during suicidal crisis (Berg, Rørtveit & Aase, 2017). However, given that safety is only one of the many concerns raised by service-users in relation to in-patient care (see above), it seems important to explore service-users’ experiences of both hospital services and alternative services more widely.

1.1. Grey-Literature

Suicidology, the “scientific study of suicide” (Maris, Berman, & Silverman, 2000, p. 3), has long been dominated by positivist, quantitative approaches (Hjelmeland, 2016). Indeed, the editor of one of the main suicide journals has specified that within the *Suicide and Life Threatening Behavior*, quantitative studies “will compete for journal space more successfully” than qualitative (Joiner, 2011, p472). As a consequence, Rose (2008) has argued that qualitative, first-person accounts may be under-represented in academic journals. With the hope of accessing more first-person accounts, this review will therefore include ‘grey-literature’, a term which refers to publicly available literature, published but not in academic journals (U.S. Interagency Grey-Literature Working Group 1995). It is important to acknowledge that grey-literature has not been subject to peer-review and

therefore does not come with any promise of academic rigour. The implications of this will be explored below.

1.2. Aims

Given the recognised need to improve care for those in suicidal crisis and the lack of qualitative research exploring first-person accounts of residential crisis services at a time of suicidal distress, this review aims to draw on both academic and grey-literature to answer the following question:

What themes emerge from first-person accounts of experiences of residential services during a time of suicidal crisis?

2. Method

2.1. Literature Search

2.1.1 Qualitative research published in academic journals. An electronic search of ASSIA, CIHAL, MEDLINE and PsychINFO databases was completed using variations of the search terms (suicide* AND treatment OR care OR respons* OR prevent* AND interview* OR focus group* AND qualitative). Where possible, 'suicide*' was specified to appear in the title and 'interview', 'focus group*' and 'qualitative' were terms linked to methodology. The search was restricted to articles written in English. Table 1 shows the initial inclusion and exclusion criteria, although this was later expanded.

Table 1. Initial inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
Data gathered were first-person accounts of residential crisis services at a time of suicidal crisis	Authors did not distinguish between residential crisis services and other forms of services (such as community teams, CR/HT teams, therapy)
The focus of the article or one of the research or interview questions was on experiences of care	The focus was on crisis care in medical settings (i.e. A&E or intensive care)
Accounts were from adults	Accounts were from children or teenagers
Articles were written in English	Articles written in languages other than English

Following the search, duplicates and articles whose titles suggested that they did not fit the inclusion criteria, were discarded. Reference lists were hand searched and Google Scholar was used to identify citing articles and for a final search. The abstracts of the remaining articles were read and discarded if they did not fit inclusion criteria. Remaining articles were read in full and discarded if irrelevant (see Figure 1 for search strategy). The Critical Appraisal Skills Program (CASP) tool for qualitative research (Public Health Resource Unit, 2006) was used to score the quality of articles (see appendix A).

Grey-literature. Google, Google Scholar and the British Library catalogue (<https://bl.uk>) were used to search for unpublished theses, reports or service evaluations. Residential crisis services were identified through Google searches and asking experts in the field. Websites of these services were then visited and scanned for service evaluations, and authors were contacted to request unpublished reports. Inclusion criteria for grey-literature were the same as for published literature (see table 1 above) and grey-literature were also scored for quality. Although autobiographic accounts in books or on blogs also include experiences of residential services, for both practical reasons and due to the difficulties in systematically searching such sources, they were not included.

Expanding inclusion criteria for alternative services. Given the scarcity of literature including first-person accounts of residential alternatives to hospitalisation during suicidal crisis, the inclusion criteria were expanded. For alternative services only, published and grey-literature were accepted if they included first-person accounts of residential crisis services (even where not specific to suicide).

Given that one of the key reasons for the development of alternative services was to meet the needs of those in suicidal crisis who either do not want or do not benefit from hospitalisation (Paton et al., 2016), such expansion of the inclusion criteria seemed justified.

Indeed, one of the subsequently accepted studies (Johnson et al., 2004) detailed that the main reasons for admission to the crisis house under study were self-harm and suicidal ideation.

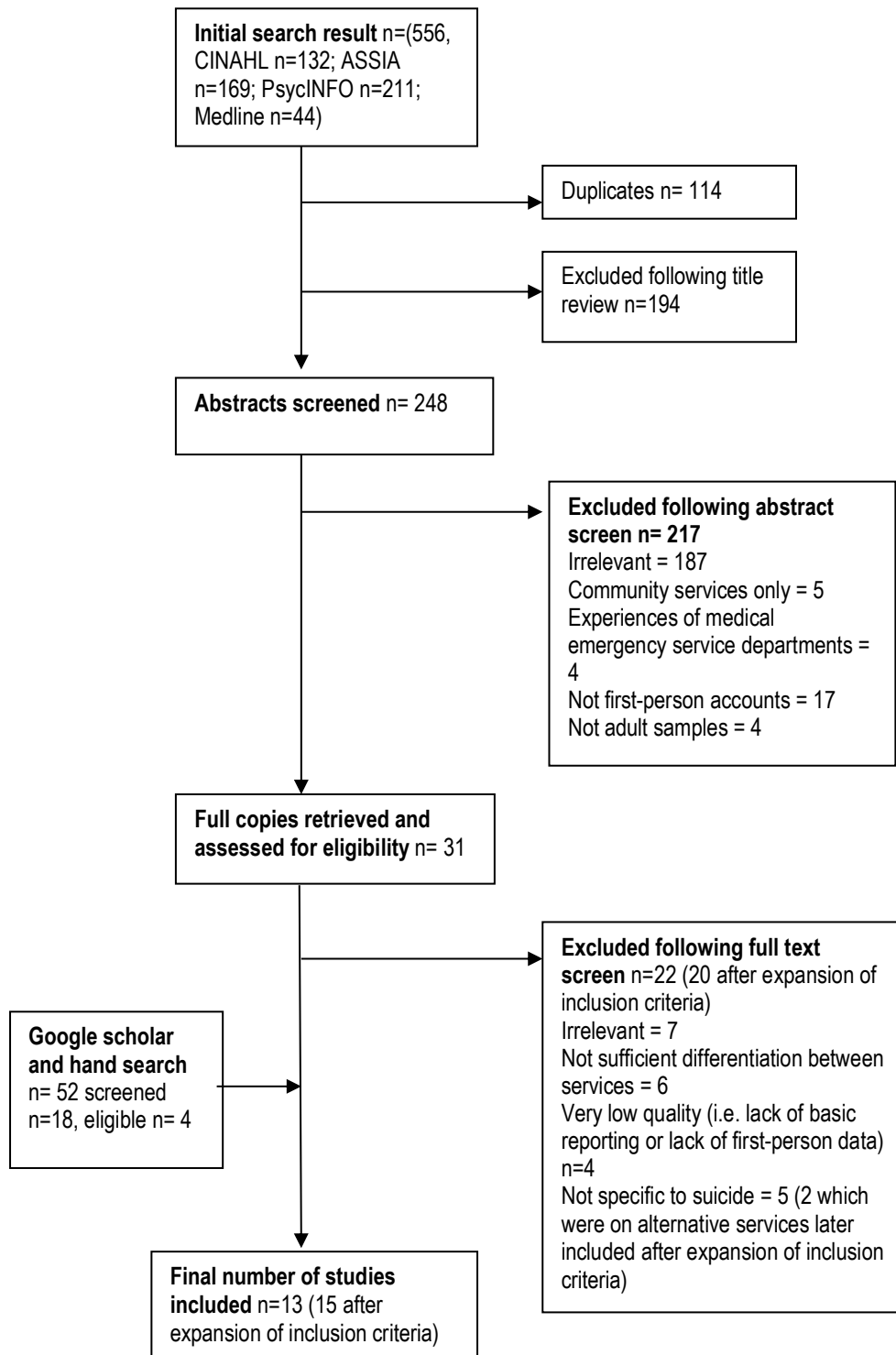


Figure 1. Search strategy for qualitative research published in academic journals

Synthesis. The studies examining experiences of hospitalisation were analysed first, followed by the reports on experiences of alternative services. Thematic synthesis (Thomas & Harden, 2008) was used to draw together and analyse findings across studies. The papers were read in chronological order, attending to both the content and the language used by the authors. The ‘findings’ section of each study was analysed using thematic analysis (Braun & Clarke, 2006). Some studies included accounts given by both clinicians and service-users. In these studies, only the data that was clearly representing service-user experiences was analysed. The PhD thesis explored experiences following a suicide attempt generally so only the results from the section on experiences of hospitalisation were analysed. Line-by-line coding enabled translation of codes between papers. Codes were then grouped together under central organising concepts in an active process, driven by the research question. Theme development was a recursive process, with repeated re-organisation and checks against the original data.

Studies of alternative residential services were analysed separately, again in chronological order. Results sections were analysed, where clearly labelled as such. One study (Mind, 2011) did not have a clear ‘results’ section and so in this study, any quotes or sections clearly reporting service-user feedback under the heading “*Crisis houses and other alternatives*”, were included in analysis. After expanding the inclusion criteria, a number of non-suicide-specific studies were accepted which compared first-person accounts of hospital with alternative residential services. Only the data that was clearly representing service-user experiences of alternative services was analysed.

3. Results

A brief description of the literature characteristics will be provided followed by an overview of the literature (tables 2 and 3) and the themes generated by the thematic synthesis.

3.1. Literature Characteristics

The search produced 20 items of literature: 15 peer-reviewed qualitative research articles and five 'grey-literature' reports. The peer-reviewed articles included 13 studies providing first-person accounts of hospital services during suicidal crisis and two providing first-person accounts of alternative services, non-specific to suicide. The grey-literature consisted of a chapter from a PhD thesis which included first-person accounts of hospital during suicidal crisis, an independent evaluation of an alternative residential service that provides care to those in suicidal crisis and three independent evaluations of alternative residential crisis services that were not specific to suicide.

The studies of hospital services were conducted across 6 countries, whereas all of the studies on alternative services were conducted in the UK. Three of the published studies on experiences of hospital repeated analysis with data from previous studies (see table 2).

3.2. Literature Appraisal

CASP appraisal criteria were applied to all studies (see appendix A & table 2), except for the report published by MIND (2011), which provided very little information on methodology. Regarding the peer-reviewed literature, the quality generally improved over the twenty-year span in which studies were conducted, with no notable difference between the quality of published studies on hospital services and those on alternative services. In all studies, aims were clearly stated and qualitative methodology was appropriate. However, none of the studies conducted before 2006 justified their use of particular qualitative

methodologies. While all studies provided some details on recruitment strategy, only Lees, Procter and Fassett (2014) explained barriers to recruitment. Information on data collection and analysis varied, tending to be more detailed in the later studies. Other than in the earliest studies, ethical issues were mostly addressed. Findings and value of the research were generally clear. The relationship between the researchers and data was only acknowledged in two studies (Vatne & Naden, 2014; 2016) and even in these, the ways in which formulation of questions, conduct in interviews or interpretation of data may have been influenced was not explored.

CASP scores for grey-literature varied. Whilst one study achieved a very low score (Briggs, Linford & Harvey, 2012) due to lack of information on choice of research design, recruitment, data collection, research relationship, ethical issues and data analysis, another study (Graham, 2012) actually achieved a higher CASP score than any of the published articles.

Overall, the literature appears to be of a sufficient quality to provide a robust answer to the research question. However, findings of some of the earlier peer-reviewed studies of hospitalisation (Cardell & Pitula, 1999; Fletcher, 1999; Pitula & Cardell, 1996) as well as three of the grey-literature studies on alternative services (Briggs et al., 2012; Mind, 2011; Ryan, Mills, Nambiar-Greenwood & Haigh 2010) may need to be read with caution. The overall quality of the literature on alternative services is slightly lower than that on hospital services, which will be considered in the discussion.

Table 2. Literature Characteristics of studies including first-person accounts of hospital services during a time of suicidal crisis

Author/s, Year, Title	Literature type	Location	Sample (people, age, location) *	Aim(s) **	Methodology	General findings **	CASP score
Pitula & Cardell (1996). Suicidal inpatients' experience of constant Observation	Qualitative research article <i>(published in academic journal)</i>	United States	14 psychiatric inpatients (8 female, 6 male, age 21-47)	To increase understanding about what constant observation contributes to the treatment of suicidal inpatients.	Individual interviews analysed using a phenomenological approach.	Constant observation contributed to physical safety and restored hope. But absence of supportive interactions, frequent staff changes and lack of privacy adversely affected experience.	9
Cardell & Pitula (1999). Suicidal inpatients' perceptions of therapeutic and nontherapeutic aspects of constant observation.	Qualitative research article <i>(published in academic journal)</i>	United States	20 inpatients (13 female, 7 male, mean age 32) who had been placed under constant observation due to suicidal intent.	Explore suicidal patients' experiences of constant observation to see if they derive any therapeutic benefits.	Individual interviews and 'analysis consistent with Hutchinson's recommended management of grounded theory data'.	Dysphoria, anxiety, and suicidal thoughts were decreased by observers who were optimistic, acknowledged the patient, provided distraction and gave emotional support. Negative experiences were associated with lack of empathy, acknowledgment, information and privacy.	9
McLaughlin (1999). An exploration of psychiatric nurses' and patients' opinions regarding in-patient care for suicidal patients.	Qualitative research article <i>(published in academic journal)</i>	Northern Ireland	17 inpatients (10 female, 7 male, aged early 20s to late 60s) admitted due to suicidal ideation or behaviour.	To explore patients' opinions regarding their care and how it could be improved.	Individual interviews analysed using content analysis.	Communication was considered the most important skill in psychiatric nursing. Nurses should spend more time helping patients to problem solve. Situational factors impinge on time available for care.	13
Talseth et al. (1999). The meaning of suicidal psychiatric in-	Qualitative research article <i>(published in</i>	Norway	21 psychiatric in-patients (12 female, 9 male aged 25-63 years) who had	To illuminate the meaning of suicidal in-patients' experiences of	Individual narrative interviews analysed using a phenomenological-	Two themes identified: confirming attitude included having time, listening without prejudice, being open, accepting	15

Author/s, Year, Title	Literature type	Location	Sample (people, age, location) *	Aim(s) **	Methodology	General findings **	CASP score
patients experiences of being cared for by mental health nurses	<i>academic journal)</i>		expressed a wish to or attempted suicide. <i>Same data set as Talseth et al., (2001).</i>	being cared for by mental health nurses.	hermeneutic method	and communicating hope; lack of confirming attitude included not having time, listening with prejudice, being closed, non-accepting and communicating hopelessness.	
Fletcher (1999). The process of constant observation: perspectives of staff and suicidal patients.	Qualitative research article <i>(published in academic journal)</i>	England	6 patients who had been at risk of suicide and therefore under constant observation (4 female, 2 male, age not specified)	Explore staff and suicidal patient's views of constant observation.	Individual interviews and data analysed using content analysis.	Two main categories identified: therapeutic interactions including ventilation of feelings and instilling hope; controlling actions, including preventing harm and being authoritarian.	12
Samuelson et al., (2000). Psychiatric care as seen by the attempted suicide patient.	Qualitative research article <i>(published in academic journal)</i>	Sweden	18 patients (6 female, 12 male, age 18-53) recently discharged from in-patient care following a suicide attempt.	Explore admission to hospital following suicide attempt; feelings and reactions; positive and negative experiences.	Individual interviews analysed using content analysis.	Importance of being well cared for and receiving confirmation and understanding. Lack of this could lead to a feeling of being burdensome or another suicide attempt. Verbal contact with staff was essential for healing.	15
Talseth et al. (2001). The meaning of suicidal inpatients' experiences of being treated by physicians	Qualitative research article <i>(published in academic journal)</i>	Norway	21 psychiatric in-patients (12 female, 9 male aged 25-63 years) who had expressed a wish to or attempted suicide. <i>Same data set as Talseth et al. (1999).</i>	To illuminate the meaning of suicidal in-patients' experiences of being treated by physicians	Individual narrative interviews analysed using a phenomenological-hermeneutic method	Two themes identified: Participating Approach included being with the patients, trust, respect and listening without prejudice; Observing Approach included leaving patients to themselves, mistrust, lack of respect and listening with prejudice.	15
Wiklander et al., (2003). Shame reactions after suicide attempt.	Qualitative research article <i>(published in</i>	Sweden	13 inpatients (5 female, 8 male, age 22-53) admitted following attempted suicide.	Explore suicidal patients' experiences of shame and	Individual interviews. Only transcripts mentioning feelings	Kind, respectful and non-judgmental staff and a tolerant and flexible atmosphere alleviated shame. Feeling	15

Author/s, Year, Title	Literature type	Location	Sample (people, age, location) *	Aim(s) **	Methodology	General findings **	CASP score
	<i>academic journal)</i>		<i>Same data corpus as Samuelson et al., (2000), but only relevant transcripts selected for this data set.</i>	highlight aspects of care associated with shame.	of shame were selected. Alternating case- and variable-oriented qualitative analysis.	exposed or negative attitudes from staff exacerbated feelings of shame.	
Sun et al. (2006a). A theory for the nursing care of patients at risk of suicide	Qualitative research article (<i>published in academic journal)</i>	Taiwan	15 in-patients (9 female, 6 male, aged 16-47) who were admitted due to suicidal ideation or attempts. <i>Same data set as Sun et al., (2006b).</i>	Explore suicidal patients' perceptions of the care offered to them on psychiatric wards.	Individual interviews analysed using grounded theory.	Provision of 'safe and compassionate care via the channel of the therapeutic relationship' is central to nursing care of suicidal people.	16
Sun et al., (2006b). Patients and nurses' perceptions of ward environmental factors and support systems in the care of suicidal patients.	Qualitative research article (<i>published in academic journal)</i>	Taiwan	15 in-patients (9 female, 6 male, aged 16-47) who were admitted due to suicidal ideation or attempts. <i>Same data set as Sun et al., (2006a).</i>	Explore suicidal patients' views of the acute psychiatric ward and they type of care received.	Individual interviews analysed using grounded theory.	Patients reported positive aspects of the ward environment such as safety and negative aspects such as noise, impaired autonomy and lack of privacy. Patients reported that nurses not having time, not caring or being insensitive were a barrier to caring.	16
Graham (2012). Experiences following a suicide attempt	Chapter from qualitative PhD thesis (<i>grey-literature)</i>	Australia	10 adults (8 women, 2 men, aged 28-52) recruited through mental health community organisations.	Explore experiences of clinical services following a suicide attempt.	Individual interviews analysed using thematic analysis.	Respect and being taken seriously vs humiliation, blame or indifference. Collaborative decision-making central to overcoming helplessness and regaining a sense of agency.	20
Lees et al., (2014). Therapeutic engagement between consumers in	Qualitative research article (<i>published in academic journal)</i>	Australia	9 consumers (six female, 3 male, average age 41) who had recently received care for and	Explore experiences and needs that consumers had, degree to which needs were met,	Individual interviews analysed using adapted forms of critical discourse, constant	Engagement can help reduce consumer isolation, loss of control, distress and objectification of the delivery of potentially-objectifying common	16

Author/s, Year, Title	Literature type	Location	Sample (people, age, location) *	Aim(s) **	Methodology	General findings **	CASP score
suicidal crisis and mental health nurses.			recovered from suicidal crisis.	role of mental health nurse engagement and key factors that impact on quality of care.	comparative and classical content analysis.	interventions. However, there is a lack of engagement.	
Vatne & Naden (2014). Patients' experiences in the aftermath of suicidal crises	Qualitative research article <i>(published in academic journal)</i>	Norway	10 people (4 women, 6 men aged 21-52) recruited from emergency psychiatric units or crisis resolution teams following suicide attempts. <i>Same data set as Vatne & Naden (2016)</i>	Explore the experiences of being suicidal and the encounter with healthcare personnel.	Individual interviews, thematic analysis and interpretation using a hermeneutic approach	Three themes: a) experiencing and not experiencing openness and trust, b) being met and not met by someone who addresses the matter, c) being met on equal terms versus being humiliated.	18
Vatne & Naden (2016). Experiences that inspire hope: Perspectives of suicidal patients	Qualitative research article <i>(published in academic journal)</i>	Norway	10 persons (4 women, 6 men, age 21-52) recruited from emergency psychiatric wards and crisis resolution teams following suicide attempt. <i>Same data set as Vatne & Naden (2014)</i>	Explore what suicidal patients see as meaningful help in care and treatment situations.	Individual interviews, thematic analysis and interpretation using a hermeneutic approach.	Three themes: A: experiencing hope through encounters, b) experiencing hope through the atmosphere of wisdom, c) experiencing a ray of hope from taking back responsibility.	18

* Copied the language that was used to refer to service-users from the original article, in order to inform analysis of language.

** Only the aims and general findings relevant to the research question were included.

Table 3. Literature Characteristics of studies including first-person accounts of alternative services

Author/s, Year, Title	Literature type	Location	Sample (people, age, location) *	Aim(s) **	Methodology	General findings **	CASP score
Johnson et al., (2004). Women's experiences of admission to a crisis house and to acute hospital wards: A qualitative study	Qualitative research article <i>(published in academic journal)</i>	England	30 women admitted to a women-only crisis house (age not specified). <i>Not suicide-specific</i>	To investigate women's experiences of admission to a women-only crisis house	Semi-structured interviews analysed using thematic content analysis.	The crisis house is highly valued. Recovery is promoted by a home-like environment, absence of disturbed male patients, ready availability of staff for talking through current and past difficulties and good support from other residents. Admission is less stigmatizing than hospital. However, the service is considered quite selective.	16
Lloyd-Evans et al., (2010). In-patient Alternatives to Traditional Mental Health Acute In-Patient Care <i>Section on service-user accounts also published in an academic journal (Gilbert et al., 2010), but with less participant data therefore grey-literature version used for analysis.</i>	Report for the National institute for Health Research Service Delivery and Organisation programme <i>(grey-literature)</i>	England	40 patient recruited from 6 different crisis houses (gender or age break-down not provided). <i>Not suicide-specific</i>	To understand patients' qualitative experience of admission to alternative services and, where possible, how this compares to previous experience of admission to a standard inpatient ward <i>Non-suicide-specific.</i>	Semi-structured interviews analysed using thematic analysis.	For patients who have acute mental illness but lower levels of disturbance, residential alternatives offer a preferable environment to traditional hospital services: they minimise coercion and maximise freedom, safety and opportunities for peer support.	16
Ryan et al., (2010). No comparison to the ward:	Independent service evaluation <i>(grey-literature)</i>	England	22 service-users (15 female, 7 male, aged 28-61) who had used Amethyst House, alternative crisis service.	To evaluate service-users' satisfaction with Amethyst House.	Semi-structured interviews analysed using thematic content analysis.	Those who were interviewed were predominantly very satisfied with the service and also in comparison with previous	11

Author/s, Year, Title	Literature type	Location	Sample (people, age, location) *	Aim(s) **	Methodology	General findings **	CASP score
A service evaluation of Amethyst House and crisis resolution home treatment team			<i>Not suicide-specific</i>			acute care services they had received.	
Mind (2011). Listening to Experience: An independent inquiry into acute and crisis mental healthcare.	Report commissioned by Mind (<i>grey-literature</i>)	United Kingdom – England and Wales	Details not given. <i>Not suicide-specific</i>	Mind commissioned an independent panel to carry out an inquiry into acute and crisis mental health care.	Call for evidence, held hearings and visited a range of services.		NA
Briggs et al., (2012). Guests experiences of Maytree during and after their stay.	Independent service evaluation (<i>grey-literature</i>)	England	Interviews with 12 ex-guests (demographics not provided).	Explore guests' experiences of an alternative residential service for people in suicidal crisis, and their impressions of longer-term impacts.	Semi-structured interviews, analysed using grounded theory.	Most guests reported reduced suicidality 4-9 months after their stay. Some reported no change and some felt the stay was transformational. Contributing factors were being physically and emotionally looked after and listened and attended to.	9
Sweeney et al., (2014). The Relationship between Therapeutic Alliance and Service-user Satisfaction in Mental Health Inpatient Wards and Crisis House Alternatives: A Cross-Sectional Study.	Mixed methods research article. Only qualitative element analysed in this review (<i>published in academic journal</i>)	England	14 service-users (8 female, 6 male, mean age not specified) who had stayed at one of four crisis houses. <i>Not suicide-specific</i>	To explore service-users' perspectives on therapeutic alliances, with a particular focus on the barriers and facilitators to positive therapeutic relationships	Semi-structured interviews analysed using thematic analysis.	Factors that influence therapeutic alliances include service-user perceptions of basic human qualities such as kindness and empathy in staff and, at service level, the extent of loss of liberty and autonomy.	15

* Copied the language that was used to refer to service-users from the original article, in order to inform analysis of language.

** Only the aims and general findings relevant to the research question were included.

4. Thematic summary: ward experiences

This section presents themes derived from studies on experiences of hospitalisation during suicidal crisis.

4.1. Overview

Findings were grouped under four themes. The first theme highlights the nature and importance of the therapeutic relationship: ‘therapeutic engagement is fundamental’. The other three themes referred to aspects which were perceived as unhelpful (see table 4): ‘barriers created by staff attitudes, fears and availability’, ‘the fear of coercion’ and ‘diagnosis overshadowing the person’.

Table 4. Themes from studies exploring first-person accounts of ward experiences during a time of suicidal crisis

Primary theme	Sub-theme
Therapeutic engagement is fundamental	Listening to service-users’ stories
	Empathy, compassion and hope
	Collaboration and respect
Barriers created by staff attitudes, fears and availability	Uncaring, judgemental or patronising
	Staff capacity to bear seriousness of suicide
	Staff having no time
The fear of coercion	
Diagnosis overshadowing the person	

4.2. Therapeutic engagement is fundamental

Participants in all studies emphasised the importance of trusting therapeutic relationships. Therapeutic engagement was facilitated by clinicians demonstrating an active and engaged interest in service-users’ stories, showing empathy, compassion, hope and respect, as well as striving for collaboration.

Listening to service-users’ stories. Service-users reported that they wanted staff to “[take] time... to [talk] about all sorts of things, not only medical talk” (Talseth, Jacobsson & Norberg, 2001, p.100). They wanted staff to listen to their stories about what had led them

to feel suicidal: these related less to mental illness than to interpersonal difficulties, abuse, trauma, bereavement and social marginalisation (Lees et al., 2014; Sun, Long, Boore & Tsao, 2006a; Talseth et al., 2001; Vatne & Naden, 2014).

I had been raped and bashed... I felt that down I couldn't go any lower. I had no one I could trust, and no one would listen to me... I'm better off dead. That was all I was thinking (Lees et al., 2014, p.309).

Service-users needed time to tell their stories and to build relationships with staff and valued when staff "took time to sit down and talk with [them]" (Talseth, Lindseth, Jacobsson & Norberg, 1999, p.1037). They said that eye-contact and questions demonstrated that staff wanted to understand their stories and that they took the suicide attempt seriously. Perceptions of being understood alleviated feelings of dysphoria, anxiety and loneliness and increased hope of being connected with others (Cardell & Pitula, 1999; Vatne & Naden, 2016). Being taken seriously helped service-users to feel less ashamed and gain respect for their own difficulties (Wiklander, Samuelson & Asberg, 2003).

When he listens he asks questions on the basis of what I have said. That shows me that he has understood what I have been saying. He asks thoughtful questions... I understand him and he takes me seriously (Talseth et al., 2001, p.101).

Empathy, compassion and hope. Empathy and compassion were described as essential to therapeutic engagement (Cardell & Pitula, 1999; Lees et al., 2014; McLaughlin, 1999; Samuelson, Wiklander, Asberg & Saveman, 2000; Sun et al., 2006a), building service-users' self-worth (Lees et al., 2014; Pitula & Cardell, 1996), decreasing suicidality (Cardell & Pitula, 1999) and enabling trust (Lees et al., 2014). Care was shown through words and body language, including physical touch, which helped service-users to feel less afraid and more human (Graham, 2012; Talseth et al., 1999). The ability of staff to "confirm that... there is

still hope” (Talseth et al., 1999, p.1038) was also identified as important for building self-worth (Cardell & Pitula, 1999; Samuelson et al., 2000).

There was one nurse who was good. He was genuine... I felt that he really cared... Him caring... it showed me that I’m worth something... that I’m worth being alive (Lees et al., 2014, p.311).

Collaboration and respect. Being respected and valued was described as vital to building trust and therapeutic engagement (Cardell & Pitula, 1999; Graham, 2012; Lees et al., 2014; Pitula & Cardell, 1996; Vatne & Naden, 2014). This included listening without prejudice or judgement and trying to get to know service-users beyond their suicide attempt or diagnosis (Fletcher, 1999; Graham, 2012; Samuelson et al., 2000; Talseth et al., 1999; Wiklander et al., 2003). One service-user said that before prescribing medication, a psychiatrist had said to her “we will wait and see, we want to see whom you are first” (Samuelson, 2000, p.639). She said that this made her feel “extremely secure, enormously respected as a person” (*ibid*).

Other behaviours that demonstrated respect were physicians keeping to appointments (Talseth et al., 2001), involving service-users in decision-making and providing information about the ward, staff and treatment plans (Graham, 2012; Wiklander et al., 2003).

4.3. Barriers created by staff attitudes, fears and availability

Some participants felt that staff attitude, fears or availability could disrupt staff capacity to engage with service-users.

Uncaring, judgemental or patronising. There were many reports of service-users feeling that staff on the ward did not care about them (Cardell & Pitula, 1999; Graham, 2012; Lees et al., 2014; McLaughlin, 1999; Samuelson et al., 2000; Talseth et al., 1999, 2001; Vatne &

Naden, 2016; Wiklander et al., 2003). Some participants reported waiting for hours, feeling ignored and abandoned by staff (Lees et al., 2014; Samuelson et al., 2000; Talseth et al., 1999) which they said left them feeling desperate, isolated, hopeless and more suicidal (Cardell & Pitula, 1999).

There was really no interaction with the nurses . . . they just left me there in bed (Lees et al., 2014, p.311).

Others reported that during observation, some staff would not respond to their initiation of conversation (Cardell & Pitula, 1999) and instead preferred to talk to each other (Samuelson, 2000), to read the paper (Graham, 2012) or watch television (Wiklander et al., 2003). In response to this service-users described feeling angry (Talseth et al., 2001), hopeless, or anxious (Cardell & Pitula, 1999) or withdrawing and shutting out further offers of help (Wiklander et al., 2003).

They don't care... It just kind of supports that hopeless kind of feeling that life isn't worth living (Cardell & Pitula, 1999, p.1068).

Some service-users also said that they felt staff were judgemental (Sun et al., 2006a; Sun, Long, Boore & Tsao, 2006b) or treated them like children (Samuelson et al., 2000). This included 'telling [them] off' (Graham, 2012, p.143) or patronising or pitying them (Vatne & Naden, 2014). Such interactions were described as humiliating, leading to aggression and an increased fear of losing control (Vatne et al., 2014).

To pity someone – feel sorry for someone – I don't like that. I felt that they... talked to me like I was a child, and ... a little sort of, 'poor little you'. That patronizing attitude, that poor-little-thing attitude, annoyed me (Vatne & Naden, 2014, p.170).

Staff capacity to bear the seriousness of suicide. Being able to bear talking about suicide without "being frightened of it [or trying] to steer [conversation] away from it" (Graham et

al., 2012, p.137) was frequently described as important (Lees et al., 2014; Sun et al., 2006a; b; Talseth et al 2001; 1999), enabling service-users to feel relaxed, safe and able to express their distress (Talseth et al., 1999; Lees et al., 2014).

However, participants in six studies said either that no-one asked about their suicidal feelings (Fletcher, 1999; Talseth et al., 2001) or that staff diverted the conversation away to 'safer' topics like depression and medication (Lees et al., 2014; Talseth et al., 1999; Vatne & Naden, 2014). Some thought that staff found it embarrassing to talk about suicide (Talseth et al., 1999). Participants said that this denial of their feelings and experiences left them feeling empty, humiliated (Talseth et al., 1999; Vatne & Naden, 2014) and unable to ask for help (Graham, 2012; Talseth et al., 1999).

I remember a nurse once telling me I wasn't suicidal, and it actually made me think, well I've got permission to kill myself because they don't think anything of it (Graham, 2012, p.139).

Staff having no time. Finally, many participants reported that staff seemed "too busy to build a relationship with [them]" (McLaughlin, 1999, p.1048) or to hear their stories (Graham, 2012; McLaughlin, 1999; Sun et al., 2006a; Talseth et al., 1999). When service-users did manage to talk to staff, some described doctors being distracted by other tasks (Talseth et al., 2001), or nurses having to "break off to do something else, like go to a meeting [or] deliver a report" (Talseth et al., 1999, p.1038).

4.4. The fear of coercion

Coercive practices were mostly described negatively. Such practices included detention without consent, being searched, having possessions confiscated and being put on 'observations' (a practice whereby one or more members of staff either stay with a service-user constantly or check on them at regular intervals). Some service-users said that they

avoided talking about their suicidal feelings in order to avoid coercive practices (Talseth et al., 2001; Vatne & Naden, 2014; Wiklander et al., 2003).

I was afraid of saying too much. I was afraid that she would start deciding and perhaps taking decisions I did not agree with. Control my life” (Talseth et al., 2001, p.102).

With regard to being detained, service-users described shock (Samuelson et al., 2000), feeling restricted (Sun et al., 2006) or like an object or “criminal” (Talseth et al., 1999, p.1038) that had been “isolated and locked away” (Lees et al., 2014, p.310). Some described being searched and having possessions confiscated as invasive (Sun et al., 2006a; b) and a “vote of no confidence” (Samuleson et al., 2000, p.640). Observations were also described as invasive and controlling (Cardell & Pitula, 1999; Fletcher, 1999; Lees et al., 2014; Vatne & Naden, 2016), leaving some service-users feeling hopeless, anxious (Cardell & Pitulla, 1999; Pitula & Cardell, 1996), “embarrassed and angry” (Pitula & Cardell, 1996, p.650). One participant reported that they “[did not] dress, take a shower or go to the bathroom” because they felt embarrassed (Cardell & Pitula, 1999, p.1068) and another reported lying about suicidal feelings to get out of observations (Pitula & Cardell, 1996).

Although there were more examples of coercive practices being described negatively than positively, some participants said that such practices helped them to feel safer, which reduced anxiety, enabled them to sleep and gave time for medication to take effect (Cardell & Pitula, 1999; Pitula & Cardell, 1996; Sun et al., 2006a). “On one-to-one I felt safer; it kept me from losing control. I had a decrease in anxiety knowing someone was going to be there to help me” (Pitula & Cardell, 1996, p.650).

Observations were also described by some as an opportunity for therapeutic engagement (Cardell & Pitula, 1999; Pitula & Cardell, 1996). When staff undertaking the

observations offered emotional support and distraction, participants reported decreased feelings of isolation and increased hopefulness, connectedness and self-worth (Pitula & Cardell, 1996).

A good one talked to me... was there if I needed to talk and I did talk to some of them... A good one acknowledged that I was a person and... didn't just read the newspaper... which a lot of them did, bloody hopeless (Graham, 2012, p.138).

4.5. Diagnosis overshadowing the person

Across a number of studies, service-users said that emphasis on medical treatments or understandings of distress could disrupt therapeutic engagement (Fletcher, 1999; Lees et al., 2014; McLaughlin, 1999; Talseth et al., 2001; 1999; Wiklander et al., 2003). For example, some participants said that being seen through a diagnosis (McLaughlin, 1999; Talseth et al., 1999) or feeling that doctors had made up their mind before meeting them, felt dehumanising, judgemental (Talseth et al., 2001), disrespectful (Wiklander et al., 2003), frustrating (Talseth et al., 1999) and prevented them from telling their stories (Lees et al., 2014; Talseth et al., 2001; Vatne & Naden, 2014). As one service-user explained "it is very frustrating trying to be oneself and not getting any response other than that it is depression" (Talseth, 1999, p.1038).

A diagnosis of personality disorder was described as leading to particularly judgemental attitudes, with one participant quoting her psychiatrist saying "you were diagnosed with [name of disorder] but accused of having borderline personality disorder" (Graham, 2012, p.141).

Participants said that they found it difficult to relate to or trust those doctors who spoke only of medication and diagnoses and that such an approach served to maintain doctors' position as the expert with the 'right' answers to solve service-users' problems

(Talseth et al., 2001, p.101). They said that they did not recognise themselves or their stories through the medical language that the doctors used to explain their 'disease' to them (Talseth et al., 2001, p.102).

I had lots of things going on, and I didn't think a pill would fix that... They thought that it was just the depression that was clouding my thoughts, but it wasn't that simple, and I needed to talk about that (Lees et al., 2014, p.102).

Service-users also complained about the side effects of medication (Sun et al., 2006b) and one described hiding suicidal feelings in order to avoid their medication being increased (Talseth et al., 2001).

Although less frequently reported, some participants described positive consequences of taking medication, such as improved sleep and mood (Cardell & Pitula, 1999) and a reduction in anxiety or command hallucinations (Cardell & Pitula 1999; Fletcher, 1999; Talseth et al., 2001). Samuelson and colleagues (2000) also reported that some participants found it helpful "to know that their difficulties could be seen as a psychiatric disorder, for which treatment is available" (p.640).

5. Thematic summary: Experiences of alternative residential services

5.1. Overview

This section presents themes derived from the studies on experiences of alternative residential crisis services. Across all studies, service-users were mostly positive about their experiences of alternative services. The importance of relationships was again a primary theme, divided into the subthemes of 'relationships with other service-users' and 'relationships with staff'. The other three themes were: 'promoting involvement and

autonomy’, ‘living a “normal” life in a “normal” environment’ and ‘transformation’ (see table 5).

Table 5. Themes from studies looking at experiences of alternative services

Primary Theme	Sub-theme
Healing through relationships	Relationships with other service-users Relationships with staff
Promoting involvement and autonomy	
Living a “normal” life in a “normal” environment.	
Transformation	

5.2. Healing through relationships

The importance of relationships was mentioned across studies: Lloyd-Evans and colleagues (2010) stated that it was the most frequently reported theme in their study and featured in every interview. Relationships included those between service-users themselves as well as between staff and service-users.

Relationships with other service-users. Participants across four studies reported forming relationships with other service-users and benefiting from the support they received, the feeling that others were going through similar experiences, as well as the opportunity to help others (Briggs et al., 2012; Johnson et al., 2004; Lloyd-Evans et al., 2010; Ryan et al., 2010).

It was all women helping each other and trying to help each other, and a lot of us got a lot out of that – you know, a feeling of community (Johnson et al., 2004, p.254).

Service-users in three studies said that residents in the crisis house did not appear to be “as ill as [those] on the ward” (Lloyd Evans et al., 2010, p.242), which some gave as a reason for forming deeper connections (Johnson et al., 2004; Ryan et al., 2010).

Some participants in the women-only service said that the all-women setting facilitated the development of relationships. Women said that “knowing that there [were]

no male residents... just [made them] feel safer” and more able to express themselves, particularly those who felt that their mental health difficulties had developed as a consequence of negative experiences with men (Johnson et al., 2004, p.253).

Relationships with staff. Descriptions of staff in crisis houses were almost exclusively positive. Across studies, staff were described repeatedly as “friendly”, “understanding”, “supportive”, “caring”, “helpful”, “approachable”, “warm”, “empathic” and “trustworthy”. For example, one service-user described staff as “absolutely brilliant. They made you feel at home, at ease. They understood what was going on” (Ryan et al., 2010, p.24). In addition to employees, some services also had voluntary befrienders, who were described as having a “normalizing effect” (Briggs et al., 2012, p.15).

Across all studies, participants said they valued the opportunity to talk. Described by one participant as a “talk-through policy” (Briggs et al., 2012, p.14), where staff “go out of their way to make you chat” (Ryan et al., 2010, p.25), the opportunities for both formal one-to-one sessions, as well as informal conversations over dinner for example, were described as helping service-users to feel safe and to verbalise and work through their distress (Briggs et al., 2012; Johnson et al., 2004; Lloyd-Evans et al., 2010; Sweeney et al., 2014).

Participants said that continuity of staff helped them to open up, and some who had been to the crisis house multiple times said they valued the continuity of staff over the years (Lloyd-Evans et al., 2010).

The time I spent in the Maytree (Maytree Suicide Respite Centre) allowed me to get a lot of verbalisation to what was rattling around in my head (Briggs et al., 2012, p.15).

5.3. Promoting involvement and autonomy

In most of the alternative services, service-users could not be detained against their will. As a result, service-users said that they had more freedom and described feeling less restricted than they had in hospital services (Briggs et al., 2012; Lloyd-Evans et al., 2010). They commented on the positive consequences of still being able to go for walks (Lloyd-Evans et al., 2010), to work and carry on with important routines (Mind, 2011).

Service-users said they appreciated that “staff [brought them] into everything and [involved them]” (Ryan et al., 2010, p.33). They described autonomy through taking more responsibility for their medication (Johnson et al., 2004; Lloyd-Evans et al., 2010; Ryan et al., 2010), being involved in decisions about their care (Johnson et al., 2004; Ryan et al., 2010; Sweeney et al., 2014) and services having more flexible schedules (Lloyd-Evans et al., 2010),

You were able to discuss [medication], rather than just being told, I think it makes a big difference. And then when I felt the medication had helped I didn't feel pressured to carry it on (Johnson et al., 2004, p.256).

Being able to self-refer or be referred by friends and family was appreciated (Johnson et al., 2004; Lloyd-Evans et al., 2010; Mind, 2011), although the majority of participants in Johnson et al.'s study (2004) said they found the lengthy and involved assessment process stressful. Some said that too much freedom felt daunting (Sweeney et al., 2014) and a few said there were “times when [they needed] to be in hospital” (Johnson et al., 2004; Ryan et al., 2010, p.32).

5.4. Living a 'normal' life in a 'normal' environment

Across studies, participants commented positively on the environment in alternative services. For example, one participant described one service as “very homely, very relaxing as you would find in your own home” (Lloyd-Evans et al., 2010, p.245). Words such as

“cosy”, “beautiful”, “comfy”, “non-clinical” “calm”, “relaxing” and “homely” were used repeatedly. Particular characteristics that were valued were cleanliness, having access to outside space, having plenty of both private and communal space, ensuite bathrooms, locks on bedrooms and attractive decor (Johnson et al., 2004; Lloyd-Evans et al., 2010).

Service-users said that such an environment facilitated therapeutic engagement (Sweeney et al., 2014), helped them to feel calm and safe, and had a positive impact on their mental health and self-esteem (Lloyd-Evans et al., 2010; Ryan et al., 2010). Some attributed this to the fact that being in a place that felt more “ordinary” felt less disruptive to “normal life” (Johnson et al., 2004, p.254).

5.5. Transformation

Service-users in three studies described lasting positive change as a consequence of staying in alternative residential services. Their descriptions included learning to manage panic attacks and to cope better, “getting back on [their] feet” (Ryan et al., 2010, p.30) and “[finding [themselves]” (Ryan et al., 2010, p.27).

It's given me a sense of life back and helped me to find myself. I couldn't have gone on any longer. Staff have taught me to cope better and manage my panic attacks (Ryan et al., 2010, p.27).

A number of participants described their stay in the service that was specifically for those in suicidal crisis as ‘life-saving’ or ‘life-changing’. For example, one service-user commented “it saved my life, let’s not beat about the bush” (Briggs et al., 2012, p.16) and another in MIND’s (2011) enquiry said: “my time at Maytree was the most transformative period I have ever had” (p.31). Finally, none of the participants who stayed in this service reported any further suicide attempts after their stay and all reported making use of their stay to help with suicidal struggles since leaving (Briggs et al., 2012).

I'm getting better actually. I'm making a lot of progress since being at the Maytree.

I'm not as suicidal as I was then (Briggs et al., 2012, p.13).

6. Discussion

Across hospital and alternative services, therapeutic engagement was consistently described as important and as leading to a reduction in distress and suicidality. Given the well-documented link between social isolation/ loneliness and suicidality (e.g. Durkheim, 1897/1951; Eynan et al., 2002; Lavigne-Pley, 1987; Stravynski & Boyer 2001; Trout, 1980), the importance of human connection in alleviating suicidal feelings should perhaps not come as a surprise. Indeed, Cutcliffe & Stevenson (2007) have argued that 'reconnecting the person with humanity' is the core task of nursing staff when working with people who are suicidal.

The fact that negative experiences were reported consistently across hospital studies is concerning. It needs to be acknowledged that the accounts reported represent participants' perceptions, influenced by a range of fears, desires and emotions. A number of participants reported feeling angry about having failed in their suicide attempt (e.g. Vatne & Naden, 2014) which could have influenced subsequent experience. Similarly, as McGinley and Rimmer (1992) pointed out, after attempting suicide, a person may be expecting negative judgement and therefore more inclined to interpret actions as such. Graham (2012) reported that individual participants in her study gave a range of views, which suggests that they were able to register positive as well as negative experiences. However, such information was not provided in any other study, meaning that it is possible that participants gave polarised accounts, heavily influenced by their own prior emotions and expectations. Despite these concerns, the consistency with which certain behaviours or practices were described negatively across studies suggests that something beyond individual participants' own subjectivities may have been influencing their experiences. As

McGinley and Rimmer (1992) point out, there is also a reality to staff behaviour and practices and this reality matters.

Across hospital studies, participants reported feeling that attitudes, behaviours and availability of staff, coercive practices and a dominance of medicalised understandings of distress could prevent or disrupt therapeutic engagement and lead to increased distress and suicidality. The authors of two papers suggested that “the principles of listening, respect and empathy, widely accepted as a foundation for clinical practice... can be quite often not adhered to” (Graham, 2012, p195; Vatne & Naden, 2014) and offered explanations for how this might happen. Vatne & Naden (2014) drew on psychoanalytic ideas to suggest that the fears and emotions that suicidality can bring up in clinicians can disrupt their ability to engage with someone in crisis (Lindstrom, 2000, as cited in Vatne & Naden., 2014). Similarly, Graham (2012) referred to McGinley and Rimmer’s (1992) ideas about how suicide can lead to defensive splitting by clinicians, who come to see the suicide attempter as either a passive victim or a cruel aggressor, the latter leading to hostility or avoidance (Michel et al., 2002). Such theories were supported by the words of nurses in Lees et al.’s (2014) study who described feeling “scared”, “nervous” and “afraid” to talk about suicide with service-users (p.311), but do not explain why such experiences were not reported by service-users in alternative services.

The authors of two studies commented on the potential negative consequences of medical and custodial practices. Lees et al., (2014) remarked that the dominance of a medical-custodial model can affect the quality of care, and Graham (2012) stated that empathy can become lost in “the emphasis given to risk factor and diagnostic-based decision-making” (p196). However, these authors did not articulate the ideas or assumptions that underlie a medical model of care, nor did they explore how such ideas

might influence practice. Indeed, Johnstone & Boyle (2018) have argued that whilst “the theoretical positions underpinning medicalisation and psychiatric diagnosis have profound implications for real life policy and practice... [the underlying] assumptions and discourses... are rarely challenged or even consciously identified” (p.48).

Authors within the field of critical suicidology have suggested that the conceptualisation of suicide as individual pathology dictates a response of ‘control’ and ‘treatment’ of individuals within a clinical setting (Marsh, 2015; Pabst Battin, 2005; Wexler & Gone, 2015). For example, assumptions that suicide is a result of mental illness and that mental illness can affect insight can be used to justify coercive forms of control, like detention, observation and restraint (Cooke, 2017). Similarly, if suicide is a consequence of an illness, then it follows that ‘patients’ will need ‘treating’ with medication (Johnstone & Boyle, 2018). Whilst therapeutic relationships might facilitate this process they are unlikely to be conceptualised as the ‘treatment’ in themselves. This might explain why either at an individual or organisational level, some practitioners might not prioritise, or be given time to develop meaningful relationships with service-users.

In alternative services, service-users reported predominantly positive relationships with staff and other service-users, an emphasis on talking, as well as more freedom, privacy and autonomy. Interestingly these services also tended to be described as less medical. Although again, none of the studies explicitly explored how the model of care might influence service-user experience, another peer-reviewed article (Briggs, Webb, Buhagiar & Braun, 2007) which describes the model of care used in Maytree, the suicide specific crisis service, does give more attention to such ideas.

Briggs and colleagues (2007) describe Maytree as nonmedical, where “people who stay are “‘guests’ not patients” (p140). The foremost values are described as trust,

openness, confidentiality, and exploration of feelings. Authors explain the rationale behind such values: “the offer of trust invites the reciprocation of trust and conversely mistrust breeds mistrust” (p.141). The authors quote from the Maytree Policy and Guidelines “We believe that the seemingly high-risk option of sticking with trust often, in the end, carries lesser risks” (p.141). Such an approach is underpinned by the Samaritan value that everyone has the right to decide to die by suicide. This contrasts with the approach used in hospital services where ‘zero-suicide’ targets (Mental Health Today, 2018) place responsibility on clinicians to prevent suicide and as mentioned, the concept of ‘lack of insight’ resulting from ‘mental illness’ (Cooke, 2017) is used to justify coercion in the service of this aim. Briggs and colleagues (2007) contrast the approach used in Maytree with “the medical model” (p.141), which they suggest can compound difficulties through stigmatization. They quote the Maytree director: “we don’t have answers to these illnesses so labels (medical diagnoses) don’t help. The medical model is also excluding of the person you are talking about – the patient” (p141).

In the current review, only one of the studies of alternative services described the model of care that the service aimed to adopt, and it concluded that it was not possible to judge how far participants’ experiences were influenced by the application of this particular model (Johnson et al., 2004). A number of studies analysed participants’ experiences of different services together without differentiation (Lloyd-Evans et al., 2010; Mind, 2011; Sweeney et al., 2014). This makes it difficult to draw any meaningful conclusions about what alternative services are and the process through which they might be able to offer something different to inpatient care. Nonetheless, there appears to be an overall trend towards services-users describing better therapeutic engagement in services that they characterised as less medically-oriented and less coercive.

6.1. Methodological considerations

Any conclusions drawn must be considered within the context of a number of methodological issues.

Design. The majority of the studies did not discuss epistemology nor justify their choice of particular qualitative methods. Therefore, it was difficult to assess whether the findings can be meaningfully synthesized (Dixon-Woods et al., 2006). Moreover, Thorne (2017) has questioned whether the process of synthesising, which often equates to drawing out commonalities across papers fits with the philosophical underpinnings of qualitative research, which generally aims to understand the richness of individual experience in context.

Samples. Most studies provided limited information on recruitment strategy, with none (other than one of the grey-literature studies; Ryan et al., 2010) providing information on reasons that participants chose not to take part. Such information might inform interpretation if only particular groups of people or people with particular opinions chose to participate.

Comparability between hospital and alternative services. It needs to be acknowledged that there were a number of methodological and service-related factors which could have contributed to the differences reported between hospital and alternative services. Firstly, a higher proportion of the studies on alternative services were grey-literature and therefore not peer-reviewed. Overall, they were also of a lower quality compared to studies of hospital services. Although all appeared to be independent evaluations, rather than carried out by the services themselves, the lack of quality assurance means that their findings need to be taken with caution.

Secondly, some participants reported that people in the crisis house appeared to be less distressed than in hospital, highlighting the fact that hospital services may have a more difficult task than alternative services. This could contribute to hospital services being described more negatively. Similarly, if the participants in hospital were more distressed, this could also have coloured their memories or retelling of their experiences. On this point, it is important to remember that all the hospital studies were suicide specific and all except for two studies (Graham, 2012; Lees et al., 2014) recruited people who were currently in hospital. In contrast, only one of the studies on alternative services (Briggs et al., 2012) was specific to suicide and in this study, participants were interviewed 4-9 months after leaving the service, by which point they may not have been feeling suicidal anymore. To be suicidal is perhaps to experience a deep ambivalence about life and other people, which would presumably colour any description of experiences. Therefore, it is possible that the more favourable accounts of alternative services could partially be explained by differences in the emotional state of those being interviewed.

Reflexivity. The fact that there was so little exploration by authors into how models of care might influence practice and participants' experiences is interesting. And here, it is important to remember that the data drawn on in this review were filtered not only through participants' perceptions, but also through the assumptions, beliefs and expectations of the authors who wrote the studies. Other than the two studies which alluded to the influence and dominance of medical understandings of distress (Graham, 2012; Lees et al., 2014), all of the hospital studies referred at some point to participants as 'patients' who were in the receipt of 'treatment'. Four studies included a breakdown of participants' 'disorders' (Cardell & Pitula, 1999; Pitula & Cardell, 1996; Samuelson et al., 2000; Wiklander et al., 2003) and four referred to the participants' 'illnesses' (Samuelson et al., 2000; Sun et al.,

2006b; Talseth et al., 2001; Vatne & Naden, 2016). One study referred to participants' 'insight into the necessity of receiving... professional help' (Samuelson et al., 2000, p.638). The studies of alternative services generally used less medicalised language, but all except for the study on Maytree (Briggs et al., 2012) still referred at some point to 'patients', 'illnesses', 'disorders' or 'treatments'. Most of the studies did not include information on the researchers' relationship with the participants or subject-matter, making it difficult to assess the extent to which personal subjectivities may have influenced research question, data collection or analysis (Newton, Rothlingova, Gutteridge, LeMarchand, & Raphael, 2011). However, such medicalised language suggests that many of the authors of both hospital and alternative studies may themselves have been subject to the same medicalised discourses that influence services, which may have limited their ability to reflect on the influence of such processes. Indeed, as Marsh (2015) has argued, such discourses or "regimes of truth" (Foucault, 2002, p.131) can render the field of suicidology somewhat "uncritical in relation to the assumptions under which it operates" (p.19) and reduce the possibilities for thought and action available to the field of suicide prevention (*ibid*).

6.2. Recommendations

Clinical recommendations. The results of this review suggest that the development of trusting therapeutic relationships is a priority for service-users in the midst of suicidal crisis. They describe wanting a chance to tell their story, which for many included experiences of abuse, trauma, bereavement or discrimination. Whilst some referred to 'mental illness' or diagnoses, most participants reported wanting staff to listen compassionately to their stories and not to be restricted by pre-defined medical frameworks.

Although in the current climate, clinicians may feel and be pressurised to prioritise the management of risk over therapeutic engagement, the findings of this review suggest

that therapeutic engagement can actually aid risk management through counteracting the isolation which is often central to suicidality. Moreover, the custodial practices that a medicalised understanding of distress can legitimise were reportedly experienced as traumatic by some and felt to disrupt therapeutic engagement; both consequences that perversely, may increase risk.

Given that more medicalised services were described as more coercive, and providing fewer opportunities to talk or to build positive relationships, managers of current services and developers of future alternative services might be advised to consider how the assumptions underlying different models of care may influence practice and service-user experience. Mixed experiences were reported across services and so it is important not to characterise particular approaches as entirely positive or negative but rather to examine the advantages and disadvantages of each. Likewise, it is important to recognise that all services, both standard and alternative are likely influenced by a range of models and assumptions. However, at present there seems to be little attempt to articulate the ideas that guide practice (Johnstone & Boyle, 2018) and without such reflection, services could miss opportunities to develop or utilise alternative discourses that may sometimes enable them to better meet the needs of those in suicidal crisis.

Research recommendations. Alternative residential services may provide one way of addressing some of the concerns that service-users have expressed with standard hospital care. However, so far there has been little research into alternative services in general and only one study was found which interviewed people who had used an alternative service specifically during a time of suicidal crisis. Moreover, there does not seem to be any research which aims to articulate the assumptions upon which standard care is based and from which alternative services might differ. In order to create alternative services that are

meaningfully different and that might be able to more successfully meet the needs of those in suicidal crisis, further research might seek the opinions of more people who have used alternative services at a time of suicidal crisis, particularly services which attempt to explicitly articulate the model/s of care used.

7. Conclusions

This was the first review to explore first-person accounts of experiences of residential services for people in suicidal crisis. Qualitative peer-reviewed articles and grey-literature accounts were reviewed and analysed using thematic synthesis. Given that there were very few examples of studies exploring experiences of residential alternatives for people in suicidal crisis, inclusion criteria for this part of the review were expanded to include studies looking at alternative residential services that were not specific to suicide.

Methodological limitations mean that findings need to be taken with caution. However, tentatively, there seemed to be a pattern in that experiences of hospital services, which were characterised as being more dominated by medical approaches and making more use of coercive practices were more often described negatively than alternative services. In alternative services, service-users reported experiencing more autonomy and involvement, more opportunity to talk to staff and better relationships with both staff and other users within what they often described as a less medicalised setting. However, authors gave very little attention to how the model of care adopted by services might influence practice and service-user experience. Future research and service-development might benefit from exploring such processes further.

References

- Barbour, R. S. (2001). Checklists for improving rigour in qualitative research: A case of the tail wagging the dog. *British Medical Journal*, *322*, 1115–1117.
<https://doi.org/10.1136/bmj.322.7294.1115>
- Beaton, S.J. (2012). *The Audrey Fagan Churchill Fellowship to study models of care for suicide and crisis support*. The Winston Churchill Memorial Trust of Australia. Retrieved from <https://www.churchilltrust.com.au/fellows/detail/3635/susan+beaton>
- Berg, S. H., Rørtveit, K., & Aase, K. (2017). Suicidal patients' experiences regarding their safety during psychiatric in-patient care: a systematic review of qualitative studies. *BMC Health Services Research*, *17*, 1–13. <https://doi.org/10.1186/s12913-017-2023-8>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*, 77–101. <https://doi.org/10.1191/1478088706qp063oa>
- Briggs, S., Linford, H., & Harvey, A. (2012). Guests experiences of Maytree during and after their stay. Retrieved from <http://repository.tavistockandportman.ac.uk/1497/>
- Briggs, S., Webb, L., Buhagiar, J., & Braun, G. (2007). Maytree: A respite center for the suicidal: An evaluation. *Crisis*, *28*, 140–147. <https://doi.org/10.1027/0227-5910.28.3.140>
- Campbell, R., Pound, P., Pope, C., Britten, N., Pill, R., Morgan, M., & Donovan, J. (2003). Evaluating meta-ethnography: A synthesis of qualitative research on lay experiences of diabetes and diabetes care. *Social Science and Medicine*, *56*, 671–684.
[https://doi.org/10.1016/S0277-9536\(02\)00064-3](https://doi.org/10.1016/S0277-9536(02)00064-3)

- Cardell, R. & Pitula, C. R. (1999). Suicidal inpatients' perceptions of therapeutic and nontherapeutic aspects of constant observation. *Psychiatric Services*, 50, 1066–1070. <https://doi.org/10.1176/ps.50.8.1066>
- Cleary, M., Hunt, G.E., Horsfall, J. & Deacon, M. (2012). Nurse-patient interaction in acute adult inpatient mental health units: A review and synthesis of qualitative studies. *Issues in Mental Health Nursing* 33, 66–79. <https://doi.org/10.3109/01612840.2011.622428>
- Cooke, A. (2017). Therapeutic relationships: the perniciousness of 'insight' and 'expertise' [Workshop notes]. Retrieved from <http://programme.exordo.com/isps2017/delegates/presentation/4/>
- Cutcliffe, J.R. & Stevenson, C. (2007). *Care of the suicidal person*. London: Churchill Livingstone.
- De Leo, D., & Svetlicic, J. (2010). Suicides in psychiatric in-patients: What are we doing wrong? *Epidemiology and Psychiatric Sciences*, 19, 8–15. Retrieved from <http://ezproxy.usherbrooke.ca/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2011-13051-002&site=ehost-live>
- Dixon-Woods, M., Bonas, S., Booth, A., Jones, D. R., Miller, T., Sutton, A... Young, B. (2006). How can systematic reviews incorporate qualitative research? A critical perspective. *Qualitative Research*, 6, 27-44. <https://doi.org/10.1177/1468794106058867>
- Department of Health (2012). *Preventing suicide in England A cross-government outcomes strategy to save lives*. London: Crown. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/430720/Preventing-Suicide-.pdf

Department of Health (2017). *Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives*. London: Crown. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/430720/Preventing-Suicide-.pdf

Durkheim, E. (1951). *Suicide: A study in sociology* (JA Spaulding & G. Simpson, trans.). Glencoe, IL: Free Press. (Original work published 1897).

Eynan, R., Langley, J., Tolomiczenko, G. Rhodes, A.E., Links, P., Wasylenki, D. & Goering, P. (2002). The association between homelessness and suicidal ideation and behaviors: results of a cross-sectional survey. *Suicide and Life Threatening Behavior*, 33, 418-427. <https://doi.org/10.1521/suli.32.4.418.22341>

Fitzpatrick, S. (2011). Looking beyond the qualitative and quantitative divide: Narrative, ethics and representation in suicidology. *Suicidology Online*, 2, 29-37. Retrieved from <http://www.suicidology-online.com/pdf/SOL-2011-2-29-37.pdf>

Fletcher, R. F. (1999). The process of constant observation: Perspectives of staff and suicidal patients. *Journal of Psychiatric and Mental Health Nursing*, 6, 9–14. <https://doi.org/10.1046/j.1365-2850.1999.00181.x>

Foucault, M. (2002). *Power (Essential Works Vol. 3)*. J. D. Faubion (Ed.). London: Penguin.

Gilbert, H., Slade, M., Rose, D., Lloyd-Evans, B., Johnson, S., & Osborn, D. P. J. (2010). Service users' experiences of residential alternatives to standard acute wards: Qualitative study of similarities and differences. *British Journal of Psychiatry*, 197, 26-31. <https://doi.org/10.1192/bjp.bp.110.081075>

- Graham, A. C. (2012). *Experiences following a suicide attempt*. Retrieved from <http://vuir.vu.edu.au/25827/1/Anne%20Carolyn%20Graham.pdf>
- Hjelmeland, H. (2016). A critical look at the current suicide research. In J. White, I. Marsh, M. J. Kral & J. Morris (Eds.), *Critical suicidology: Transforming suicide research and prevention for the 21st century* (pp. 31-55). Vancouver, BC: University of British Columbia Press.
- Hjelmeland, H., & Knizek, B.L. (2010). Why we need qualitative research in suicidology. *Suicide and Life-Threatening Behavior*, 40, 74–80. doi: 10.1521/suli.2010.40.1.74
- Howard, L.M., Rigon, E., Cole, L., Lawlor, C. & Johnson, S. (2008). Admission to women's crisis houses or to psychiatric wards: women's pathways to admission. *Psychiatric Services*, 59, 1443-9. <https://doi.org/10.1176/appi.ps.59.12.1443>
- Healthcare Quality Improvement Partnership. (2015). *National confidential inquiry into suicide and homicide by people with mental illness*. Retrieved from <http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/NCISHReport2015bookmarked2.pdf>
- Johnson, S., Bingham, C., Billings, J., Pilling, S., Morant, N., Bebbington, P., ... Dalton, J. (2004). Women's experiences of admission to a crisis house and to acute hospital wards: A qualitative study. *Journal of Mental Health*, 13, 247–262. <https://doi.org/10.1080/09638230410001700880>
- Johnstone, L. & Boyle, M. with Cromby, J., Dillon, J., Harper, D., Kinderman, P... & Read, J. (2018). *The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis*. Leicester: British Psychological Society.

Joiner, T. (2011). Editorial: scientific rigor as the guiding heuristic for SLTB's editorial stance.

Suicide and Life-Threatening Behavior, 41, 471-473. <https://doi.org/10.1111/j.1943-278x.2011.00056.x>

Johnstone, L. & Boyle, M. with Cromby, J., Dillon, J., Harper, D., Kinderman, P... & Read, J.

(2018). *The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis*. Leicester: British Psychological Society.

Katsakou, C., & Priebe, S. (2006). Outcomes of involuntary hospital admission: a review.

Acta Psychiatr Scand, 114, 232–41. <http://dx.doi.org/10.1111/j.1600-0447.2006.00823.x>

Killaspy, H., Dalton, J., McNicholas, S., & Johnson, S. (2000). Drayton Park, an alternative to

hospital admission for women in acute mental health crisis. *Psychiatric Bulletin*, 24, 101– 104. <https://doi.org/10.1192/pb.24.3.101>

Large M, Ryan C. (2014). Disturbing findings about the risk of suicide and psychiatric

hospitals. *Social Psychiatry and Psychiatric Epidemiology*, 49, 1353-5.

Lavigne-Pley, C. (1987). Le suicide chez les personnes agees (Suicide among the elderly),

Canadian Journal of Community Mental Health, 6, 55-77.

Lees, D., Procter, N., & Fassett, D. (2014). Therapeutic engagement between consumers in

suicidal crisis and mental health nurses. *International Journal of Mental Health Nursing*, 23, 306–315. <https://doi.org/10.1111/inm.12061>

Lloyd-Evans B., Johnson, S. Slade, M. Barrett B. Byford, S, Gilbert, H., ... Thornicroft, G.

(2010). Report for the National Institute for Health Research Service Delivery and

Organisation programme: In-patient alternatives to traditional mental health acute in-patient care. London: Crown. Retrieved from

<https://njladmin.nihr.ac.uk/document/download/2008737>

Lloyd-Evans B., Slade M., Jagielska D. & Johnson S. (2009). Residential alternatives to acute psychiatric hospital admissions: systematic review. *British Journal of Psychiatry* 195, 109-117. <https://doi.org/10.1192/bjp.bp.108.058347>

Maris, R. W., Berman, A. L., & Silverman, M. (Eds.). (2000). *Comprehensive textbook of suicidology*. New York, NY: Guilford Press.

Marsh, I. (2016). Critiquing contemporary suicidology. In J. White, I. Marsh, M. J. Kral & J. Morris (Eds.), *Critical suicidology: Transforming suicide research and prevention for the 21st century* (pp. 15-30). Vancouver, BC: University of British Columbia Press.

McGinley, E., & Rimmer, J. (1992). The trauma of attempted suicide. *Psychoanalytic Psychotherapy*, 7, 53-68. <https://doi.org/10.1080/02668739300700051>

McLaughlin, C. (1999). An exploration of psychiatric nurses' and patients' opinions regarding in-patient care for suicidal patients. *Journal of Advanced Nursing*, 29, 1042–1051. <https://doi.org/10.1046/j.1365-2648.1999.01000.x>

Mental Health Today (2018). *Hunt sets NHS zero suicide target*. Retrieved from <https://www.mentalhealthtoday.co.uk/news/crisis-care/hunt-sets-nhs-zero-suicide-target>

Mind (2011). *Listening to experience: an independent inquiry into acute and crisis mental healthcare*. London: MIND. Retrieved from https://www.mind.org.uk/media/211306/listening_to_experience_web.pdf

Michel, K., Maltzberger, J. T., Jobes, D. A., Leenaars, A. A., Orbach, I., Stadler, K., ... Valach, L. (2002). Discovering the truth in attempted suicide. *American Journal of Psychotherapy*, 56, 424-437.

Murphy, E., Dingwall, R., Greatbatch, Parker, S., & Watson, P. (1998). *Qualitative research methods in health technology assessment: a review of the literature*. Southampton: National Coordinating Centre for Health Technology Assessment. Retrieved from <http://www.hta.ac.uk/fullmono/mon216.pdf>

Newton-Howes G, Mullen R. (2011) Coercion in psychiatric care: systematic review of correlates and themes. *Psychiatric Services*, 65, 465-70.
<https://doi.org/10.1176/appi.ps.62.5.465>

Newton, B. J., Rothlingova, Z., Gutteridge, R., LeMarchand, K., & Raphael, J. H. (2011). No room for reflexivity? Critical reflections following a systematic review of qualitative research. *Journal of Health Psychology* 17, 866-85.
<https://doi.org/10.1177/1359105311427615>

Office for National Statistics (2017). *Statistical bulletin: suicides in Great Britain: 2016 registrations*. Retrieved from <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2016registration>

Pabst Battin, M. (2005). *Ending Life: Ethics and the Way We Die*. Oxford: Oxford University Press

Paton, F., Wright, K., Ayre, N., Dare, C., Johnson, S., Lloyd-Evans, B., ... Meader, N. (2016). Improving outcomes for people in mental health crisis: a rapid synthesis of the

evidence for available models of care. *Health Technology Assessment*, 20.

<https://doi.org/10.3310/hta20030>

Pitula, C.R., & Cardell, R. (1996). Suicidal inpatients' experience of constant observation.

Psychiatric Services, 47, 649–651. <https://doi.org/10.1176/ps.47.6.649>

Public Health Resource Unit. (2006). *Critical Appraisal Skills Programme (CASP)*. Retrieved

from http://media.wix.com/ugd/dded87_29c5b002d99342f788c6ac670e49f274.pdf

Rose, D. (2008). Commentary: Madness Strikes Back. *Journal of Community & Applied Social*

Psychology, 18: 638–644. <https://doi.org/10.1002/casp.981>

Rose, D., Evans, J., Laker, C., & Wykes, T. (2015). Life in acute mental health settings:

experiences and perceptions of service users and nurses. *Epidemiology and psychiatric sciences*, 24, 90-96. doi:10.1017/S2045796013000693

Ryan, T. Mills, C., Nambiar-Greenwood, G. & Haigh, C. (2010). No Comparison to the Ward:

A Service Evaluation of Amethyst House and Crisis Resolution Home Treatment Team.

Retrieved through contacting author (info@tonyryan.org)

Slade, M., Byford, S., Barrett, B., Lloyd-Evans, B., Gilbert, H., Osborn, D., . . . Johnson, S.

(2010). Alternatives to standard acute in-patient care in England: Short-term clinical outcomes and cost-effectiveness. *British Journal of Psychiatry*, 197, S14-S19.

doi:10.1192/bjp.bp.110.081059

Samuelsson, M., Wiklander, M., Asberg, M., & Saveman, B.I. (2000). Psychiatric care as seen

by the attempted suicide patient. *Journal of Advanced Nursing*, 32, 635–643.

<https://doi.org/10.1046/j.1365-2648.2000.01522.x>

- Stenhouse, R.C. (2011). 'They all said you could come and speak to us': patients' expectations and experiences of help on an acute psychiatric inpatient ward. *Journal of Psychiatric Mental Health*, 18, 74–80. <https://doi.org/10.1111/j.1365-2850.2010.01645.x>
- Stravynski, A., & Boyer, R. (2001). Loneliness in relation to suicide ideation and parasuicide: a population-wide study. *Suicide and Life-Threatening Behaviour*, 31, 32-40. <https://doi.org/10.1521/suli.31.1.32.21312>
- Sun, F., Long, A., & Boore, J. (2006a). A theory for the nursing care of patients at risk of suicide. *Journal of Advanced Nursing*, 53, 680–690. <https://doi.org/10.1111/j.1365-2648.2006.03774.x>
- Sun, F.K., Long, A., Boore, J., & Tsao, L.I. (2006b). Patients and nurses' perceptions of ward environmental factors and support systems in the care of suicidal patients. *Journal of Clinical Nursing*, 15, 83–92. <https://doi.org/10.1111/j.1365-2702.2005.01232.x>
- Sweeney, A., Fahmy, S., Nolan, F., Morant, N., Fox, Z., Lloyd-Evans, B., ... Johnson, S. (2014). The relationship between therapeutic alliance and service user satisfaction in mental health inpatient wards and crisis house alternatives: A cross-sectional study. *PLoS ONE*, 9. <https://doi.org/10.1371/journal.pone.0100153>
- Talseth, A.G., Jacobsson, L. & Norberg, A. (2001). The meaning of suicidal psychiatric inpatients' experiences of being treated by physicians. *Journal of Advanced Nursing*, 34, 96–106. <https://doi.org/10.1046/j.1365-2648.2001.3411729.x>
- Talseth, A. G., Lindseth, A., Jacobsson, L., & Norberg, A. (1999). The meaning of suicidal psychiatric in-patients' experiences of being cared for by mental health nurses. *Journal*

of *Advanced Nursing*, 29, 1034–1041. <https://doi.org/10.1046/j.1365-2648.1999.00990.x>

The Schizophrenia Commission (2012). *The abandoned illness: A report by the Schizophrenia Commission*. London: The Schizophrenia Commission. Retrieved from <https://mentalhealthpartnerships.com/resource/the-abandoned-illness-a-report-by-the-schizophrenia-commission/>

Thomas, J, & Harden, A. (2008). Methods for the thematic synthesis of of qualitative research in systematic reviews. *BMC Medical Research Methodology*, 8, 45. <https://doi.org/10.1186/1471-2288-8-45>

Thorne, S. (2017). Metasynthetic Madness. *Qualitative Health Research*, 27, 3–12. <https://doi.org/10.1177/1049732316679370>

Trout, D.L. (1980). The role of social isolation in suicide. *Suicide and life-threatening behaviour*, 10, 10-23. <https://doi.org/10.1111/j.1943-278x.1980.tb00693.x>

U.S. Interagency Grey Literature Working Group. (1995). *Gray information functional plan*. Retrieved from <http://www.osti.gov/graylit/whatsnew.html>

Vatne, M., & Nåden, D. (2014). Patients' experiences in the aftermath of suicidal crises. *Nursing Ethics*, 21, 163–175. <https://doi.org/10.1177/0969733013493218>

Vatne, M., & Naden, D. (2016). Experiences that inspire hope: Perspectives of suicidal patients. *Nursing Ethics*, 1–14. <https://doi.org/10.1177/0969733016658794>

Wang, D. W. L., & Colucci, E. (2017). Should compulsory admission to hospital be part of suicide prevention strategies? *BJPsych Bulletin*, 41, 169–171. <https://doi.org/10.1192/pb.bp.116.055699>

Webb, D. (2010). *Thinking about suicide: Contemplating and comprehending the urge to die*. Ross-on-Wye, England: PCCS Books.

Weich, S., Griffith, L., Commander, M., Bradby, H. & Sashidharan, S.P. (2012). Experiences of acute mental health in an ethnically diverse inner city: qualitative interview study. *Society of Psychiatric Epidemiology*, 47, 119–128. <https://doi.org/10.1007/s00127-010-0314-z>

Wexler, L.M., & Gone, J.P. (2016). Exploring Possibilities for Indigenous Suicide Prevention: Responding to Cultural Understandings and Practices. In J. White, I. Marsh, M. J. Kral & J. Morris (Eds.), *Critical suicidology: Transforming suicide research and prevention for the 21st century* (pp. 56-70). Vancouver, BC: University of British Columbia Press.

White, J. (2016). Qualitative evidence in suicide ideation, attempts, and suicide prevention. In L. Olsen, R. A. Young, & I. Z. Shultz (Eds.), *Handbook of qualitative health research for evidence-based practice* (pp. 335-354). London, England: Springer.

Wiklander, M., Samuelsson, M., & Åsberg, M. (2003). Shame reactions after suicide attempt. *Scandinavian Journal of Caring Sciences*, 17, 293–300. <https://doi.org/10.1046/j.1471-6712.2003.00227.x>

Willig, C. (2008). *Introducing qualitative research in psychology (2nd ed)*. Open University Press: Berkshire, England.

Wiklander, M., Samuelsson, M., & Åsberg, M. (2003). Shame reactions after suicide attempt. *Scandinavian Journal of Caring Sciences*, 17, 293–300. <https://doi.org/10.1046/j.1471-6712.2003.00227.x>

World Health Organization (2016). *Suicide fact sheet*. Retrieved from

<http://www.who.int/mediacentre/factsheets/fs398/en/>

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SECTION B

Section Title:

The power of ideas: women's experiences of a trauma-informed
crisis house and hospital when feeling suicidal

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SALOMONS
CANTERBURY CHRIST CHURCH UNIVERSITY

Abstract

Background and aims. Improving care for people in suicidal crisis remains high on the UK government agenda. Trauma-informed approaches (TIAs) have been advocated to address the concerns raised by service-users with psychiatric hospital services. This study explores service-users' accounts of staying at a women's trauma-informed crisis house and in hospital whilst experiencing suicidal distress.

Methods. Eight women were interviewed using a semi-structured interview schedule. Interviews were transcribed and analysed using thematic analysis within a critical realist framework.

Results and discussion. Seven themes were developed: the power of talking, the limitations of medication, managing emotional safety through trusting relationships, managing physical safety through coercion, a home rather than a hospital, fostering compassion and the benefits of gender sensitivity. Participants described hospital as being dominated by a medical and custodial approach, which they said could undermine therapeutic engagement and exacerbate distress. By reframing suicidal feelings as a reasonable response to events in people's lives, the TIA was described as enabling participants to safely work through their suicidal feelings, whilst maintaining freedom and control. This research was carried out with a small sample and both recruitment and context likely privileged positive accounts of TIAs. Clinical implications and areas for further research are discussed.

Key words. Suicide, trauma-informed, alternative, crisis care, acute care, residential services

The power of ideas: women's experiences of a trauma-informed crisis house and hospital when feeling suicidal

1. Introduction

Suicide is one of the leading causes of death globally (WHO, 2016), with 5,668 recorded in the UK in 2016 (ONS, 2017). The UK government has recently invested an additional £25 million for suicide prevention from 2018 to 2021 (DOH, 2017). Mental health services are a key player in the prevention strategy, particularly inpatient psychiatric services that offer residential care to people in crisis (DOH, 2012). However, given the ethical and practical difficulties involved in measuring the effectiveness of hospitalisation, no substantial evidence exists to show that hospitalisation actually prevents suicide (De Leo & Svetlicic, 2010). Some have suggested that the isolation, stigma, discrimination and trauma that can result from hospitalisation, particularly forced detention, could in some cases increase suicidality (Large & Ryan, 2014; Wang & Colucci, 2017).

Service-users have reported dissatisfaction with hospital services, describing wards as frightening (Mind, 2011; Rose, Evans, Laker & Wykes, 2015) and infringing their human rights (Katsakou & Priebe, 2006). A lack of therapeutic engagement has been reported frequently (Cleary, Hunt, Horsfall & Deacon, 2012; Stenhouse, 2011; Weich et al., 2012) as well as a lack of information and involvement in decision-making (Katsakou & Priebe, 2006). In 2012, a report by the Schizophrenia Commission (2012) found that 'reform of acute care' was the highest priority for service-users in England.

Why is hospital care so frequently described as unhelpful? Research into experiences of hospitalisation during suicidal crisis has suggested that the dominance of a 'medical-custodial' model might disrupt quality of care (Lees, Procter & Fassett, 2014,

p.311). Indeed service-users have reported finding medicalised conceptualisations of their distress unhelpful, stating that they wanted staff to listen to their stories, which often included experiences of abuse, trauma, bereavement and discrimination, without being constrained by pre-defined medical frameworks (e.g. Lees et al., 2014; Vatne & Naden, 2014). Some service-users said they could not recognise their stories in the medicalised descriptions of their “diseases” (Talseth et al., 2001, p.102) and were left feeling frustrated, judged, disrespected, and unheard (e.g. Graham, 2012; Lees et al., 2014; Vatne & Naden, 2014). Some felt that medicalised language disrupted therapeutic engagement and was used by staff to maintain a position of expertise (Talseth, Jacobsson & Norberg, 2001).

Within a medical framework, ideas about ‘lack of insight’ resulting from ‘mental illness’ are used to justify coercive practices like compulsory admission, observations and restraint (Cooke, 2017; Johnstone & Boyle, 2018). Service-users have described such practices as humiliating, invasive, and traumatising (e.g. Thornhill, Clare & May, 2004; Lees et al., 2014; Vatne & Naden, 2016). Others have reported increased anxiety and hopelessness and admitted lying about their suicidal feelings to avoid coercive practices (e.g. Talseth et al., 2001; Vatne & Naden, 2014; Wiklander, Samuelsson & Åsberg, 2003).

Drayton Park (named with permission), an alternative residential crisis service that aims to work in a trauma-informed way has been set up to address some of the concerns outlined above (McNicholas, Rose & Cooke, in press). Trauma Informed Approaches (TIAs) share many of the assumptions that underlie the *Power Threat Meaning (PTM) Framework*, proposed recently by the British Psychological Society (BPS) as an alternative to medicalised, diagnostic frameworks (Johnstone & Boyle, 2018). TIAs assume that most people who come into contact with human services will have experienced trauma and adversity (Harris &

Fallot, 2001; Mendelsohn, Herman, Schatzow, Coco, Kallivayalil & Levitan 2011) and that their distress is an understandable response to such experiences, rather than a consequence of illness or a problem with their brain (Sweeney, Clement, Filson & Kennedy, 2016). TIAs promote recognition of the social, political and cultural context within which adversity is experienced (Sweeney et al., 2016). TIAs do not assume that every service-user has experienced trauma, or where they have, wishes to address it (Johnstone & Boyle, 2018). TIAs are described as offering “a respectful way to interact that is also appreciated by people without a traumatic past” (Elliott, Bjelajac, Fallot, Markoff & Reed, 2005 p.474).

Since trauma often occurs within the context of relationships, TIAs assume that the development of trusting relationships, within which experiences can be witnessed and validated, is necessary and central to healing (Elliot et al., 2005). Conversely, Johnstone & Boyle (2018) suggest that the ‘medical model’ conceptualises mental and emotional distress “as if they were the same kind of phenomena as physical problems like cancer, measles or diabetes”, (p.19) and therefore prioritises “diagnosis... [and the] administration of drugs” (*ibid*). Whilst good therapeutic relationships might be seen to facilitate engagement, they are unlikely to be considered ‘treatment’ in themselves.

Given that trauma and abuse often involve betrayal and secrecy, TIAs assume that service-users may have difficulty trusting others, but that without trust, they may be unable to access services (Sweeney et al., 2016). TIAs therefore promote involvement and collaboration and object to the use of coercive practices which are seen as potentially re-traumatising and to undermine the development of trust (Bloom & Farragher, 2010; Johnstone & Boyle, 2018).

Whilst trauma-informed and related approaches are gaining traction (Johnstone & Boyle, 2018), to the author's knowledge, there has not been any research exploring how TIAs are experienced by service-users. Therefore, little is known about whether and, if so, how these 'alternative' approaches translate into different experiences for users and which elements, if any, are perceived as important. Given the drive to improve acute care, particularly for those in suicidal crisis (DOH, 2012; 2017), this seems an important area of inquiry.

1.1. Aims

This study therefore aims to explore service-users' experiences of a trauma-informed women-only crisis house at a time of suicidal crisis, with an emphasis on how the theoretical assumptions that underlie TIAs are translated into practice and experienced by users. The study will aim to answer the following questions:

1. How do women describe their experiences of a women-only crisis house, which aims to use a TIA, during a time of suicidal crisis?

2. How do they feel that their experiences compare to previous experiences of hospital admission during a time of suicidal crisis?

3. How (if at all) do they feel that the approach used in the crisis house influenced their suicidal feelings and related distress?

2. Method

2.1. Design

A qualitative methodology was chosen, given the potential for such approaches to explore issues in depth and to learn from those with direct experience of suicidality (Fitzpatrick,

2011; White, 2016) whose voices Webb (2015) argues have been largely excluded. The study takes a critical realist stance (Collier, 1994). This assumes that participants offer accounts of their experiences that have been constructed and reconstructed through language and memory. Whilst at its core, the experience is assumed to be real, construction is thought to be influenced not only by the process of articulating experience, but by emotional needs, the research context and wider social and political factors.

Individual interviews, transcribed and analysed using thematic analysis (Braun & Clarke, 2006), were used to attempt to access participants' experiences. The flexibility of thematic analysis (Clarke & Braun, 2014) was suitable for the epistemological stance and research questions posed in this study. Neither discourse analysis, which aims to explore how social and psychological life are constructed in language (Willig, 2008), nor grounded theory, which is used to develop theories (*ibid*), were appropriate for the current research questions. Whilst IPA is about understanding people's experiences, the focus is on the ideographic phenomenology of experience (Smith, 2015), rather than using experience to try to understand something about the world, as was the aim of the current study.

Two service-user consultants from the Salomons Advisory Group of Experts by Experience (SAGE), both with experience of suicidality and hospitalisation, offered advice on the design, recruitment and interview schedule and conduct.

2.2. Personal positioning

The author is a 30-year-old white female, who is training to be a clinical psychologist. Influenced by her training programme which promotes critical thinking, she questions the dominance of the 'medical model' which, through positioning distress in individuals, she feels may sometimes be used to avoid addressing issues of power and societal injustice.

The interest in suicide came from a concern about the ethical implications of denying people the right to end their lives in situations where society and services may be failing to support them to find reasons for living. The way in which these beliefs may have influenced evolving understandings will be explored below.

2.3. Participants

Table 1 summarises inclusion and exclusion criteria

Table 1. Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria	Reason
Having been admitted to Drayton Park within the last 10 years	Most recent admission was over 10 years ago	To ensure relevance to current practice, since both professional practice and policy have changed over time.
Having spent time in hospital within last 10 years	Most recent admission was over 10 years ago	As above
Understood both of these admissions to be a consequences of their suicidal feelings	Understood that either one or both of their admissions were not a consequence of their suicidal feelings	To ensure relevance to the study
Over the age of 18	Under the age of 18	To ensure sample were all adults
Able and willing to talk about their experiences and no current plans to end their life	Either unable or unwilling to talk about their experiences, or current plans to end their life	To protect safety, given that the interview could cover some distressing experiences.
Able to engage in an interview.	Any communication, cognitive difficulties or active psychosis that would affect the interview process.	To enable the interview process.

Participant demographics. Eleven women who either had or were currently staying at the crisis house were approached by staff, eight of whom volunteered to participate. The three who declined did not give reasons. Women ranged from 22 years of age to 53. Five were White British and three were of other ethnicities. Given that the service has been named, no further demographic details are provided in order to maintain confidentiality.

2.4. Procedure

Ethical Considerations. Research was conducted in line with the BPS Code of Conduct (BPS, 2009). An NHS ethics committee and host trust approved the research (see appendix B). A summary of the results were sent to the Trust's Research and Development unit, the ethics panel and all participants who requested a copy (appendix C & D).

The setting. As detailed in McNicholas et al (in press), Drayton Park aims to use a TIA and all staff and residents are women. Women can be referred by others or refer themselves, and can stay for a maximum of four weeks. The children of women who are admitted can also be accommodated. There are 12 rooms, all ensuite, each furnished differently. There is a communal garden, living area and home-cooked food. One to one sessions are offered daily and a support group once a week. Individual therapy and massage are offered. The emphasis is on trusting relationships as the main mechanism through which support is offered. All treatment is consensual and planned together in an 'agreement plan'.

Research has found that, generally, service-user populations are comparable in hospitals and crisis houses in terms of recent history of self-harm and previous psychiatric hospital admission (Johnson et al., 2007). Indeed, a study of the characteristics of users of Drayton Park specifically found that 78% had been admitted to psychiatric hospital at least once previously (Killaspy, Dalton, McNicholas & Johnson, 2000).

Recruitment. Purposive sampling was used to recruit women from the crisis house. As part of a 'safety net' of support (Lakeman & Fitzgerald, 2009), current residents were recruited via staff at the crisis house, who explained the project briefly and offered a leaflet (see appendix E) to those residents whom they felt fitted the criteria. Two participants were recruited through this route. Four previous residents were recruited through a weekly

support group. Finally, two previous residents were recruited from the women's strategy group, where a staff-member gave out leaflets. This strategy group consists of women service-users and a network of staff on a mailing list and their aim is to raise awareness of women's issues across the Trust, run training events on women's' mental health and audit services for gender sensitivity. Initial contact was made either by email or telephone. The research was explained and women confirmed that they met the inclusion criteria.

Informed consent. All participants were given an information sheet at interview (see appendix F) and they all signed consent forms (see appendix G). All were informed of their right to withdraw at any point.

Interviews. Interviews were semi-structured and lasted between 49 and 77 minutes. In the opening question, women were asked to talk about what led up to their last admission to the crisis house. From here, seven questions were used where necessary to guide conversation towards experiences at the crisis house, in hospital and the impact of these experiences (see appendix H for interview schedule). All interviews were audio recorded and notes were made at the end of the interview on the researcher's thoughts and feelings. To debrief, the researcher asked participants how they were feeling and how they had found the interview. All said they had found the process interesting and although some had become emotional, none reported feeling distressed at the end.

Risk. Interviews were likely to cover some distressing experiences. However, inclusion criteria and recruitment aimed to minimise the risk of participants becoming overly distressed. No incentives were offered for participation so that 'emotional capacity to engage with the interview content' would remain the primary consideration in the decision to take part. Transport expenses up to £10 were covered. Prior to interview, all

participants were asked who, if anyone, they would like to be contacted if they became distressed. All were given copies of contact numbers, including the crisis house number, where staff had agreed to offer support. Interviews were conducted at the crisis house both to minimise threat to the researcher and so that a support network was available for participants.

Data protection and confidentiality. Recorded interviews were moved to a password protected USB stick before leaving the crisis house and deleted from the digital recorder. One Excel file with demographics and contact information was kept on a password protected computer and names were kept in a separate file.

2.5. Data analysis

The six stages of Braun and Clarke's (2006) approach to thematic analysis were followed, as described in table 2. Analysis was a recursive process, involving movement backwards and forwards between stages. Analysis was carried out inductively because of the scarcity of relevant research in this area and to remain open to participants' descriptions of services.

Table 2. Six stages of thematic analysis (Braun & Clarke, 2006)

Stage	Description
Familiarisation with the data	Interviews were transcribed, read and re-read, aiming for deep engagement with the data. Casual observational notes were made.
Generating codes	Meaningful labels attached to specific segments of the dataset were created thoroughly and systematically. Both semantic (descriptive) and latent (interpretive) codes were developed.
Constructing themes	Codes were clustered together under central organising concepts in an active process, driven by the research question.
Reviewing potential themes	Candidate themes were reviewed to ensure that they accounted for the coded data. The entire data set was reviewed to check fit of themes and that nothing had been missed.
Defining and naming themes	Short summaries of the core idea and meaning of each theme were developed and themes were named.
Producing the report	Data and analysis were weaved together into a results section and linked to theoretical and empirical literature in the discussion section.

2.6. Quality assurance

The current research followed the quality guidelines outlined by Yardley (2000):

Transparency and Coherence: Ongoing reflexivity was used to identify the researcher's prior assumptions and then examine and either challenge or acknowledge how these assumptions may have influenced the research process; from phrasing of research questions and behaviour in interview through to analysis and the eventual communication through language of evolving meanings (Fischer, 2009). A reflective journal was kept throughout (see appendix I) and three bracketing interviews were completed (Tufford & Newman, 2010) to support this process.

Commitment and Rigour (Yardley, 2000): an independent researcher reviewed one coded transcript to check that the analysis was not confined to one perspective (Yardley, 2015).

Similarly, the analysis was sent to all participants to seek their feedback. Four replied and

all said that they agreed with the analysis. The research journal was also used to keep a 'paper-trail' of the analysis (Flick, 1998).

Sensitivity to Context (Yardley, 2000): interview questions were open-ended and careful attention was paid to language to try to limit, or where this was not possible, reflect on how the interviewer's choice of language may have influenced participant responses (Wilkinson, Joffe and Yardley, 2004). After initial analysis, the researcher "re-look[ed]" (Fischer, 2009, p.584) at the data for 'disconfirming instances', particularly those which disconfirmed the researcher's own expectations (Pope & Mays, 1995).

3. Results

Seven initial themes were developed. However, in the "second bracketing engagement" (Fischer, 2009, p.586) the researcher, recognising the potential for "imposing meanings on the data", attempted to "knowingly [shift] stance" (p.584). After discussion with other professionals, she "re-look[ed]" at the full data set "to see what other meanings might appear" (*ibid*, p.584). This process resulted in the development of seven alternative themes, including new themes and more nuanced versions of the initial themes; as discussed below.

3.1. The power of talking

All participants said that they valued regular one-to-one meetings at the crisis house. They said that the "undivided attention" helped them to feel "valued as an individual" (Yinka) and gave them an opportunity to talk about things they had not been able to speak about before. Yinka said that "talking about it, all the experiences that [she had] had... made [her] feel... so much better", whilst others said that it helped them to "realise... what [they] lacked... growing up" (Allison) or to "underst[and] why [they] get suicidal" (Jess).

Participants said they were asked about experiences of trauma. Two participants said they initially found this difficult, one because she “got paranoid about why they wanted to know so much about [her]” (Grace) and the other because she originally had not identified as a trauma survivor so felt “like I don’t have any right to... have these problems because other people have had these experiences and I haven’t” (Ruth). Both participants said that eventually this approach helped them to name past abuse that either they had not thought of in such terms or had kept “in a really tight kind of locker in [their] mind” (Grace). Although Ruth said that it “really hurt when [she] made that connection...and created a lot of... anxiety around... urgh is this a label that I can use?”, she said she thought “it matter[ed] to be able to use words that accurately say what happened to you and to be able to acknowledge it”.

Participants said that exploring how their experiences might have contributed to their distress, having their experiences validated within trusting relationships and being “encouraged to accept that [they were] angry” (Grace) about the injustices that they had suffered was helpful.

Ruth: I think someone you trust saying something like that, like ‘you were a child, like it’s never gonna have been your fault’, is different when it comes from someone you trust.

However, two participants also felt that talking had its limits. As Claire explained “it might help to like talk to someone for two weeks but you’re not gonna get a rapid f** change in your life unless people are here to get rehoused and stuff”. Similarly, although a number of participants felt that staff at the crisis house did “really kind of care about the social aspect of... life” (Grace) and had demonstrated this through help with “practical

things” (Alix), and referrals to other services, Grace pointed out that any psychological or social intervention that is targeted at individuals does not address the wider societal injustices that she described as contributing to distress.

Grace: I get really angry about it. And it helps to be angry. But... I’m still being ostracised by society because I’m on benefits.

3.2. The limitations of medication

Participants compared their experiences in the crisis house to their experiences in hospital where all felt the focus had been on medication.

Jo: it’s just like ‘would you like some medication or would you like to f-off?’ basically.

Participants said the focus on medication had stopped staff from “thinking about the reasons that people we[re] acting the way they we[re]” (Jo) and had appeared to negate the need for talking.

Grace: Even the really good [staff] didn’t want to sit and talk. They just felt like that it wasn’t their job... it was just their job to monitor people and if someone is having a hard time, the first port of call would be reach out for the medication cabinet.

Although three participants said that “chemical imbalance” (Allison) might have had a part to play in their difficulties, none thought that this was the whole picture. All thought that their difficulties were either significantly or entirely due to experiences of both current and past adversity. As such, whilst most participants thought that medication helped them to feel “kind of OK”, they said that “healing someone [requires] dealing with everything that happened before” (Jo).

Jo: I do think medication is necessary for a lot of people, it's definitely necessary for me... but I don't think people should be just treated with medication.

Participants described being seen as a "diagnosis" (Grace; Ruth) a "number", a "sick person" (Yinka), a "patient" and a "thing" (Jess). Jo described this as "dehumanising" and three participants explained how it could be disempowering because they felt that, once labelled, if they had tried to complain about what they considered to be unsatisfactory treatment on the ward, "people [wouldn't have believed] them because they [we]re mentally ill" (Claire). Although participants described not liking to be viewed through a diagnostic lens, they all described themselves in diagnostic terms at some point and some used the term 'mentally ill' to describe others (Claire) or themselves (Jo). Three participants identified with the label 'borderline personality disorder' (BPD) but felt that "professionals in hospitals... might be quite judgemental about BPD" (Jess).

3.3. Managing emotional safety through trusting relationships

All participants talked positively about having the freedom to make snacks and drinks in the crisis house, to manage their own medication (supervised by staff) and to leave the house (with safety planning beforehand). They said that being able to leave meant that they were able to maintain important social roles. Most described being involved in planning and making decisions about their care. They also described having more privacy than in hospital, for example by having keys to their rooms and knowing that staff would never search their belongings and would always knock three times before entering their room.

When asked how they kept themselves safe, most participants referred to trust. They explained how through being involved and being given responsibility they "fe[lt] trusted. Whereas on the ward, by definition, [one is] on the ward cos [they] are not trusted

with [their] own safety” (Alix). This, combined with the regular opportunities to talk “ma[de] it at least possible to trust [staff]... obviously it’s never guaranteed but at least it [wa]s a possibility” (Ruth).

Developing trusting relationships was in itself described as healing because as Jo explained “mental illness in general is a very isolating experience and something I really believe is that people need connections with other people... to get better”. Moreover, through trusting relationships, participants said that they felt able to talk about their distress, to hand blades in or to ask for support when they needed it.

Grace: It was about building that kind of relationship and being able to trust them enough to go and approach them when I was feeling like doing something stupid or harming myself or running out and going onto a train track.

Whilst Jess said that the responsibility initially felt “scary and quite daunting”, she also described it as quite “empowering”. Ruth explained how, because this approach to risk management appeared to focus on “emotional safety” rather than just “physical safety” and aimed to “reach a point where people start wanting to keep themselves safe”, she felt that it was “the only way to manage risk” in the long-term.

Allison: Here, it was the, given a choice that you can take [an overdose] but we’ll support you not taking it... Whereas if it was in a hospital it’s like I want to take an overdose but I physically can’t do it. You know, it made me think and re-evaluate why I should take my life when I’m at Drayton Park. Because when I think about it, life isn’t that bad.

Despite generally positive descriptions, five participants said that they did not think the approach used in the crisis house would work for everyone. Jess explained that if a service-user was unable to abstain from alcohol or drugs, or to agree to hand things in that she could use to self-harm, she would not be allowed to stay at the crisis house. Similarly, Grace explained that she was denied entry to the crisis house for many years because her risk was deemed too high. Ruth explained that the crisis house is only able to function as it does because “they like kind of have hospital as a back-up” and Alix said she had seen people being sent from the crisis house to hospital. Allison questioned the nature of choice in this context.

Allison: ‘You have a choice, we’re here to support you whatever choice you make’, well not, if you self-harm you’re out of here.

3.4. Managing physical safety through coercion

Participants compared the approach used at the crisis house to their experiences in hospital where they said that risk was managed through coercion. They said that they had no access to the kitchen, many of their belongings were confiscated and some were not allowed to leave the ward.

Allison: You knock on the door and then, they don’t answer immediately, they might just say ‘we’re having hand over’ and then we’ll have to wait half an hour for them to go and unlock the toilets, I mean that’s just ridiculous... I just think ‘is there anything I can actually do in there?’ All the rooms are locked, the kitchen is locked ... it’s literally worse than prison isn’t it cos at least you know when you’re getting out.

Participants also described a lack of privacy on the ward. They said that when they entered the ward, their belongings were “scrutinise[d]” (Allison) and Jess said she was strip-searched. Participants said that all the doors had “peep-holes” (Jess) and staff could “barge in [to their room] without even knocking, even while [they were] getting undressed” (Grace). Many service-users described being placed on observations, meaning that at least one member of staff was with them at all times.

All participants were critical of this focus on what they saw as “short-term crisis intervention” through “physically keeping people alive” (Jo). They did not think it was effective in “dealing with anything on an emotional level” (Jo) and Ruth explained that she didn’t “think that you can have [physical safety] without emotional safety”. Jess said that her risk fluctuates all the time, so if she was admitted every time she felt suicidal, she would be detained all the time and “never have a chance to get better”. Both she and Jo said that whilst hospital might be helpful for someone who is going through an acute psychotic episode, for someone with their difficulties (which they both labelled as ‘personality disorder’), there was a risk of institutionalisation and dependency.

Jo: I’ve been very shocked by the way that people get so deeply institutionalised to the point where it’s like impossible to break out of the system but the system’s making you more ill... People die really slowly and really painfully, being admitted over and over again, using up services and using up tons of money.

Others said that “a lot of people who have... mental health problems as adults, it’s cos there’s been situations in [their lives] where [they have] had no power, when [they] really needed it” (Ruth). Ruth explained that for her, and she believed for many people, self-harm was a means of trying to regain some control. As such, participants explained that

being “trapped” (Jess, Alix) on a ward, where they have “[taken] away everything... even your control”, could replicate the sensation of “complete powerlessness” (Ruth) that they felt had led to their distress in the first place. They said they then might “resort to maybe worse coping strategies or... get more and more desperate to a point that [they] might feel more impulsive to kill [themselves]” (Jess). Indeed, a number of participants said that coercive practices felt “re-traumatising” (e.g. Grace, Alix) and others used words such as “assault” (Ruth) and “torture” (Allison). They said such practices could “exacerbate the situation” (Jo) and that if there was more attempt to meet people’s emotional needs, much coercion “could be avoided” (Grace).

Alix: It’s traumatic, you just get re-traumatised by your own treatment.

Finally, participants said that coercive practices undermined their potential to trust staff. Alix said, “once you’ve been medicated against your will and physically restrained... you don’t see professionals in the same light” and Ruth said “I’m never gonna trust someone who I know can hold me down... while there’s that bigger power imbalance and while patients have that little control, it’s never going to be therapeutic”. Participants explained how they felt that this could actually increase risk, as they were then less likely to seek support from staff when they felt distressed.

Allison: sometimes I feel suicidal but I can’t say it because by saying it, they’ll keep me in a bit more...I have to almost put on an act and pretend that I’m well in order to get out so that I could kill myself.

3.5. A home rather than a hospital

All participants described differences between the physical environment in the crisis house compared to hospital and thought this gave a message about the underlying approach. As Grace described, “hospital equals medication equals clinical... approach, whereas a house means like a homely kind of environment”. Indeed, most participants described the crisis house as more “homely” (e.g. Yinka), “comfortable” (e.g. Claire) and “normal” (Jess), with “living rooms that feel like living rooms and... a dining room that feels like a dining room and a garden and bedrooms that feel like normal bedrooms” (Jess). Participants said that the fact that they had “taken the time to care about what the rooms look like” made them feel “valued more as a person rather than just a patient” (Grace) and “like you’re actually living a life” (Jo).

In contrast, participants described the environment on the ward as “clinical” (e.g. Allison), “sterile” (Jess) and “so far back from the road that you don’t even see real people” (Jo). Yinka explained that since she “always goes [to hospital] when [she is] ill”, being in a hospital made her feel like she was “just a sick person”. Similarly, Jess said that being in an environment that was “so clinical” made her feel worse because it was “basically just like emphasising how ill [she was]”.

3.6. Fostering compassion

Staff at the crisis house were mostly described as “caring” (Yinka), “compassionate” (Jo), “non-judgemental” (Jess), “respectful” (Grace) and “genuine” (Allison). In contrast, some participants said that whilst there were staff “with whom [they] worked very well” in hospital, ward-staff just “don’t have time to talk” (Alix). Others described staff on the ward as “lacking compassion” (e.g. Jo), “uncaring” (e.g. Jess) or “disdainful” (Claire).

Jo suggested that such differences could partly be accounted for by the fact that staff on the ward often “are dealing with people who are very difficult”, but both she and Allison also felt that the underlying approach used on the ward did not foster compassionate ways of working. As Allison explained “I wouldn’t say that the people are that bad it’s just the environment that makes it not therapeutic”.

Jo: if you were a compassionate person already, you probably wouldn’t want to work on the acute ward because it’s not an environment that fosters that behaviour, which is obviously like a very... deep institutionalised problem.

Three participants said that there was a higher staff turn-over on the ward, and high percentage of bank staff, which meant that there was a lack of consistency. At the crisis house however, participants generally liked that they were allocated two workers, at least one of whom was on shift every day. Two participants also commented on the benefits of staff consistency between admissions.

Ruth: I’ve been [to the crisis house] quite a few times... but there’s one or two people that I’ve known kind of off and on for three years and there’s like in NHS mental health services, you never get that kind of long term relationship, it just doesn’t happen.

3.7. The benefits of gender sensitivity

Seven participants said they felt unsafe on mixed-sex wards, where they described some male service-users as rude, aggressive and predatory. Ruth said that “even if people aren’t being like actively aggressive or sexually inappropriate, [she] just fe[lt] like the object of attention” and that she “just want[ed] to be inconspicuous” when she is distressed. Two

participants said that this meant they spent most of the time in their room, which gave them “more time on their own for [their] thoughts to go round and round” (Ruth).

Many participants had experienced violence at the hands of male care-givers and so also said that male staff could be “re-traumatising” (Grace), particularly when they were carrying out coercive measures.

Ruth: I don’t understand why anyone would ever think it was OK to like tell a woman who’s just been sectioned like ‘ok go quietly to bed while a strange man watches you sleep’. Like sorry what? Just cos he’s got an NHS lanyard doesn’t mean he stops being a man with access to your bedroom.

Seven participants said that they felt safer being in an environment where all staff and service-users were women. They reported spending more time in communal areas and felt more able to show emotion and to “open up [to staff]... about anything... the sexual abuse or anything” (Yinka).

Three participants said that, at the crisis house, they learned about women’s mental and physical health, as well as about the social and political issues faced by women. They described how they started to see their mental health difficulties in a gender context and became involved in gender activism.

Grace: I just talked about how I feel in my community... as a woman that was brought up in a really strict upbringing... just wasn’t allowed to do anything. Was devalued um as a woman, as a girl, where men were kind of worshiped. Women came second best. So I kind of learned about all that here. That actually yes we are equal and we can kick ass as much as men can.

Despite overall positive accounts, one participant explained that the sensitivity to women's issues had made her feel "as if [she] had to confess that [she had a husband]" and made her wonder whether she was "allowed to talk about male relationships" (Alix).

4. Discussion

In the crisis house, in line with the principles of TIAs (Sweeney et al., 2016), participants described having regular opportunities to talk to staff whom they felt were compassionate and interested in the psycho-social context of their distress. They said they experienced privacy, control and freedom within collaboratively agreed boundaries. They felt they were involved in decisions regarding their care and none described experiencing coercion. They compared these experiences to their experiences in hospital where, in line with previous research (e.g. Graham, 2012; Lees et al., 2014), they felt there had been an emphasis on diagnosis, medication and physical safety, which was managed through coercive practices that restricted control, privacy and freedom. Participants also described differences in the physical environment between the two settings, which they thought reflected differences in the underlying approach. They mostly described the crisis house as 'homely' and compared this to the ward environment, which, being situated in a hospital, they associated with illness.

Participants said the TIA used in the crisis house enabled the development of therapeutic relationships. As predicted by TIAs (Sweeney et al., 2016), most said they had experienced interpersonal trauma and therefore felt that relationships were central to healing. Within both suicide and wider literature, therapeutic relationships have been described as essential to effective care (e.g. Cutcliffe & Stevenson, 2007; Pilgrim, Rogers & Bentall, 2009). Whilst most participants reported finding medication helpful, they said that

in services that seemed to prioritise medicalised approaches to understanding and treating distress, staff appeared to have less time or interest in talking, which could inhibit therapeutic engagement. Such findings have been reported previously (e.g. Lloyd-Evans et al, 2010) and fit with the assumptions underlying the ‘medical model’, as outlined in the introduction.

As has been reported previously (Cutcliffe & Stevenson, 2007; Graham, 2012; Lees et al., 2014) participants said that diagnoses, which positioned them as ‘mentally ill’, could feel disempowering or, especially in relation to a diagnosis of BPD, lead to judgmental attitudes. Filson and Mead (2016) have suggested that medicalising human distress can cause a division between those that use and those that offer services. They argue that through this division the rights, needs and humanity of those that are viewed as ‘other’ may become eroded.

In line with TI theory (Sweeney et al., 2016) and previous research (e.g. Thornhill et al., 2004; Freuh et al., 2005), participants described coercive measures as traumatising, and at times reminiscent of previous abuse and leading to increased suicidality. These findings may be explained by evidence that loss or lack of control is a central feature of both traumatic experience (Blanch et al., 2012) and suicidality (Pavulans, Bolmsjö, Edberg & Ojehagen, 2012), and that the “power-over” relationships inherent in coercive practices can be similar to the power dynamics often at play in situations of abuse and trauma (Blanch et al, 2012).

TIAs suggest that institutional forms of coercion can also have an impact on staff. Bloom and Farragher (2010) have suggested that staff may ‘shut off’ their ability to empathise in order to carry out practices that may conflict with their ethical code. This

might explain why staff in hospital were described as less compassionate than in the crisis house. From a TI perspective, the 'chronic stress' that can result from carrying out practices that conflict with one's ethical code (Sweeney et al., 2016), could explain the reportedly high rates of staff attrition and bank staff in hospital compared to the crisis house. Finally, Bloom (2006) has argued that by feeding service-user distress, coercion can escalate. Indeed, some participants in the current study said that if staff had focussed on building relationships rather than using coercion, incidents resulting in the use of physical restraint could have been avoided.

In line with both TI theory (Sweeney et al., 2016) and previous research (Johnstone, 1999), some participants said coercive practices also undermined their ability to trust staff. From a TI perspective, measures that undermine trust are never thought to be effective long-term since the development of trusting relationships is considered central to healing (Sweeney et al., 2016). Indeed, most participants in the present study reported that the approach used in hospital did not contribute to long-term healing. Of concern given the NHS commitment to 'do no harm' (NHS England, 2016), some participants suggested that the focus on physical safety to the neglect of emotional safety could foster dependence and ultimately make people "more ill" (Jo). In contrast, participants said that in the crisis house, the emphasis on emotional safety meant that although they had more opportunity to self-harm, mostly they felt less urge to. Moreover, the fact that they had developed trusting, therapeutic relationships with staff and knew that staff would not use coercion meant that they felt able to seek help.

The crisis house was described as displaying the TI principle of gender sensitivity (Sweeney et al., 2016) because all service-users and staff were women, and staff had

knowledge about social and political issues faced by women. Given that most participants described having experienced interpersonal trauma perpetuated by men, the majority said they felt safer in a women-only environment, as has been reported previously (Johnson et al., 2004). They said that they felt more able to trust female staff and, in line with previous findings (Archer, Lau & Sethi, 2016; Blanch et al., 2012), commented on how coercion was particularly traumatising when carried out by male staff.

Participants said that being supported to understand how their experiences linked in with wider gender-based issues was helpful. They said this did not happen within the medicalised approach that they described in hospital. Indeed, given that a medical model positions distress within an individual, authors have suggested it fails to acknowledge wider structural inequalities and abuses of power that leave women more vulnerable to circumstances such as poverty, lone-parenting, discrimination and violence (Archer et al., 2016; Fullagar & O'Brien, 2016).

4.1. Limitations of Trauma Informed Approaches

Whilst all participants said they preferred the TIA, they continued to use diagnostic or medicalised language. Johnstone & Boyle (2018) have suggested that TIAs fall short of “presenting a comprehensive and conceptually coherent alternative to psychiatric diagnosis” (p.189), pointing out that many leading proponents of TIAs still use diagnostic categorisation (see Burstow, 2003). Authors have argued that without such alternatives, there is a risk that these approaches will be assimilated back into dominant, medicalised frameworks (Johnstone & Boyle, 2018) and “water[ed] down” (Penney & Prescott, 2016, p.35). Boyle (2006) has even argued that the word ‘trauma’, which avoids articulating people’s actual experience, can draw attention away from harmful operations of power

such as inequality, poverty and discrimination. Indeed, two service-users in the present study highlighted the limitations of TIAs in meaningfully addressing societal issues that they felt had either led to or maintained their distress.

This study recruited participants from a TI crisis house, where they were staying out of choice. As such, the views of service-users who do not find TIAs helpful are unlikely to be represented. One participant said that regularly being asked about trauma initially made her feel like she did not deserve to be experiencing distress. Although she later identified as a trauma survivor, this comment highlights that those who do not identify as such, might find a TIA unhelpful and may feel that a medicalised framework better explains their experiences. However, it is important to highlight that neither proponents of TIAs or the PTM framework deny that biology plays a role in the development and maintenance of distress; merely that alternative language, built on alternative assumptions, which recognises the influence of context, also needs to be available (Johnstone & Boyle, 2018).

Finally, most participants said that if they had not been able to agree to certain 'rules', they would have been sent to hospital. Libertarian critics have questioned the nature of voluntary contact within a system where involuntary detention and treatment exists (Szasz, 1970). Moreover, this highlights that hospital services may be tasked with supporting people with greater levels of distress. Given that proponents of TIAs (Sweeney et al., 2016) as well as participants in the present and previous studies (e.g. Thornhill et al., 2004; Freuh et al., 2005) have claimed that coercion can increase distress, it is possible that higher levels of distress in hospital are in part a consequence of the approach. Nonetheless it is likely that at least some of the differences that participants described between services are due to differences in the populations that use each service. It is also possible that

participants' memories of hospital services were coloured by their own higher levels of distress during such times.

4.2. Research Limitations

As discussed, this research is an interpretation of only eight women's accounts, all of whom were recruited either from the crisis house or through groups linked to it. It seems unlikely that women who did not take something positive from a TIA would have continued to attend such groups. Moreover, as a safety-measure, the ethics board required that interviews took place at the crisis house. However, those who did not feel that the TIA helped them, may not have wanted to return. This requirement is also based on the assumption that the crisis house feels safe to participants. Those who felt that their experiences were better described by a medicalised framework may have felt safer being interviewed in hospital where medication would be available were they to have become distressed. Therefore, whilst it is hoped that the research might be of relevance to some people, particularly given the high rates of trauma experienced by users of mental health services (Pilgrim et al., 2009; Johnstone & Boyle, 2018), the findings of this study are unlikely to be generalisable to all women in suicidal distress.

Whilst the researcher used ongoing reflexivity to identify and then either challenge or articulate the perspectives through which meanings evolved (Fischer, 2009; see results section and appendix J), there may have been influences that were beyond her control or conscious awareness. For example, most participants said they had wanted to participate because they had valued the approach used in the crisis house and hoped that similar services could be created. This might have led them to leave out negative details about their experiences in the crisis house or over-emphasise such experiences in hospital.

Whilst qualitative research generally strives to democratise the research process (Strier, 2007), which has typically been an “activity carried out by those who have power upon those who do not” (Oliver, 1992, p.110), the genuine redistribution of power within research relationships is challenging (Karnieli-Miller, Strier & Pessach, 2009) and thus unlikely to have been fully achieved within the present research. Therefore, it is possible that some participants, having picked up on the researcher’s beliefs through comments or body language, said what they thought she, in her relative position of power, wanted to hear. Although it is important to reflect on such processes, from a critical realist epistemology the impossibility of removing all subjectivity is recognised (Collier, 1994). As such, the findings are not presented as truth claims, but as one interpretation that is “far enough along to make a contribution to our evolving body of understandings” (Fischer, 2009, p.586) but with the assumption that “there is always more to become mindful of” (*ibid*).

4.3. Clinical implications

Whilst the treatments and practices used in standard care are generally assumed to minimise risk and optimise chances of recovery, the results of this study put such assumptions into question. Findings suggested that the practices that are justified and prioritised by the ‘medical model’, which participants described as dominating standard care, can actually be experienced as unhelpful or felt to exacerbate distress. Therefore, it seems important that more services that draw on different theoretical assumptions, are made available. The results of this study suggest that TIAs may offer an alternative theoretical model, which may be experienced as helpful by some people in suicidal distress.

It was recognised that TIAs may not be helpful for everyone, and there does appear to be a need for some services that offer the containment of a locked environment. Nevertheless, even such services may benefit from reflecting on the assumptions upon which they operate, which Johnstone & Boyle (2018) argue are currently rarely articulated. Once such assumptions are articulated, there may be scope to incorporate some ideas from TIAs alongside current practice. Given that both TIAs and the PTM framework draw heavily on psychological theory, the latter published by the BPS, clinical psychologists will clearly have a key role to play in the promotion of such ideas and the recommended service developments.

4.4. Research implications

This was the first study to explore service-user experiences of a TI alternative residential service during a time of suicidal distress. As outlined above, both the recruitment process and context likely privileged positive accounts of the crisis house in comparison to hospital. Therefore, further research could interview people in a more neutral setting or specifically interview those who chose not to stay at a TI crisis house. Alternatively, participants could be recruited simultaneously from both settings and their accounts compared. Finally, it would be useful to interview staff about their experiences of working for a TI service to understand from their perspective how the assumptions underlying TIAs are translated into practice and sustained, and difficulties that may be encountered.

5. Conclusion

In the context of the current drive to improve services for people in suicidal crisis, this study used thematic analysis to explore eight women's accounts of their experiences both in hospital and in a trauma-informed women's crisis house during a time of suicidal distress.

Participants described the medical model, which they felt dominated hospital services as inhibiting the development of therapeutic relationships and at times exacerbating distress. In contrast, by reframing suicidal feelings as a reasonable response to events in women's lives, and recognising the central role of power, control and trust both in the development of and recovery from mental distress, the TIA was described as enabling women to safely work through their suicidal feelings, whilst maintaining freedom and control. This research was carried out with a small sample and both recruitment and context likely privileged positive accounts of TIAs. Nonetheless, given the high rates of trauma experienced by users of mental health services, it is hoped that the findings of this study may be relevant to others in suicidal crisis. Future research which explores further how TIAs are translated into practice and encourages alternative viewpoints is recommended.

References

- Archer, M., Lau, Y., & Sethi, F. (2016). Women in acute psychiatric units, their characteristics and needs: a review. *BJPsych Bulletin*, *40*, 266–272.
<https://doi.org/10.1192/pb.bp.115.051573>
- Blanch, A., Filson, B., Penney, D. & Cave, C. (2012), *Engaging women in trauma-informed peer support: A guidebook*. Rockville, MD: National center for trauma-informed care.
- Bloom, S. & Farragher, B. (2010), *Destroying sanctuary: The crisis in human service delivery systems*. New York, NY: Oxford University Press.
- Burstow, B. (2003). Toward a radical understanding of trauma and trauma work. *Violence against Women*, *9*, 1293–1317. <https://doi.org/10.1177/1077801203255555>
- British Psychological Society. (2014). *Understanding psychosis and schizophrenia*. Leicester, England: BPS. Retrieved from
https://www1.bps.org.uk/system/files/Public%20files/rep03_understanding_psychosis.pdf
- British Psychological Society. (2009). *Code of ethics and conduct*. Leicester, England: BPS. Retrieved from <https://www1.bps.org.uk/system/files/user-files/Division%20of%20Clinical%20Psychology/public/Code%20of%20Ethics%20and%20Conduct%20%282009%29.pdf>
- Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*, 77–101. <https://doi.org/10.1191/1478088706qp063oa>
- Collier, A. (1994). *Critical realism: An introduction to Roy Bhaskar's philosophy*. London: Verso.

- Clarke, V. & Braun, V. (2014). Thematic analysis, in T. Teo (ed.), *Encyclopedia of Critical Psychology* (pp. 1947-52). New York: Springer.
- Cleary, M., Hunt, G.E., Horsfall, J. & Deacon, M. (2012). Nurse-patient interaction in acute adult inpatient mental health units: A review and synthesis of qualitative studies. *Issues in Mental Health Nursing* 33, 66–79. <https://doi.org/10.3109/01612840.2011.622428>
- Cooke, A. (2017). Therapeutic relationships: the perniciousness of 'insight' and 'expertise' [Workshop notes]. Retrieved from <http://programme.exordo.com/isps2017/delegates/presentation/4/>
- Cutcliffe, J.R. & Stevenson, C. (2007). *Care of the suicidal person*. London: Churchill Livingstone.
- De Leo, D., & Sveticic, J. (2010). Suicides in psychiatric in-patients: What are we doing wrong? *Epidemiology and Psychiatric Sciences*, 19, 8–15. Retrieved from <http://ezproxy.usherbrooke.ca/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2011-13051-002&site=ehost-live>
- Department of Health (2012). *Preventing suicide in England A cross-government outcomes strategy to save lives*. London: Crown. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/430720/Preventing-Suicide-.pdf
- Department of Health (2017). *Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives*. London: Crown. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/430720/Preventing-Suicide-.pdf

Elliot, D., Bjelajac, P., Fallot, R., Markoff, L. & Glover Reed, B. (2005). Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. *Journal of Community Psychology, Vol. 33*, 461-77.

<https://doi.org/10.1002/jcop.20063>

Filson, B. & Mead, S. (2016). Intentional peer support: An alternative approach. In J. Russo & A. Sweeney (Eds.), *Searching for a rose garden: Fostering real alternatives to psychiatry* (pp. 109-17). Ross-on-Wye: PCCS Books.

Fischer, C. T. (2009). Bracketing in qualitative research: Conceptual and practical matters. *Psychotherapy Research, 19*, 583–590. <https://doi.org/10.1080/10503300902798375>

Fitzpatrick, S. (2011). Looking beyond the qualitative and quantitative divide: Narrative, ethics and representation in suicidology. *Suicidology Online, 2*, 29-37. Retrieved from <http://www.suicidology-online.com/pdf/SOL-2011-2-29-37.pdf>

Flick, U. (1998). *An introduction to qualitative research*. London: Sage

Frueh, B.C., Knapp, R.G., Cusack, K.J., Grubaugh, A.L., Sauvageot, J.A., Cousins, V.C., ... Hiers, T.G. (2005). Special section on seclusion and restraint: Patients' reports of traumatic or harmful experiences within the psychiatric setting. *Psychiatric Services, 56*, 1123–33. Retrieved from <https://ps.psychiatryonline.org/doi/abs/10.1176/appi.ps.56.9.1123>

Fullagar, S. & O'Brien, W. (2016). Speaking of suicide as a gendered problematic: Suicide attempts and recovery within women's narratives of depression. In J. White, I. Marsh, M. J. Kral & J. Morris (Eds.), *Critical suicidology: Transforming suicide research and prevention for the 21st century* (pp. 94-114). Vancouver, BC: University of British Columbia Press.

- Gill, R. (2000). Discourse analysis. In M.W. Bauer & G. Gaskell (Eds.), *Qualitative research with text image and sound: A practical handbook* (pp. 172-190). London: Sage.
- Graham, A. C. (2012). *Experiences following a suicide attempt*. Retrieved from <http://vuir.vu.edu.au/25827/1/Anne%20Carolyn%20Graham.pdf>
- Harris, M. & Fallot, R. (2001), *Using Trauma Theory to Design Service Systems. New Directions for Mental Health Services*. San Francisco, CA: Jossey-Bass, San Francisco.
- Johnson, S., Gilbert, H., Lloyd-Evans, B. & Slade, M. (2007). Acute in-patient psychiatry: residential alternatives to hospital admission. *Psychiatric Bulletin*, 31, 262–4. <https://doi.org/10.1192/pb.bp.106.011197>
- Johnstone, L. & Boyle, M. with Cromby, J., Dillon, J., Harper, D., Kinderman, P... & Read, J. (2018). *The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis*. Leicester: British Psychological Society.
- Karnieli-miller, O., Strier, R. & Pessach, L. (2009). Power relations in qualitative research, *Qualitative Health Research*, 19, 279–289. <https://doi.org/10.1177/1049732308329306>
- Katsakou C. & Priebe S. (2006). Outcomes of involuntary hospital admission: a review. *Acta Psychiatr Scand*, 114, 232–41. <http://dx.doi.org/10.1111/j.1600-0447.2006.00823.x>
- Killaspy, H., Dalton, J., McNicholas, S., & Johnson, S. (2000). Drayton Park, an alternative to hospital admission for women in acute mental health crisis. *Psychiatric Bulletin*, 24, 101– 104. <https://doi.org/10.1192/pb.24.3.101>

- Lakeman, R. & FitzGerald, M. (2009). The ethics of suicide research: The views of ethics committee members. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, 30, 13–19. <https://doi.org/10.1027/0227-5910.30.1.13>
- Large M, Ryan C. (2014). Disturbing findings about the risk of suicide and psychiatric hospitals. *Social Psychiatry and Psychiatric Epidemiology*, 49, 1353-5.
- Lees, D., Procter, N., & Fassett, D. (2014). Therapeutic engagement between consumers in suicidal crisis and mental health nurses. *International Journal of Mental Health Nursing*, 23, 306–315. <https://doi.org/10.1111/inm.12061>
- Lloyd-Evans B., Johnson, S. Slade, M. Barrett B. Byford, S, Gilbert, H., ... Thornicroft, G. (2010). Report for the National Institute for Health Research Service Delivery and Organisation programme: In-patient alternatives to traditional mental health acute in-patient care. London: Crown. Retrieved from <https://njladmin.nihr.ac.uk/document/download/2008737>
- McNicholas, S., Rose, A. & Cooke, A. (in press) Women and Power: The Drayton Park Womens' Crisis House. In: H. Gijbels, L. Sapouna & G. Sidley (eds.), *Inside out and outside in: alternatives to mainstream mental health services*. Ross-On –Wye: PCCS Books
- Mendelsohn, M., Herman, J.L., Schatzow, E., Coco, M., Kallivayalil, D. & Levitan, J. (2011). *The trauma recovery group: A guide for practitioners*. New York: Guilford Press.
- Mind (2011). *Listening to experience: an independent inquiry into acute and crisis mental healthcare*. London: MIND. Retrieved from https://www.mind.org.uk/media/211306/listening_to_experience_web.pdf

- NHS England, (2016). *Patient safety in the NHS*. Retrieved from <https://www.nhs.uk/NHSEngland/thenhs/patient-safety/Pages/about-patient-safety.aspx>
- Oliver, M. (1992). Changing the Social Relations of Research Production? *Disability, Handicap & Society*, 7, 101–114. <https://doi.org/10.1080/02674649266780141>
- Office for National Statistics (2017). *Statistical bulletin: suicides in Great Britain: 2016 registrations*. Retrieved from <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2016registration>
- Pavulans, K. S., Bolmsjö, I., Edberg, A. K., & Öjehagen, A. (2012). Being in want of control: Experiences of being on the road to, and making, a suicide attempt. *International Journal of Qualitative Studies on Health and Well-Being*, 7, 16228. <https://doi.org/10.3402/qhw.v7i0.16228>
- Penney, D. & Prescott, L. (2016). The co-optation of survivor knowledge: The danger of substituted values and voice. In J. Russo & A. Sweeney (Eds.), *Searching for a rose garden* (pp.35–45). Ross-on-Wye: PCCS Books.
- Pilgrim, D., Rogers, A., & Bentall, R. (2009). The centrality of personal relationships in the creation and amelioration of mental health problems: The current interdisciplinary case. *Health*, 13, 235–254. <https://doi.org/10.1177/1363459308099686>
- Richards, S., & Mughal, A. F. (2010). *Working with the Mental Health Act* (3rd ed.). North Waltham: Matrix Training Associates.

- Rose, D., Evans, J., Laker, C., & Wykes, T. (2015). Life in acute mental health settings: experiences and perceptions of service users and nurses. *Epidemiology and psychiatric sciences*, 24, 90-96. doi:10.1017/S2045796013000693
- Smith, J.A. & Osborn, M. (2015). Interpretative phenomenological analysis. In J.A. Smith (ed.), *Qualitative psychology: A practical guide to research methods* (pp. 25-52), London: SAGE.
- Stenhouse, R.C. (2011). 'They all said you could come and speak to us': patients' expectations and experiences of help on an acute psychiatric inpatient ward. *Journal of Psychiatric Mental Health*, 18, 74–80. <https://doi.org/10.1111/j.1365-2850.2010.01645.x>
- Strier, R. (2007). Anti-oppressive research in social work: A preliminary definition. *British Journal of Social Work*, 37, 857-871. <https://doi.org/10.1093/bjsw/bcl062>
- Sweeney, A., Clement, S., Filson, B., & Kennedy, A. (2016). Trauma-informed mental healthcare in the UK: what is it and how can we further its development? *Mental Health Review Journal*, 21, 174–192. <https://doi.org/10.1108/MHRJ-01-2015-0006>
- Talseth, A.-G., Jacobsson, L., & Norberg, A. (2001). The meaning of suicidal psychiatric inpatients' experiences of being treated by physicians. *Journal of Advanced Nursing*, 34, 96–106. <https://doi.org/10.1046/j.1365-2648.2001.3411729.x>
- Thornhill, H., Clare, L., & May, R. (2004). Escape, enlightenment and endurance: Narratives of recovery from psychosis. *Anthropology & Medicine*, 11, 181-199. <https://doi.org/10.1080/13648470410001678677>

- Tufford, L. & Newman, P. (2010). Bracketing in qualitative research. *Qualitative Social Work*, 11, 80-96. doi: 10.1177/1473325010368316
- Vatne, M., & Nåden, D. (2014). Patients' experiences in the aftermath of suicidal crises. *Nursing Ethics*, 21, 163–175. <https://doi.org/10.1177/0969733013493218>
- Vatne, M., & Naden, D. (2016). Crucial resources to strengthen the desire to live: Experiences of suicidal patients. *Nursing Ethics*, 23, 294–307. <https://doi.org/10.1177/0969733014562990>
- Wang, D. W. L., & Colucci, E. (2017). Should compulsory admission to hospital be part of suicide prevention strategies? *BJPsych Bulletin*, 41, 169–171. <https://doi.org/10.1192/pb.bp.116.055699>
- Weich, S., Griffith, L., Commander, M., Bradby, H., Sashidharan, S. P., Pemberton, S., ... Bhui, K. S. (2012). Experiences of acute mental health care in an ethnically diverse inner city: qualitative interview study. *Social psychiatry and psychiatric epidemiology*, 47, 119-128. <https://doi.org/10.1007/s00127-010-0314-z>
- White, J. (2016). Qualitative evidence in suicide ideation, attempts, and suicide prevention. In L. Olsen, R. A. Young, & I. Z. Shultz (Eds.), *Handbook of qualitative health research for evidence-based practice* (pp. 335-354). London, England: Springer.
- WHO (2016). *Suicide fact sheet*. Retrieved from <http://www.who.int/mediacentre/factsheets/fs398/en/>
- Wiklander, M., Samuelsson, M., & Åsberg, M. (2003). Shame reactions after suicide attempt. *Scandinavian Journal of Caring Sciences*, 17, 293–300. <https://doi.org/10.1046/j.1471-6712.2003.00227.x>

Wilkinson, S., Joffe, H. & Yardley, L. (2004). Qualitative data collection. In D. Marks and L. Yardley (Eds.), *Research Methods for Clinical and Health Psychology* (pp. 39-55). London: Sage.

Willig, C. (2008). *Introducing qualitative research in psychology* (2nd ed). Maidenhead, England: Open University Press.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, 15, 215-228. doi: 10.1080/08870440008400302

Yardley, L. (2015). Demonstrating validity in qualitative psychology. In J.A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 257-272), London: SAGE.

SECTION C

Appendices of supporting material

A thesis submitted in partial fulfilment of the requirements of
Canterbury Christ Church University for the degree of
Doctor of Clinical Psychology

April 2018

SALOMONS
CANTERBURY CHRIST CHURCH UNIVERSITY

Appendix A

CASP Qualitative Checklist Quality Ratings

CASP Qualitative Checklist Quality Ratings for peer-reviewed research articles

	Clear statement of aims	Qualitative methodology appropriate	Appropriate research design	Appropriate recruitment strategy	Consideration of data collection	Consideration of research relationship	Ethical issues considered	Rigorous data analysis	Findings clearly stated	Value of the research	Total score
Pitula & Cardell, (1996)	2	2	1	1	1	0	0	0	1	1	9
Cardell & Pitula, (1999)	2	2	1	1	1	0	0	0	1	1	9
McLaughlin, (1999)	2	2	1	1	2	0	2	0	1	2	13
Talseth et al., (1999)	2	2	1	1	2	0	2	1	2	2	15
Fletcher, (1999)	2	2	1	1	1	0	0	1	2	2	12
Samuelsson et al., (2000)	2	2	1	1	2	0	2	2	1	1	15
Talseth et al., (2001)	2	2	1	1	2	0	2	2	2	1	15
Wiklander et al., (2003)	2	2	1	1	2	0	2	2	2	1	15
Johnson et al., (2004)	2	2	1	2	2	0	2	1	2	2	16
Sun et al., (2006a)	2	2	2	1	1	0	2	2	2	2	16
Sun et al., (2006b)	2	2	2	1	1	0	2	2	2	2	16

	Clear statement of aims	Qualitative methodology appropriate	Appropriate research design	Appropriate recruitment strategy	Consideration of data collection	Consideration of research relationship	Ethical issues considered	Rigorous data analysis	Findings clearly stated	Value of the research	Total score
Lees et al., (2014)	2	2	2	2	1	0	2	1	2	2	16
Sweeney et al., (2014)	2	2	1	1	1	0	2	2	2	2	15
Vatne & Naden (2014)	2	2	2	1	2	1	2	2	2	2	18
Vatne & Naden (2016)	2	2	2	1	2	1	2	2	2	2	18

Note. The CASP checklist has a binary scoring system (yes/no). To enable a more sensitive comparison of studies each criterion was scored 0-2; a score of 0 if the criterion was not met; 1 if partially met; 2 if fully met

CASP Qualitative Checklist Quality Ratings for grey-literature articles

	Clear statement of aims	Qualitative methodology appropriate	Appropriate research design	Appropriate recruitment strategy	Consideration of data collection	Consideration of research relationship	Ethical issues considered	Rigorous data analysis	Findings clearly stated	Value of the research	Total score
Briggs et al., (2012)	2	2	1	1	1	0	0	0	1	1	9
Graham (2012)	2	2	2	2	2	2	2	2	2	2	20
Lloyd-Evans et al., (2010)	2	2	1	1	2	0	2	2	2	2	16
Ryan et al., (2010)	2	2	1	1	1	0	1	1	1	1	11

Note. The CASP checklist has a binary scoring system (yes/no). To enable a more sensitive comparison of studies each criterion was scored 0-2; a score of 0 if the criterion was not met; 1 if partially met; 2 if fully met

Appendix B – Letter of Ethical Approval

This has been removed from the electronic copy

Appendix C – Feedback Summary for Ethics Panel



Date: 12th April 2017

REC reference number: 17/LO/0134

Original Study Title: How do women who have used a women-only Crisis House understand their previous suicidal feelings, their recovery, and the role of the Crisis House?

New Study Title: The power of ideas: women's experiences of a trauma-informed crisis house and hospital when feeling suicidal

Dear [chair of REC/ R&D manager],

I am writing to inform you that the above research project is now complete. The research was conducted as planned and the research objectives were achieved.

Summary of the research

Although the original study title focused on the experience of staying in a crisis house, without reference to the approach used, through the research process, I realised that crisis houses actually vary significantly. Therefore, from a theoretical perspective, it was more useful to think about how the Trauma-Informed Approach (TIA) used in the crisis house influenced women's experiences rather than how 'crisis houses' influence recovery.

The UK government has recently invested an additional £25 million for suicide prevention from 2018 to 2021 (DOH, 2017), recognising the need to improve acute care (DOH, 2012). Service-users have reported dissatisfaction with hospital services, describing wards as frightening (Rose, Evans, Laker & Wykes, 2015; Mind, 2011) and infringing their human rights (Katsakou & Priebe, 2006). A lack of therapeutic engagement has been reported frequently (Cleary, Hunt, Horsfall & Deacon, 2012; Stenhouse, 2011; Weich et al., 2012) as well as a lack of information and involvement in decision-making (Katsakou & Priebe, 2006). In 2012, a report by the Schizophrenia Commission (2012) found that 'reform of acute care' was the highest priority for service-users in England. Some researchers have suggested that the dominance of a 'medical-custodial' model might disrupt quality of care in hospital settings (Lees, Procter & Fassett, 2014, p.311).

TIAs have been suggested as an alternative to medicalised approaches (Sweeney, Clement, Filson & Kennedy, 2016). They share much in common with the recent *Power Threat Meaning Framework* published by the British Psychological Society. TIAs assume that most people who come into contact with human services will have experienced trauma and adversity (Harris & Fallot, 2001; Mendelsohn, Herman, Schatzow, Coco, Kallivayalil & Levitan 2011) and that their distress is an understandable response to such experiences, rather than

a consequence of illness or a problem with their brain (Sweeney, Clement, Filson & Kennedy, 2016). They therefore see that relationships are essential to both engagement and healing and object to the use of coercive practices, like involuntary detention and treatment. This study therefore aimed to explore service-users' experiences of a trauma-informed women-only crisis house at a time of suicidal crisis, with an emphasis on how the theoretical assumptions that underlie TIAs are translated into practice and experienced by users.

Methods

Eight women were interviewed about their experiences in the crisis house compared to previous experiences in hospital. Women were asked if and how the approach used in the crisis house had contributed towards recovery from suicidal feelings. Interviews were transcribed and analysed using thematic analysis.

Results

Seven themes were developed and are outlined below with illustrative quotes (names are pseudonyms).

1. The power of talking

Participants said that they found the regular one-to-one sessions useful, and that these sessions helped them to talk about things that they had not spoken about before. They said that being asked about whether they had experienced trauma could feel difficult at first but eventually enabled them to talk about such experiences. Talking about the experiences and being encouraged to be angry about things that had happened to them was described as helpful. However, some women did point out that talking has its limits and that more drastic social change is needed.

Yinka: by talking about it, all the experiences that I had... made me feel, it's so much better you know, you come out and be like 'ah' you know? even after crying you know, it's really good.

Jess: I think like, I do think like each time I've come here, I've left here with some, more of an understanding because, because, you're talking about it all the time.

Claire: it might help to like talk to someone for two weeks but you're not gonna get a rapid f** change in your life unless people are here to get rehoused and stuff"

2. The limitations of medication

Participants said that in hospital there had not been much opportunity to talk and the focus was on medication. Most thought that their suicidality was a consequence of trauma or adversity. Therefore, though they said they found medication helpful, they did not think medication alone could help them. Participants said that being seen as 'a diagnosis' could be disempowering or lead to judgmental attitudes, particularly a diagnosis of borderline personality disorder.

Grace: Even the really good [staff] didn't want to sit and talk. They just felt like that it wasn't their job... it was just their job to monitor people and if someone is having a hard time, the first port of call would be reach out for the medication cabinet.

Becca: I do think medication is necessary for a lot of people, it's definitely necessary for me... but I don't think people should be just treated with medication.

3. Managing emotional safety through trusting relationships

Participants described having more freedom and privacy in the crisis house. When asked how they managed to keep themselves safe, most referred to trust. They explained that being given responsibility showed that staff trusted them, and this made it possible for them to trust staff. Participants said that forming trusting relationships was healing in itself, but also meant that they were more able to ask for support when they felt distressed. They said that by focusing on their emotional safety, rather than just physical safety, this approach to risk management was more effective in the long-term. However, most participants pointed out that this approach would not work for everyone.

Alix: I feel trusted. Whereas on the ward, by definition, you are on the ward cos you are not trusted with your own safety.

Grace: It was about building that kind of relationship and being able to trust them enough to go and approach them when I was feeling like doing something stupid or harming myself or running out and going onto a train track.

Allison: Here, it was the, given a choice that you can take [an overdose] but we'll support you not taking it... Whereas if it was in a hospital it's like I want to take an overdose but I physically can't do it. You know, it made me think and re-evaluate why I should take my life when I'm at Drayton Park. Because when I think about it, life isn't that bad.

4. Managing physical safety through coercion

Participants said that in hospital, risk was managed through coercive practices such as detention, observation, the confiscation of belongings or searching. Participants were critical of this focus on physical safety, which they said failed to address their emotional needs and therefore was not effective in the long term. Some participants said that their difficulties had developed through situations of abuse, in which they had had no control or power. Therefore, they said that having their control and power taken away on the ward could actually replicate the very processes that had led to their distress in the first place. Some described this as re-traumatising and said that it contributed to their distress and suicidality. Others said that it made it difficult for them to trust staff so when they felt distressed, they were less likely to ask staff for help.

Alix: It's traumatic, you just get re-traumatised by your own treatment.

Ruth: "I'm never gonna trust someone who I know can hold me down... while there's that bigger power imbalance and while patients have that little control, it's never going to be therapeutic".

Allison: sometimes I feel suicidal but I can't say it because by saying it, they'll keep me in a bit more...I have to almost put on an act and pretend that I'm well in order to get out so that I could kill myself.

5. A home rather than a hospital

Participants talked about differences between the environment in the crisis house compared to hospital, which they said reflected differences in the underlying approach. They described the hospital as 'clinical' and said that it could make them feel worse because it reminded them that they were 'ill'. The crisis house was described as 'homely'. Participants said this felt valuing and "like you're actually living a life" (Becca).

Jess: It's a house for a start, you walk in you've got living rooms that feel like living rooms and you've got a dining room that feels like a dining room and a garden and the bedrooms that feel like normal bedrooms with normal bathrooms.

6. Fostering compassion

Participants described the staff in the crisis house as compassionate and caring. Although some said that there were staff whom they worked well with on the ward, they said that in hospital staff rarely had time to talk. Others said that staff in hospital did not seem to care or seemed actively disdainful. One woman suggested that this might be partly because staff on the ward have to deal with people who are more distressed and two women said that the environment on the ward did not foster compassionate ways of working. Some women said that there were a lot of bank staff on the ward. They compared this to the crisis house where they said there was more consistency in the staff and this helped them to build relationships.

Allison: I wouldn't say that the people are that bad it's just the environment that makes it not therapeutic.

Becca: if you were a compassionate person already, you probably wouldn't want to work on the acute ward because it's not an environment that fosters that behaviour, which is obviously like a very... deep institutionalised problem.

7. The benefits of gender sensitivity

Finally, most participants said that they felt safer in a women's only environment at the crisis house. They said that on the ward they had often felt unsafe around male patients and so had stayed in their room. They also described feeling unsafe around male staff, particularly because many had experienced abuse from men. They said that it was easier to open up to women staff. Some women also liked the fact that they had the opportunity to learn about how their experiences fit into a wider social context. Some talked about becoming more involved in gender politics since staying at Drayton Park.

Yinka: the fact that they're women as well, it just feels so comfortable to be, to open up to them about anything you know like in terms of like it could be about the abuse, the sexual abuse or anything.

Ruth: I don't understand why anyone would ever think it was OK to like tell a woman who's just been sectioned like 'ok go quietly to bed while a strange man watches you sleep'. Like sorry what? Just cos he's got an NHS lanyard doesn't mean he stops being a man with access to your bedroom.

Grace: I just talked about how I feel in my community... as a woman that was brought up in a really strict upbringing... Was devalued um as a woman, as a girl, where men were kind of worshiped. Women came second best. So I kind of learned about all that here. That actually yes we are equal and we can kick ass as much as men can.

Discussion

These seven themes were then discussed within the wider literature and within the context of Trauma-informed theory. Recommendations were made, suggesting that more trauma-informed services be created and that current services think about how they could try to work in a more 'trauma-informed' way. However, It was also acknowledged that the findings represent the views of only eight women, and both recruitment and context likely favoured positive accounts of TIAs.

Arrangements for publication/ dissemination

The findings of this study will be submitted for publication in either *Crisis, Suicidology Online* or the *Journal of Mental Health*.

Feedback to participants

Participants who expressed an interest were already emailed the analysis of the findings. Four responded to say that they were happy with the analysis. All participants have been sent a summary of the final themes and those who requested a copy of the full report have been sent this also.

Yours sincerely,

Hannah Prytherch
Principle Researcher

Appendix D – Feedback Summary for participants



Dear **Participant**,

I'm writing to you because you took part in a research study about people's experiences of using Drayton Park, a trauma-informed women's crisis house during a time of suicidal distress.

Firstly, thank you again for giving up your time to participate. The government recognises that it is important to improve care for people who are feeling suicidal. Service-users have complained about their experiences in psychiatric hospital, particularly experiences like involuntary detention, observations and restraint. Some researchers have suggested that the approach used in hospital can be unhelpful and so have developed an approach which they call the Trauma Informed Approach (TIA). This is the approach that Drayton Park tries to use. However there has not yet been any research looking at what it feels like to stay in a trauma-informed service and whether people like the approach and if so why. The government has planned to build more crisis houses and there has been a push from psychologists to create more trauma-informed services. I hope that when I submit this research for publication, it will help people to think about how to create services that users will find more supportive.

The Study

I interviewed eight women about their experiences in the crisis house and how this compared to previous experiences in hospital. I also asked them whether they thought the approach used in the different services had helped them with their suicidal feelings and if so, how. I then used a research method called 'thematic analysis' to analyse the interviews. Thematic analysis involves looking through the interviews for common themes.

The Results

These results are my best effort to summarise what people spoke about in the interviews. As it is a summary of everyone's experiences there may be some parts that don't feel relevant to your experience. However, I hope that some of it will be familiar. I will outline the seven themes that I developed with some example quotes.

1. The power of talking

Women said that they found the regular one-to-one sessions useful, and that these sessions helped them to talk about things that they had not spoken about before. Women said that being asked about whether they had experienced trauma could feel difficult at first but helped them to talk about such experiences. Talking about the experiences and being encouraged to be angry about things that had happened to them was described as helpful. However, some women did point out that talking has its limits and that more drastic social change is needed.

Yinka: by talking about it, all the experiences that I had... made me feel, it's so much better you know, you come out and be like 'ah' you know? even after crying you know, it's really good.

Jess: I think like, I do think like each time I've come here, I've left here with some, more of an understanding because, because, you're talking about it all the time.

Claire: it might help to like talk to someone for two weeks but you're not gonna get a rapid f** change in your life unless people are here to get rehoused and stuff"

2. The limitations of medication

Women said that in hospital there had not been much opportunity to talk and the focus was on medication. Most thought that the reason they got suicidal was related to experiences in their lives. Therefore, though women said they found medication helpful, they did not think medication alone could help them. Women said that being seen as 'a diagnosis' could be disempowering or lead to judgmental attitudes, particularly a diagnosis of borderline personality disorder.

Grace: Even the really good [staff] didn't want to sit and talk. They just felt like that it wasn't their job... it was just their job to monitor people and if someone is having a hard time, the first port of call would be reach out for the medication cabinet.

Becca: I do think medication is necessary for a lot of people, it's definitely necessary for me... but I don't think people should be just treated with medication.

Claire: People won't believe them because they're mentally ill.

3. Managing emotional safety through trusting relationships

Women described having more freedom and privacy in the crisis house. When asked how they managed to keep themselves safe, most women referred to trust. They explained that being given responsibility showed that staff trusted them and this made it possible for them to trust staff too. Women said that forming trusting relationships was healing in itself, but also meant that they were more able to ask for support when they felt distressed. Women said that by focusing on their emotional safety, rather than just physical safety, this approach to risk management was more effective in the long-term. However, most women pointed out that this approach would not work for everyone.

Alix: I feel trusted. Whereas on the ward, by definition, you are on the ward cos you are not trusted with your own safety.

Grace: It was about building that kind of relationship and being able to trust them enough to go and approach them when I was feeling like doing something stupid or harming myself or running out and going onto a train track.

Allison: Here, it was the, given a choice that you can take [an overdose] but we'll support you not taking it... Whereas if it was in a hospital it's like I want to take an overdose but I

physically can't do it. You know, it made me think and re-evaluate why I should take my life when I'm at Drayton Park. Because when I think about it, life isn't that bad.

4. Managing physical safety through coercion

Women said that in hospital, risk was managed through "coercion", so for example not letting them leave the ward or taking away belongings or searching them. Women were critical of this focus on physical safety, which they said didn't deal with anything on an emotional level and therefore was not effective in the long term. Some women said that their difficulties had developed from situations of abuse, where they had had no control or power. Therefore, they said that being on a ward where they take away your control and power could actually feel re-traumatising. Some said that it made them feel worse and more suicidal. Others said that it made it difficult for them to trust staff so when they felt distressed, they were less likely to ask staff for help.

Alix: It's traumatic, you just get re-traumatised by your own treatment.

Ruth: "I'm never gonna trust someone who I know can hold me down... while there's that bigger power imbalance and while patients have that little control, it's never going to be therapeutic".

Allison: sometimes I feel suicidal but I can't say it because by saying it, they'll keep me in a bit more...I have to almost put on an act and pretend that I'm well in order to get out so that I could kill myself.

5. A home rather than a hospital

Women talked about differences between the environment in the crisis house compared to hospital, which they said reflected differences in the underlying approach. They described the hospital as 'clinical' and said that it could make them feel worse because it reminded them that they were 'ill'. The crisis house was described as 'homely'. Women said this felt valuing and "like you're actually living a life" (Becca).

Jess: It's a house for a start, you walk in you've got living rooms that feel like living rooms and you've got a dining room that feels like a dining room and a garden and the bedrooms that feel like normal bedrooms with normal bathrooms.

6. Fostering compassion

Women described the staff in the crisis house as compassionate and caring. Although some women said that there were staff whom they worked well with on the ward, they said that in hospital staff didn't have time to talk. Others said that staff in hospital just didn't seem to care or seemed "revolved by the mentally ill" (Claire). One woman suggested that this might be partly because staff on the ward have to deal with people who are more distressed. Two women said that the environment on the ward didn't foster compassionate ways of working. Some women said that there were a lot of bank staff on the ward. They compared this to the crisis house where they said there was more consistency in the staff and this helped them to build relationships.

Allison: I wouldn't say that the people are that bad it's just the environment that makes it not therapeutic.

Becca: if you were a compassionate person already, you probably wouldn't want to work on the acute ward because it's not an environment that fosters that behaviour, which is obviously like a very... deep institutionalised problem.

7. The benefits of gender sensitivity

Finally, most women said that they felt safer in a women's only environment. They said that on the ward they had often felt unsafe around male patients and so had stayed in their room. They also described feeling unsafe around male staff, particularly because many had experienced abuse from men. They said that it was easier to open up to women staff. Some women also liked the fact that they had the opportunity to learn about how their experiences fit into a wider social context. Some talked about becoming more involved in gender politics since staying at Drayton Park.

Yinka: the fact that they're women as well, it just feels so comfortable to be, to open up to them about anything you know like in terms of like it could be about the abuse, the sexual abuse or anything.

Ruth: I don't understand why anyone would ever think it was OK to like tell a woman who's just been sectioned like 'ok go quietly to bed while a strange man watches you sleep'. Like sorry what? Just cos he's got an NHS lanyard doesn't mean he stops being a man with access to your bedroom.

Grace: I just talked about how I feel in my community... as a woman that was brought up in a really strict upbringing... Was devalued um as a woman, as a girl, where men were kind of worshiped. Women came second best. So I kind of learned about all that here. That actually yes we are equal and we can kick ass as much as men can.

Discussion

In the full report, I compared these seven themes with findings that other researchers have reported. Particularly I thought about how the results fit with the ideas of 'Trauma Informed Approaches'. I suggested that more trauma-informed services be created or that current services think about how they could try to work in a more 'trauma-informed' way. However, I also acknowledged that I only spoke to eight women, all of whom I recruited through Drayton Park. I pointed out that there may be people who did not like the approach used in Drayton Park and that it is important to do further research which includes their views too. If you would like the full report, please let me know and I will be happy to send it to you. Thank you again for taking the time to be a part of this research and I hope that it can make a difference to future services.

Yours sincerely,

Hannah Prytherch
Principle Researcher

RESEARCH ABOUT DRAYTON PARK – ARE YOU INTERESTED?

My name is Hannah and I would like to find out about your experiences at Drayton Park. At the moment, there are not many options for people who are experiencing a mental health crisis. Mostly people are offered support from a crisis team or hospital – often being admitted against their will. I want to compare women's experiences at Drayton Park with their experiences in hospital to find out what kind of services women prefer and why. I hope that by finding out more about what women find helpful, we can improve services for women in crisis. I would like to speak to women who have been in hospital and stayed at Drayton Park during times of crisis. I am specifically looking for women whose crises were related to suicidal feelings. I know this can be a difficult topic to talk about and so if you would like to meet me to find out more about the research before deciding to participate, I am happy to do this.



Please talk to a member of staff at Drayton Park and they can give me your details. Or you can contact me directly on:



h.m.prytherch195@canterbury.ac.uk



**0333 011 7070 – leave a message and I will call you back.
(Please specify that it is for 'Hannah Prytherch', project on Drayton Park Crisis House).**

Appendix F – Participant Information sheet

Faculty of Social and Applied Sciences
Clinical Psychology Doctoral Programme
Canterbury Christ Church University
Tunbridge Wells Campus

Suicide and Crisis Care: How Crisis Houses Influenced Recovery

My name is Hannah Prytherch. I am a trainee clinical psychologist at Canterbury Christ Church University studying for a doctorate in clinical psychology. My research will look at why women chose a women only Crisis House in a moment of suicidal crisis. The project has been approved by my training organisation (Canterbury Christ Church University). Ms Anne Cooke and Dr Ian Marsh (Canterbury Christ Church University) supervise this project. Please take time to read the following information. Please ask if anything is unclear.

What is the study about and why is it being done?

It is recognised that suicide is complex and that suicidal feelings can be influenced by many things, including relationships and social circumstances. However at the moment, when people feel suicidal, their main treatment options are hospital or crisis teams where they are often given medication. Crisis houses are usually a bit different. Their treatment normally involves less focus on medication and more space for exploring the circumstances that led to someone feeling suicidal. Given that many people choose to go to a crisis house rather than hospital, it seems like at least for some people, crisis houses are helpful. However, there has not been much research looking at why people choose crisis houses and how crisis houses can influence recovery.

What does the study involve?

I am interviewing 10 to 12 people about their experiences. To take part you must:

- Be aged 18 or over.
- Have been admitted to hospital because you were feeling suicidal in the last 10 years.
- Chosen to go to Drayton Park Crisis House because you were feeling suicidal in the last 10 years.
- Not have plans to end your life at the moment.

Interviews will take between 60 and 90 minutes and will take place at Drayton Park Women's Crisis House.

All interviews are confidential. They will be audio-recorded and typed up. Anything that could identify you will be removed from the typed-up interview (e.g. if you mention the street you live on). To assure the quality of my work, my research advisors will look at parts

of the anonymised typed-up interviews and will supervise my work. I will read and re-read the typed up interviews and then draw some interpretations about how I understand your story and the links I see between different people's stories. I will then ask to share my interpretations with you and ask for your feedback on how well you think my understanding of your experience fits with yours. I may change my interpretations based on your feedback and then type up what I hope will be our shared understanding into a research paper.

Unfortunately, once 10-12 people have been recruited I will be unable to interview more people.

Do I have to take part?

No. You are in no way obliged to take part in this research. If you do decide to take part, you have the right to withdraw your consent at any time without giving a reason. In that case your interview recording will be deleted and not used for research purposes. If you lose the capacity to consent during the research process, but the interviews have already been conducted and transcribed, then the data will still be used in the study.

What are possible risks in taking part?

In the interview, we might talk about experiences that were distressing, embarrassing or uncomfortable. You do not have to talk about anything that makes you feel like this. If you become very distressed during the interview, please let me know. You can take a break or stop the interview at any time. If I feel that the interview is a distressing experience for you, I will ask you whether this is true and I might ask to stop the interview. All participants will be debriefed when the interview has finished. I will ask you about your experience of the interview, your current mood, how safe or at risk you feel, and the level of support that is available to you if you feel you require it. If you feel you need to plan support to feel safe I will stay with you until we have planned this. If you feel you need to extend our debrief at a later time we can also plan this. Contact details for support services are on this form and will also be on the debrief form, for example Samaritans 24- hour helpline (Tel.: 08457 90 90 90).

What are possible benefits of taking part?

The findings of this study could improve people's understanding of what can help people in a suicidal crisis. This could lead to improved services and treatment. Some people also find that talking about their experience can be useful.

Will my participation be kept confidential?

Everything you say in the interview is confidential, unless I have reason to believe that you or another person is at risk of harm. All information will be kept securely and confidentially on password-encrypted memory sticks or computers. Information that could identify you, like your name will be locked separately from interview data. I will be responsible for keeping this data secure until the study is finished. When the study is finished, in line with the University regulations, the written, anonymous transcripts will be put on a password protected CD and stored by the University for 5 years in a locked filing cabinet in a building with 24 hour security. After the 5 years, this CD will be destroyed. All data use is strictly within the Data Protection Act (1998).

How is the research funded?

The research is partially funded through my training programme. Your travel expenses can be reimbursed up to a maximum of £10.

What will happen to the results of the research?

I hope to publish the results of this study in a scientific journal and in media for mental health service users and health care professionals. Please be assured that only anonymised quotes will be used and that individual participants will not be identifiable in the write-up.

What next?

You may wish to have a think about this project and have a discussion with family, friends, or other significant people in your life before confirming your participation.

If you would like to take part please contact me by email on h.m.prytherch195@canterbury.ac.uk. If you do not have access to the internet you can telephone 03330 117070 or you can speak to a member of staff at Drayton Park Women's Crisis House and they can pass your details on to me. I will then contact you by email or telephone (whichever you prefer), to answer any further questions you might have and arrange meeting for an interview. Before the Interview, I will ask you to sign a consent form, to confirm that you are willing to take part in the study. However, you can withdraw your consent at any time without giving a reason.

Further information

Please feel free to contact me should you have any more questions about this study:

Hannah Prytherch
Salomons Centre for Applied Psychology
Department of Psychology, Politics and Sociology
Canterbury Christ Church University
Tunbridge Wells
Kent, TN3 0TF
email: h.m.prytherch195@canterbury.ac.uk

Complaints procedure

If you are at all dissatisfied with the conduct of this research please first contact the researcher (Hannah Prytherch, h.m.prytherch195@canterbury.ac.uk, Tel.: 03330 117 114). If you still wish to complain about any aspect of the research project, please contact Professor Paul Camic, Research Director, Dept. of Applied Psychology, at paul.camic@canterbury.ac.uk or on 03330 117 114. Canterbury Christ Church University is the sponsor of this research and is therefore responsible for its conduct. If you feel that you have been harmed by this research please contact Professor Paul Camic and he will discuss with you the complaints process of the university.

I am very grateful for your time and attention.

Hannah Prytherch, Trainee Clinical Psychologist.

In crisis?

If you are feeling distressed or want to end your life, please take steps to find the help you need. There are services available to support you. Some of these are listed below.

- Drayton Park Women's Crisis House (020 7607 2777)
- Your general practitioner (GP)
- The Samaritans: 24 hour confidential telephone, email and text message service, www.samaritans.org, call (free) on [116 123](tel:116123).
- Emergency services – 999 free call from landline or mobile.
- NHS Direct: 24 hour national helpline offering health advice and information 111 free call from landline or mobile.
- Saneline: Telephone helpline 6pm-11pm 0300 304 7000
- Nightline: confidential listening line for students run by students: nightline.ac.uk

Distress protocol during Interview

I hope that the interview will be a positive experience for you. However, if you were to become distressed, I would stay with you until a satisfactory plan was made to keep you safe. This could include:

- Staying with you and talking to you/planning how to stay safe
- Planning follow up debrief sessions for another day or by phone
- Assisting you to access further debriefing with a research supervisor who has extensive clinical experience in mental health services
- Assisting you make contact with family members/carers/friends
- Accompanying you to access health services (e.g. Crisis House, GP, A&E).

Appendix G - Consent form

Faculty of Social and Applied Sciences
Clinical Psychology Doctoral Programme
Canterbury Christ Church University
Tunbridge Wells Campus

Suicide and Crisis Care: How Crisis Houses Influenced Recovery

	<i>After having read the participant information sheet, please read the following:</i>	<i>Please initial in the box</i>
1	I have read and understood the participant information sheet for the above study.	
2	I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
3	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason, and without it affecting my rights in any way.	
4	I understand that the interview will be audio recorded for the purpose of the research, and I hereby give permission for the interview to be recorded.	
5	I understand that the interview will be transcribed and that any information that might identify me will be removed from the transcript.	
6	I understand that research supervisors may see a sample of my anonymised transcript.	
7	I understand that anonymised quotes from my interview may be included in publications.	
8	I understand that the content of the interview is confidential as long as the researcher is not concerned about my safety or the safety of others.	

9	<p>I confirm that I meet the criteria (below) to participate and agree to take part in the above research study.</p> <ul style="list-style-type: none"> • I have been admitted to hospital within the last 10 years because I was feeling suicidal. • I have stayed at Drayton Park Crisis House within the last 10 years because I was feeling suicidal. • I am over 18 • I do not currently have plans to end my life 	
10	I wish to have a copy of the transcript of my interview to check its accuracy (you may change your mind about this at any time)	Yes / No
11	I wish to take part in checking findings from the research and offering my comments on the work (you may change your mind about this at any time)	Yes / No
12	I wish to receive a summary of the results at the completion of the study (you may change your mind about this at any time)	Yes / No
13	I wish to be informed by email if the research is published (you may change your mind about this at any time)	Yes / No

Name of participant: _____

Signature: _____ Date: _____

Name of person taking consent: _____

Signature: _____ Date: _____

Appendix H – Interview Schedule

Preamble “The main focus of the interview is on your experiences at Drayton Park Women’s Crisis House. That’s what we will be spending most of our time talking about together. But just to start, I would like to ask you a few general questions about yourself, to learn a bit about you. We won’t spend too much time on this.”

1. Can you tell me about yourself?
2. What made you want to talk about your experience?

Main Section

Thank you. I think it helps to know a bit about you. Maybe now we can move on. I am really interested in your story, about what led you to feeling suicidal in the past and how people or services have tried to help.

We can stop at any time. Please tell me if you would like to take a break, or stop, and we can straight away. Do you have any questions before we begin?”

1. Main question: OK so why don’t we start from the beginning. Do you feel able to talk about what was going on for you before your last stay at the Crisis House?
2. Why did you choose to come to the Crisis House rather than asking for help from somewhere else?
3. What was your experience like in the Crisis House?
4. How was your experience in the Crisis House different to your experience in hospital?
5. Do you think that coming to the Crisis House changed your understanding of your suicidal feelings?
6. Did your experience in the Crisis House have an impact on your suicidal feelings? And if so how?
7. How did the fact that it was for women only affect your experience?
8. If the Crisis House had not been available, what would you have done?

Appendix I – Excerpts from Research Diary

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