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Coercion or collaboration: service-user experiences of risk management in hospital and a trauma-informed crisis house

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ABSTRACT

Background and aims. Improving care for people in crisis remains high on the UK government agenda. Trauma-informed approaches (TIAs) have been advocated to address concerns raised about psychiatric hospital services by service-users, particularly around the use of coercion in risk management. This study explores service-users' experiences of risk management in both hospital services and a trauma-informed crisis house.

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. Four themes were developed. In the first two ('The Medical-Custodial Approach: They Only Think About Physical Safety' and 'Coercion is Counterproductive') participants described hospital as being dominated by a medical-custodial approach, which they said was ineffective in managing long term safety and could exacerbate distress. In the next two themes ('Talking Heals' and 'Relationships as Risk Management') the crisis house was described as using a relational approach to risk management that enabled women to maintain some freedom, privacy and control and was felt to be more effective long term. 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.

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approach; risk-management;
coercion

1. Introduction

Improving care for people in acute mental health crisis is a key demand of the service-user movement and a priority for the UK government (Parkin, 2018). The Kings Fund (2015) has reported that much crisis care is of poor quality, whilst the Care Quality Commission (the body that inspects health and social services in England) has described it as "unsafe, unfair and completely unacceptable" (Care Quality Commission, 2015). Inpatient psychiatric services, key to current provision, have been described as frightening (Rose et al., 2015) and as lacking therapeutic engagement (Stenhouse, 2011). The government has recently allocated £400 million for the development of alternative forms of crisis care (Parkin, 2018). This paper looks at one example of alternative provision, comparing it with conventional care.

Why is hospital care so frequently described as unhelpful? Research into service-users' experiences suggests that part of the explanation might lie in the dominance of a "medical-custodial" model (Prytherch et al., *in press*) which conceptualises mental health problems as "the same kind of phenomena as physical problems like cancer" (Johnstone et al., 2018, p. 19) and treatment focuses

on “diagnosis ... [and the] administration of drugs” (*ibid*). Some service-users report that this focus can lead to life experiences such as trauma and discrimination being ignored, leaving them feeling judged and disrespected (Lees et al., 2014).

Of particular concern is the widespread and increasing use of coercive measures such as compulsory admission, restraint and forced medication (Independent Review of the Mental Health Act, 2018). Within a medical-custodial model, such measures are seen as necessary for risk management. However, service-users often experience them as humiliating, invasive and traumatising (Lees et al., 2014).

In an attempt to address some of these problems, some services have made a conscious effort to draw on alternative practice frameworks, for example, “Trauma-Informed approaches” (TIAs) (Sweeney et al., 2016), which developed out of psychological models of trauma (e.g., Herman, 2015; Van Der Kolk, 1987). TIAs recognise that many people who come into contact with mental health services will have experienced trauma and adversity, and that their distress is in many cases an understandable response to such experiences. TIAs also attend to the social, political and cultural context within which adversity is experienced.

Since trauma often occurs within the context of relationships, TIAs view collaboration and trusting relationships as central to healing (Sweeney et al., 2016). Coercive measures are seen as potentially re-traumatising and as inimical to the development of trusting relationships and therefore to good care (Sweeney et al., 2018). However, this raises the question of how risk can be managed within a trauma-informed framework.

1.1. Aims

This study aimed to explore people’s experiences of risk management in both hospital services and a trauma-informed crisis house. Within the UK’s National Health Service (NHS) alternatives to hospital include home treatment teams and crisis houses (Parkin, 2018). Crisis houses offer intensive, voluntary treatment within a more homely residential setting than is possible in hospital, but like hospital services, their approach can vary. Participants in the current study were interviewed about their experience of one particular crisis house in North London, which states that it uses a TIA. All participants had also experienced admission to hospital, with experience of many different hospitals between them.

2. Method

2.1. Design

Thematic analysis (Braun & Clarke, 2006) was used to analyse semi-structured qualitative interviews within a critical realist framework (Collier, 1994). The latter assumes that participants offer accounts of their experiences that have been constructed and reconstructed through memory and language. Accounts are seen as influenced by research context, wider social and political factors, and the researchers’ own beliefs, but nevertheless as giving valuable insights into the phenomena described. The authors of this paper believe that the medical-custodial approach is overused and value trauma-informed care. The reader is invited to take this into account in judging the analysis and conclusions. See below and Prytherch (2018) for further details of design and analysis.

2.2. Procedure

2.2.1. Ethical Considerations

Research was conducted in line with the British Psychological Society’s Code of Ethics and Conduct (British Psychological Society, 2009). An NHS ethics committee and the Camden and Islington NHS Trust approved the research.

2.2.2. The setting

The research took place in an NHS crisis house where all staff and residents are women. This service was set up in response to concerns regarding some women's emotional and physical safety in mixed-gender services, particularly given the high proportion of female service users who have experienced abuse from males (Cooke et al., 2019). One major criterion for admission is that a woman is otherwise likely to be admitted to hospital: a previous study found that most women admitted to the crisis house had had previous hospital admissions (Killaspy et al., 2000). If risk is felt to be too high to be contained in a voluntary setting, women are transferred to hospital, sometimes under the Mental Health Act. This happens approximately once a month.

The service runs on trauma-informed lines but is also open to those who have not experienced trauma. The staff team is appointed on the basis of their skills, attitudes, knowledge and experience rather than professional qualifications. All staff are trained and supervised in the TIA and the initial assessment includes routine inquiry about trauma. There are 18 full-time equivalents in the team who work on a shift basis. The senior members of staff have usually worked directly within mental health services in the past but also the majority will have completed some form of psychological training. When required, medical reviews are requested from medical doctors within the crisis team. When possible, the crisis team will send a female member of staff and when this is not possible, residents are asked whether they would be willing to meet a man. Staff also work closely with GP's to support women to have up-to-date prescriptions. There are 12 places within a residential setting and women stay 2 weeks on average, though the maximum stay is 4 weeks.

Risk is managed through psychological (safety planning, regular one-to-one sessions, agreed phone calls and check-ins) rather than physical containment, recognising the key role played by relationships and the potential for coercive measures to be re-traumatising. All care is consensual and rather than "observations", there are regular "contacts" where staff check-in verbally with women. Women have keys to their rooms and staff only use master keys if they have knocked three times and had no response. Service-users have been involved in the design and management of the service from the beginning. Self-referrals are accepted and care is planned consensually by the woman and her worker. Staff anxieties regarding risk are managed through clear structures and procedures, and through the constant availability of other team members working together and based in the same office within the house. For further details about the crisis house see (Cooke et al. 2019).

2.2.3. Recruitment

Eight women were recruited. Five current residents were approached by crisis house staff, two of whom volunteered to participate. Four previous residents volunteered after hearing about the research through a support group based at the crisis house which is open to all previous residents (approximately ten attend per week). Finally, two previous residents volunteered after hearing about the research through a women's strategy group (a core group of six service-users plus staff who aim to raise awareness of women's issues across the Trust). See below for a discussion of the possible implications of the sampling strategy.

2.2.4. Participants

Participants were aged from 22 to 53 years. Five were White British, one was British Chinese, one Black African and one Greek Cypriot. All had stayed at the crisis house within the last year. All had also been admitted to hospital within the last four years (except one whose most recent admission was 9 years previously). However, none had been transferred from the crisis house to hospital during an admission.

2.2.5. Interviews

Interviews took place at the crisis house and lasted approximately 1 hour. Participants were asked about their experiences in the crisis house and in hospital services (see Prytherch, 2018 for interview

questions). All interviews were audio-recorded. Pseudonyms have been used to protect confidentiality.

2.3. Data analysis

The analysis followed Braun and Clarke (2006) guidelines for thematic analysis. Analysis was a recursive process, involving movement backwards and forwards between stages. Stages included reading the transcripts, forming codes, clustering codes together under central organising concepts and “re-looking” at the data for “disconfirming instances” (Fischer, 2009). Given the scarcity of previous research in this area, an inductive approach was adopted. Whilst there is debate in the field about how many items are required to achieve “theoretical saturation”, Braun and Clarke (2019) argue that the concept of “theoretical saturation” is rooted in positivist epistemology and not consistent with a critical realist framework. As such, rather than aiming for “theoretical saturation”, these findings are presented as one interpretation that is “far enough along to make a contribution to our evolving body of understandings” (Fischer, 2009, p. 586). The sample size is comparable to that in similar studies (e.g., Ruddle, 2017). The analysis was sent to all participants, five of whom replied, all confirming that they agreed with the analysis. Yardley’s (2000) quality guidelines were followed. For example, an independent researcher reviewed one coded transcript, a reflexive research journal was kept throughout and three bracketing interviews were carried out. Please see Prytherch (2018) for a full description of this process.

3. Results

Four themes were developed, the first two of which related to participants’ experiences of hospital and the last two to their experiences in the crisis house. The first theme was *The medical-custodial approach: they only think about physical safety*. Whilst some participants felt that medication was helpful and that coercion kept them physically safe in the short term, they described having little space in hospital for the talking that they felt was necessary for long term healing. The second theme was *Coercion is counterproductive*. Participants felt that the coercive practices they experienced in hospital could actually make things worse through replicating past traumas and undermining the development of trusting relationships. The third theme, *Talking Heals* describes the processes that facilitated the development of trusting relationships in the crisis house and the healing nature of such relationships. The final theme *Relationships as risk management* describes how trust was used to manage risk in the crisis house and why this approach may be more effective long term. In relation to the latter two themes participants also named a number of limitations to the approach used in the crisis house.

3.1. The medical-custodial approach: they only think about physical safety

All participants felt that in hospital the focus was on medication. One explained: “it’s just like ‘would you like some medication or would you like to f-off?’ basically” (Jo). Participants also described various forms of coercion. For example, women described having their belongings confiscated and one reported being strip-searched. They explained that the bedroom doors had “peep-holes” (Jess) and staff could “barge in without even knocking, even while you’re getting undressed” (Grace).

Allison: We’ll have to wait half an hour for them to go and unlock the toilets ... All the rooms are locked, the kitchen is locked ... it’s literally worse than prison.

The majority of participants described having been “on observations”:

Jess: I spent most of my time on observations, which is where there’s one or two members of staff with you at all times including when you’re showering, going to the toilet and you just feel so humiliated and embarrassed.

Four reported having been physically restrained and forcibly medicated.

Alix: it's written into law ... they have the right to be physical, to make you ingest things that you are not willing, inject you with stuff that will make you compliant.

Participants were generally critical of this approach. Although three felt that a "chemical imbalance" (Allison) might contribute to their difficulties, all participants saw their problems as partly or completely caused by experiences of adversity. They wanted to be able to talk about their experiences, but this had not been possible in hospital.

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 ... healing someone [requires] dealing with everything that happened before.

Participants described how the dominance of the medical-custodial approach appeared to prevent staff "thinking about the reasons that people were acting the way they were" (Jo) and meant that staff were less likely to make time for talking.

Grace: Even the really good [staff] didn't want to sit and talk. They just felt 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.

Jess: In hospital, it's not about talking, about working through ... why you're feeling like this, it's literally about keeping you on medication and making sure you're alive.

Whilst participants acknowledged that the medical-custodial approach was often effective in "physically keeping people alive" (Jo), they did not feel that it was effective in managing risk long term because there was no space to "deal with anything on an emotional level" (Jo).

Ruth: You get so much talk about safety and they only ever mean physical safety and I don't think that you can have that without emotional safety.

3.2. Coercion is counterproductive

Participants also described how coercive practices could potentially be harmful. Firstly, participants felt that the restrictive environment made them feel worse because it "basically just like emphasises how ill you are" (Jess). Secondly, two participants raised the issue of institutionalisation. Jess explained that her risk fluctuates all the time, so if she was admitted every time she felt suicidal, she would be detained continuously and "never have a chance to get better".

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.

Thirdly, as Ruth explained "a lot of people who have ... mental health problems as adults, it's cos there's been situations in your life where you've had no power, when you really needed it". She described how for her (and in her view for many others), self-harm was a means of regaining some control. Therefore, being "trapped" (Jess, Alix) on a ward, with staff having "taken everything away" (Jess), often replicated the sensation of "complete powerlessness" (Ruth) which they felt had played an important role in their distress. Jess felt that this feeling of being trapped and powerless often led her to "resort to worse coping strategies or ... get more and more desperate to a point that I might feel more impulsive to kill myself". Indeed, a number of participants described the coercive practices of detention and forced treatment as "re-traumatising" (e.g., Grace, Alix) and others used words such as "assault" (Ruth) and "torture" (Allison). They felt that such practices could "exacerbate the

situation" (Jo) and that if more effort was made 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.

Many participants had experienced violence at the hands of men in the past and therefore found it particularly "re-traumatising" (Grace) when coercive measures, such as one-to-one observations (which are compulsory even if the person objects to them) were implemented by male staff.

Ruth: I don't understand why anyone would think it was OK to tell a woman who's just been sectioned '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.

Finally, participants emphasised that coercive practices undermined their ability to trust staff. They felt that this increased risk as they were then less likely to seek support from staff when they felt distressed.

Ruth: I'm never gonna trust someone who I know can hold me down ...

Allison: Sometimes I feel suicidal but I can't say it because ... they'll keep me in ... 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.

3.3. *Talking heals*

All participants valued the regular one-to-one meetings offered in the crisis house. These were always with one of their two allocated workers and women felt this consistency enabled relationships to develop. Many of the women had experienced violence perpetuated by men and found that being in a women-only environment felt safer and made it easier to "open up [to staff] ... about anything ... the sexual abuse or anything" (Yinka). Staff were described as "caring" (Yinka), "compassionate" (Jo), "non-judgemental" (Jess), "respectful" (Grace) and "genuine" (Allison). Grace put this down to management and supervision structures.

Grace: I think it's the management and ... staff supervision they have and kind of really embedding the whole model.

Through building relationships with, and telling their stories to staff who gave their "undivided attention" (Yinka) participants started to feel "valued as an individual" (Yinka) and to talk about things they had not spoken about before.

Alix: [Suicide] just becomes something that can be spoken about here ... they violate the rule, like the first rule of suicide is don't talk about suicide. You can just have these conversations.

Yinka explained that "talking about it, all the experiences that I had ... made me feel ... so much better", whilst others said that it helped them to "realise ... what I lacked ... growing up" (Allison) or to "understand why I get suicidal" (Jess).

Two participants reported that being directly asked about trauma during the assessment had felt difficult at first. Grace explained "I got paranoid about why they wanted to know so much about me" whilst Ruth, who had not previously identified as a trauma survivor, worried that "I don't have any right to ... have these problems because other people have had these experiences and I haven't". Both participants stressed that eventually, being asked helped them to name and talk about 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 had found that it "really hurt when I made that connection ... and created a lot of ... anxiety around ... urgh is this a label that I can use?", she emphasised that "it matters to be able to use words that accurately say what happened to you and to be able to acknowledge it".

Most participants said that this focus on relationship building, combined with the feeling that they were genuinely involved in decisions about their care, made it “at least possible to trust [staff] ... obviously it’s never guaranteed but at least it is a possibility” (Ruth). Trusting relationships were described as healing through facilitating connections with other people and through providing a powerful context for validation.

Jo: Mental illness in general is a very isolating experience ... people need connections with other people ... to get better (Jo).

Ruth: I think someone you trust saying ... “you were a child, like it’s never going to have been your fault” – it’s different when it comes from someone you trust.

However, two participants also noted that talking had its limits. Claire explained, “it might help to talk to someone ... but you’re not gonna get a rapid f** change ... unless people are here to get rehoused”. Similarly, although a number of participants felt that staff at the crisis house did “really care about the social aspect of ... life” (Grace), Grace pointed out that the interventions were still mainly focussed on the individual and therefore did not address the wider societal injustices that contribute 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.

3.4. Relationships as risk management

When asked how they kept themselves safe in the crisis house, most participants referred to the trusting relationships that the approach enabled them to build with staff. For example, 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 ... harming myself.

Ruth explained how through this approach to risk management, participants “reach a point where they start wanting to keep themselves safe” and described this as “the only way to manage risk long term”.

Allison: Here, I was 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.

Because risk was managed through trusting relationships rather than physical containment, participants were able to enjoy more freedom, privacy and comfort in the crisis house than in hospital. This was felt to contribute to healing. For example, the house itself was described as “homely” (e.g., Yinka) and “comfortable” (e.g., Claire). Participants appreciated having keys to their rooms and described the “knock three times” policy as “respectful of your privacy and dignity” (Grace). Finally, participants felt that being able to leave the house (with safety planning beforehand) enabled them to maintain social roles such as employment, which could be an important source of self-worth and help avoid institutionalisation.

Jess: you’ve got the support but you’re also encouraged to keep doing what you would usually be doing, you’re not in a complete bubble.

However, five participants also pointed out that the approach used in the crisis house was not able to contain all forms of risk. Jess explained that if a service-user was unable to abstain from alcohol or unprescribed drugs, then she would not be allowed to stay. Ruth explained that the crisis house is only able to function as it does because “they kind of have hospital as a back-up” and Alix said she had seen people being sent from the crisis house to hospital.

4. Discussion

This study used thematic analysis to explore eight participants' accounts of risk management in a trauma-informed women's crisis house and in psychiatric hospitals. Participants described hospital care as being dominated by a "medical-custodial model", which they felt prioritised medication and short term, physical safety. In contrast, the crisis house was described as prioritising the development of relationships and long term emotional healing. All participants believed that their distress was at least partially linked to difficult interpersonal experiences, and felt that the opportunity to talk about these in the context of trusting relationships was essential to recovery. Coercive practices, which were described in hospital services only, were viewed as potentially harmful and as undermining the development of trusting relationships; therefore, unhelpful in managing risk long term. In the crisis house however, participants described how through the formation of trusting relationships, they started to develop both the will and ways to keep themselves safe.

Most participants said they had experienced interpersonal trauma and felt that trusting relationships were therefore central to healing. This is consistent with trauma-informed theory (Sweeney et al., 2016) and echoes the findings of Pilgrim et al. (2009), who, in their summary of 50 years of interdisciplinary evidence, concluded that relationships are central in the creation and amelioration of mental health problems. However, consistent with previous accounts (Lees et al., 2014), participants felt that the emphasis in hospital had been on medication and physical safety, often through the use of coercive measures. Whilst most found medication helpful, and agreed that the coercive measures kept them safe in the short term, they felt that the dominance of this approach left little time for relationship-building or talking; again echoing previous findings (Stenhouse, 2011).

More concerning were participants' explanations of how coercive measures could at times exacerbate distress; being experienced as traumatising, as reminiscent of previous abuse and as sometimes leading to increased suicidality. These reports, which are in line with previous findings (Sweeney et al., 2018), may be explained by evidence that loss of control is often a central feature of traumatic experience (Blanch et al., 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 (*ibid*). Most women had experienced violence perpetuated by men, a phenomenon which is well documented (WHO, 2017). As such, and in line with previous findings (Archer et al., 2016; Blanch et al., 2012), coercive measures were described as particularly traumatising when carried out by men. Finally, in line with both trauma-informed theory (Sweeney et al., 2016) and previous empirical research (Sibitz et al., 2011), some participants reported feeling unable to trust staff who made use of coercion. Given the central importance of trusting relationships in emotional healing (Pilgrim et al., 2009), there appears to be a risk therefore that such measures could at times actually hinder the processes required for long term healing. Indeed, Krawitz et al. (2004) have warned that "frequent or lengthy use of mental health legislation [and] custodial interventions can make it more difficult for clients to work (collaboratively with clinicians) on how to reduce their risk and keep themselves safe" (p. 12).

In contrast, participants described the approach used in the crisis house as enabling the development of trusting relationships. In line with the principles of TIAs, participants described having regular opportunities to talk to staff whom they felt were compassionate, consistent and interested in the psychosocial context of their distress. Consistent with previous findings (Ciclitira et al., 2017), participants said they felt safer with, and more able to open up to women, and therefore appreciated that the service provided a women-only environment.

As well as being healing in themselves, participants described relationships as an effective way of managing risk as they felt more able to seek help when feeling unsafe. This approach to managing risk also meant that women were allowed more freedom, control and privacy and were able to maintain social roles and relationships that were important to their well-being. A sense of control, supportive relationships with family and friends and engaging in meaningful social and occupational activities have all been shown to contribute to recovery (Tew et al., 2012). The idea that taking risks in

the short term – or “allowing” service users more responsibility for their risk – might reduce risk long term is not new. Krawitz et al. (2004) have referred to this approach as “professionally indicated short term risk-taking” and argue that it can be appropriate for people with a well-documented pattern of chronic suicidal or self-harming behaviour. They emphasise the importance of undertaking a thorough risk assessment, having a strong client–clinician relationship, collaboratively agreed treatment plans and shared clinician decision-making.

4.1. Limitations of trauma informed approaches within a crisis house setting

One participant who had initially not identified as having experienced trauma or adversity said that regularly being asked about trauma had at first made her feel that 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 experience the approach taken in the crisis house as invalidating their distress. Read et al. (2007) have offered advice on how to sensitively ask about traumatic experiences. They highlight the importance of asking about specific events, rather than using the terms “abuse” or “trauma”, pointing out that many people may not have thought of their experiences in such terms.

Participants pointed out that only women who are considered able to keep themselves safe within the approach offered by the crisis house are offered a place. Those who are not may be admitted to hospital, sometimes under compulsion. Some might argue then that even within the trauma-informed crisis house, coercion still exists, albeit it covertly through the possibility of being referred to hospital. Indeed, critics have questioned whether contact can ever be truly voluntary within a system where involuntary detention and treatment exists (Szasz, 1970).

The fact that the crisis house, unlike hospital can reject referrals also highlights that hospital services may be tasked with supporting people with the greatest levels of distress and some may argue that this makes coercive practices necessary. However, as May (2008) points out, it is difficult to know how much risk could be managed using a non-coercive approach, because it is so rarely tried. In the present study, it was demonstrated that some serious crises can be managed safely through a less coercive approach. It is likely that, had the crisis house not been an option, most of the participants would have ended up in hospital. One of the criteria for admission to the crisis house is that a woman would otherwise be admitted (Cooke et al., 2019). Given that many said that they would never again consent to hospital admission, this admission would presumably have involved coercion. Therefore, whilst this study does not provide evidence that the needs of all those who are admitted to hospital could be met in a trauma-informed setting, it does suggest the availability of such alternatives could reduce the need for coercive approaches to risk management.

4.2. Study limitations

This research is based on only eight women’s accounts. All were recruited through the crisis house where the interviews took place. Participants who found the trauma-informed approach unhelpful are less likely to have maintained contact with the service or have been willing to return there for interviews. As such, whilst it is hoped that the research might be of relevance to others, particularly given the high rates of trauma experienced by users of mental health services (Johnstone et al., 2018), the findings are unlikely to be generalisable to all those in crisis. The sample was representative of those who use the crisis house in terms of age but people of colour were under-represented. Effort was made to recruit a more mixed sample but this was unsuccessful (the three participants who declined participation were of black-African or black-Caribbean heritage).

Whilst the researchers used ongoing reflexivity to identify and challenge the perspectives through which meanings evolved (see Prytherch, 2018 for details), inevitably the analysis will have also been coloured by our own beliefs and values, as stated above.

4.3. Clinical implications

Whilst standard treatments and practices in relation to mental health crises are generally assumed to minimise risk and optimise chances of recovery (e.g., Anon, 2017), the results of this study question these assumptions. The findings suggest that for those who have experienced trauma, many practices that are viewed as necessary within the dominant medical-custodial model can be experienced as unhelpful or even damaging. However, by recognising the central role of power, control and trust both in the development of, and recovery from mental distress, TIAs appear to enable some people to safely work through their distress, whilst maintaining freedom and control. Therefore, whilst such approaches may not be suitable for or desired by all in crisis, it seems important that in all localities, there is at least the option of a trauma-informed service. The availability of such services may also help to address current concerns over the high numbers of involuntary hospital admissions in the UK (Independent Review of the Mental Health Act, 2018) as some people who are not willing to go to hospital and are therefore currently being detained involuntarily, may consent to staying in a trauma-informed service.

Of course, creating new services is complicated given the current financial limitations of the NHS. Moreover, there may still be a need for some services that offer the containment of a locked environment. Therefore, it may also be useful to think about how trauma-informed ideas can be incorporated into current services. Examples might include training staff in the importance of relationships as an active part of treatment; using “observations” as an opportunity for engagement, rather than just for risk management; recruiting staff with knowledge, skills and experience in TIAs where possible; allocating two key workers for each patient and ensuring at least one of these is on shift at all times; where possible, meeting patients’ preferences regarding the gender of their key-workers (and other key characteristics); and finally, knocking on doors before entering, to respect patients’ privacy and dignity.

4.4. Research implications

This is the first study to explore service-user experiences of risk management in standard hospital care and in a trauma-informed crisis house. Future research could build on this by examining experiences of other such services. In order to seek alternative perspectives, people who specifically chose hospital over a crisis house, or those who were sent to hospital from the crisis house could be interviewed.

5. Conclusion

In the context of the current focus on improving crisis care, this study used thematic analysis to explore eight women’s experiences of risk management in hospital and in a trauma-informed crisis house. Findings suggested that for those with a trauma history, some of the practices associated with the medical-custodial approach, which participants described as dominating standard care, could be experienced as unhelpful or even damaging. In contrast, the practices prioritised by a trauma-informed approach were described as enabling the development of trusting relationships, which were felt to be central both to risk-management and long term healing. 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 people who use mental health services, it is hoped that the findings of this study may be relevant to others in crisis. Future research could interview participants with a range of experiences as well as exploring further how TIAs can usefully inform the development of crisis care.

Disclosure statement

No potential conflict of interest was reported by the authors.

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