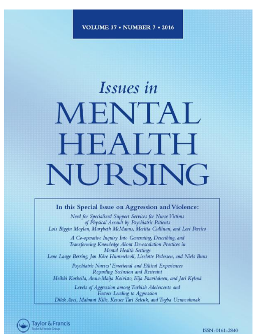

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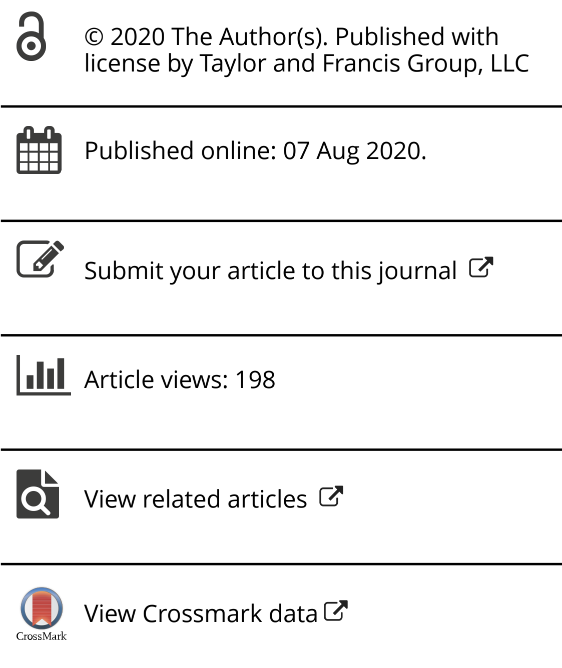

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A Brief Breathing Space: Experiences of Brief Admission by Self-Referral for Self-Harming and Suicidal Individuals with a History of Extensive Psychiatric Inpatient Care

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ABSTRACT

Individuals with severe self-harm and experiences of lengthy psychiatric admissions often have complex mental health conditions and are at risk of suicide. In this qualitative study, self-harming individuals with >180 days of psychiatric admission over 12 months shared their experiences of Brief Admission (BA), a standardized crisis-management intervention encouraging self-admission and autonomy. Phenomenological hermeneutic analysis formulated BA as a worthy respite, replacing an old system of having to prove need 'in blood' or wait and get worse. Successes and struggles in early help-seeking, interpreted in the light of human rights and person-centered care, suggested that individual development of autonomy depended on perceived focus on recovery and compassion. Future research may consider ethical and health-economic aspects of BA in a broader perspective.

Introduction

Individuals with life-threatening self-harm, imminent risk of suicide and complex psychiatric symptomatology, including borderline personality disorder (BPD), may be admitted for long periods, sometimes years, to psychiatric inpatient care, at times requiring safety interventions that include mandated measures (Bowers et al., 2014; Holth et al., 2018). Psychiatric admission is associated with adverse effects related to coercion inherent in mandated admission, resulting in consequences to the individual such as reduced autonomy, greater dependence on future admission at times of crisis and a heightened risk of repeated self-harm (Carroll et al., 2016; Coyle et al., 2018; James et al., 2012; Linehan, 1993). Accordingly, general principles of care for this group are to actively work for other solutions, while recognizing that mandated admission with a limited duration, is potentially lifesaving in situations of imminent crisis (NICE, 2011; The Swedish National Self-Injury Project, 2016). During a crisis, positive attitudes toward help-seeking demonstrated by care providers are viewed as one of the most important factors for the crisis to resolve, facilitating a quick transition to non-mandated care. Not surprisingly, studies indicate that the quality of interactions with psychiatric staff has a high likelihood of affecting the subjective experience of mandated measures (Aguilera-Serrano et al., 2018). Studies have shown that individuals who self-harm and are admitted to psychiatric inpatient care for years are likely to face attitudinal challenges from healthcare providers based on misconceptions regarding the nature of self-harm (Horn et al., 2007; Knaak et al., 2017).There is a need to address such barriers based on current understanding and knowledge of self-harm so that effective treatments may be developed in accordance with the recommended principles of compassion, respect and dignity (Klonsky et al., 2014; NICE, 2011; The Swedish National Self-Injury Project, 2016).

Brief Admission (BA) is a standardized crisis management intervention (Liljedahl et a., 2017a), inspired by experiences documented in qualitative research from the Netherlands (Helleman et al., 2014) and developed to be tested in a clinical trial in southern Sweden (Liljedahl et al., 2017b). The model aims to address the above-mentioned issues, by providing a structured and predictable option alongside other traditional treatments. BA enables individuals to admit themselves to a psychiatric ward, in times of escalating distress, without being assessed by a physician, aiming to increase autonomy and reduce full-blown crises. Access to BA is granted after the signing of an individualized contract, negotiated between the individual seeking BA, their outpatient clinician and a nurse or nurse assistant from the BA ward. The contract entails non-negotiable terms, such as time limits (up to three nights in a row three times per month) and shared responsibilities for safety

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between psychiatric staff and the individual seeking admission. Staff are explicitly instructed to approach individuals seeking BA with warmth. The contract also includes a set of personalized terms, including individual goals and needs during admission, early signs for when to use BA as well as an individualized plan for arrangements during admission relating to care of children, pets and other responsibilities. These individual terms are discussed and documented in the contract before it is signed by all three parties.

BA was compared to treatment as usual for individuals with current episodes of self-harm and/or recurrent suicidality and at least three diagnostic criteria for BPD. Over the twelve months study period the intervention group did not show any significant difference compared to the control group in the primary outcome (total number of days admitted to the hospital). However, in the intervention group about twenty percent of the total number of days admitted consisted of BA, suggesting that BA may sometimes substitute other voluntary or mandated psychiatric admissions. Among secondary outcomes, the intervention group showed significantly greater improvement in the area of mobility of daily life functioning, including for example getting out of your home and walking longer distances outside (Brief Admission Skåne Randomized Controlled Trial: BASRCT, Westling et al., 2019). The amount of psychiatric inpatient care received prior to the trial varied widely amongst study participants.

The present study focuses on the most severely ill individuals in BASRCT with the highest level of historic psychiatric inpatient care, corresponding to a severely self-harming group, where complexity of psychopathology was part of the clinical picture. Staff experiences of working with BA for this target group emphasize the value of introducing and maintaining predictability, improving individual-staff collaboration, and of working with periods of crisis more preventively, although this was sometimes challenging within the framework of a psychiatric ward (Lindkvist et al., 2019). Other studies on experiences of BA for broader groups of individuals with emotional instability (BPD) and self-harm indicate similar experiences of BA, both from nurses' and individuals' perspectives, highlighting the key role of connection and relationships (Eckerström et al., 2019; Helleman et al., 2014, Helleman et al., 2018). Considering the vulnerability of individuals with severe self-harm and histories of lengthy psychiatric admissions and the conflicting recommendations regarding clinical management (Liljedahl et al., 2017a) there is a need to further recognize lived experiences from the point of view of individuals with severe self-harming behavior. The perspective of lived experience illuminates how recommendations and guidelines for clinical management can be adapted to the target group based on inclusion, in line with the principles of compassion, dignity and respect and human rights in mental health (UN Human Rights Council, 2018).

Aim

The aim of this study was to gain knowledge of the meaning of BA for self-harming individuals at high risk of suicide, with histories of extensive psychiatric inpatient care.

Methods

Design

This is a qualitative inductive interview study analyzed with a phenomenological hermeneutic method (Lindseth & Norberg, 2004), inspired by Ricoeur's theory of interpretation (Ricoeur, 1976, pp. 71–88) and designed to make the essential meaning of gaining access to BA visible, through the narratives of lived experience voiced by participants.

Setting and participants

Eligible participants (n = 11) consisted of participants in BASRCT, who had had >180 days of psychiatric inpatient care the year prior to having access to BA. Eight individuals volunteered to participate, although one individual canceled the interview on several occasions and was therefore not interviewed.

Among the seven adults who were interviewed, five were from the intervention group (accessing BA at randomization in the BASRCT) and two were from the control group in BASRCT (accessing BA after BASRCT was completed, i.e. one year after study randomization). At the time of randomization in the BASRCT, participants (six women and one man), were between 22 and 51 years old (mean = 35 years). Five of them were living alone, two with partners and one of them had a child. One participant was living in residential care with access to staff throughout the day and one lived in residential care with access to staff during parts of the day. Two participants were in current psychiatric inpatient care during the interview.

The participants had between three and six psychiatric diagnoses (mean 4) verified by a psychiatrist; posttraumatic stress disorder (PTSD) (n = 5), depressive disorder (n = 5), attention-deficit/hyperactivity disorder (n = 3) and substance-related and addictive disorders (n = 3), social anxiety disorder (n = 2), obsessive-compulsive disorder (n = 2), BPD (n = 2), autism spectrum disorder (n = 2) and bulimia nervosa, panic disorder and general anxiety disorder (n = 1, respectively). Furthermore, four of the participants had non-psychiatric disorders including hypothyroidism, hypertension, osteoporosis, eczema and chronic pain syndrome (n = 1, respectively). They had between five and nine prescribed psychotropic medications (mean 7) and all participants but one had current psychological treatment e.g. Dialectical Behavior Therapy (DBT), treatments for PTSD or supportive conversations with a nurse. During the two weeks before participation in the trial, participants had engaged in self-harm between 0 and 16 times (mean 5 times) and two out of six (one missing response) had tried to commit suicide. The life-time frequency of self-harm as estimated by participants according to the Inventory states about self-injuries (ISAS) varied between 261 and 6,322 times (mean 3,524 times).

Prior psychiatric admissions had been frequent and lengthy, often under conditions of mandated admission and periods of constant observation. Admissions had taken place within general psychiatric care, psychiatric emergency care,

Table 1. Themes and subthemes of the structural analysis of experiences of BA.

Being worthy	Struggling in early help-seeking	Resting and recharging
Gaining control	Feeling shame and guilt	Getting a respite
Being welcomed as a unique person	Facing failures and setbacks	Communicating with others
	Being located in an emergency setting	Developing self-care and consideration

psychiatric intensive care, forensic psychiatry as well as in the medical and surgical emergency and intensive care units. The twelve months before having access to BA the mean number of days participants had been hospitalized was 260 days (SD = 61 days; ranging from 198 to 354 days). Of these, 134 days (SD = 109 days; ranging from 12 to 290 days) had been on mandated care and three (42.9%) of the seven participants had been subjected to mandated acts.

At the time of interviews participants had accessed BA for a duration of one to three years at a psychiatric ward offering BA in Skåne, Sweden (Helsingborg, Lund or Malmö). BA was offered at the same ward as other psychiatric admissions, including acute admissions. One of the participants had a temporarily paused BA-contract due to their current mental health. The number of self-referrals to BA per person varied from a few admissions to over ten admissions.

Interviews

Face-to-face semi-structured interviews (lasting 25-56 minutes) took place during September and October 2018 at a time convenient for participants in their home, a calm space at the psychiatric clinic or in another appropriate nearby location. A semi-structured interview guide was developed focusing on experiences of BA and its main features, as well as pre-expectations and reflections on potential improvements and adaptations of the intervention. All interviews were conducted by the same two interviewers together (two registered nurses specializing in psychiatric nursing programs at Lund University). Focus was on following participants' descriptions of their experiences using open-ended non-leading questions.

Data interpretation

Audio-recorded interviews were transcribed verbatim and then analyzed in a phenomenological-hermeneutic method in three methodological steps (Lindseth & Norberg, 2004) to arrive at the essential meaning of the content. Specifically, in this context the method provided a framework for transferring different and individual experiences of gaining access to Brief Admission by self-referral to a deeper common meaning of the studied phenomena. Firstly, the data was interpreted as a whole. Secondly, a structural analysis of its parts was conducted, and thirdly we aimed to critically explain findings in relation to a relevant theoretical framework consisting of human rights (UN Human Rights, 2020) and person-centered care (Munthe et al., 2012; Price, 2006), including the person-centered Tidal model of mental health nursing (Barker, 1999; Barker, 2001; Barker & Buchanan-Barker, 2010). The software Open Code was used for the structural analysis (ICT Services and System Development and Division of Epidemiology and Global Health, 2013.). Interpretation and analysis were performed by RL and discussed with KL until joint agreement was achieved.

Ethical considerations

This study was performed with special consideration of the vulnerability of participants to ensure that their rights were not violated. With ethical approval (2018/313), principal investigator (SW) provided contact information to the interviewers, who gave participants oral and written information about the study, informed that it was voluntary to participate and signed informed consent prior to interviewing. Prior to beginning the interviews, the interviewers repeated participants' right to pause or stop the interview at any time. There were several shown or stated negative feelings related to being interviewed that were considered from an ethical point of view. Interviewers aimed to be very mindful of these potential threats to participants' well-being and act on them, as deemed necessary, while also respecting participants' wishes to share their experiences. One participant asked for questions in advance and prepared a letter with written answers, with reference to her own ability to describe experiences only truly in writing. Out of respect for this statement, the letter was included in the analysis, alongside the interview.

Findings

Overall impression

The naïve reading of the interviews gave an overall impression of individuals with extensive suffering who are experiencing BA as a worthy alternative to losing control, facing rejection, or having life interrupted in times of crisis. The relief of not being questioned, reduced (but did not eliminate) negative feelings about help-seeking and care, shaped by experiences of stigma and traumatic psychiatric treatment. While BA may offer well-needed help and protection in windy weather, it was of little assistance in a full-blown storm. At times, distrust in their own abilities had led to an overwhelming desire to be kept safe, alongside feeling lost and loose while on BA. These feelings were mitigated by being seen, understood, and supported in their own unique personal journey toward crisis recovery.

Structural analysis

The structural analysis revealed three themes with subthemes (Table 1), further elaborated with examples below.

Being worthy

With BA and in the light of extensive negative experiences of psychiatric care, participants perceived worthiness and respect as they were welcome to receive care based on own unique needs, while remaining in control.

Gaining control

Experiences of help-seeking before BA were characterized by being faced with distrust and repeated failure to explain their current condition in arguments with physicians at the emergency unit, about the need to be admitted to a psychiatric ward. Prior to BA, participants had oftentimes experienced meaningless struggles to try to maintain control and prevent themselves from self-harming.

> I went to the psychiatric emergency unit and said, "I am going to take pills today and I need help not to". And then he said "well, you may begin in daycare in two weeks." And I had brought a bottle of/promethazine/because I knew that's what they were going to say. I took the pills. And then he changed his mind. The healthcare system has always been that way, necessitating self-harm. I mean, if you can't explain—and I can't explain—you have to self-harm to get help. (I2)

Participants had experienced ending up in the most comprehensive types of caregiving situations, gradually having control taken away with mandated measures and being put under constant observation. During long and difficult periods of admission, they had perceived becoming increasingly unmanageable, losing respect and belief in both self and others. The authority to self-admit with BA meant that they could avoid having to wait and get worse, risking rejection or feeling forced to prove their need for help 'in blood'. BA became an option to break a vicious cycle of losing control and experiencing increasing reluctance toward help-seeking.

> Most often, I've been seeking help at a relatively early stage, and then you get a/diazepam/and you go home. It is only when you arrive with a police escort or in an ambulance that you are admitted to compulsory care. And by then, in my case, I am so far gone that I've lost all consideration toward others. Within BA, I could seek help today if I would have needed to. Like, nothing drastic needs to happen for me to get help. And that is a huge difference. (I6)

Participants experienced relief and liberation when being trusted to keep personal items, such as headphones or lace-up shoes during BA, and not having them locked in or controlled by staff. Knowing that it was possible to go outside during admission without pre-approval was perceived as important for personal well-being, as well as self-administration of medication, independent of staff or strict schedules. Keeping control and flexibility, while getting support when asking for it gave participants a sense of independence and integrity.

Being welcomed as a unique person

Arriving at the ward often felt challenging because of traumatic memories from previous acute psychiatric admissions. However, when self-admitting to BA, participants experienced a positive atmosphere created by welcoming and encouraging staff. Knowing they were welcome to use BA with short notice gave them a sense of safety that was helpful also when not using BA.

> Already during the first conversation, they said 'you may come within a few hours, we have a bed available for you'. Like, it has never failed for me, rather I have been met with a positive and engaged attitude from staff and they have helped me receive a bed quite quickly. (I1)

At arrival participants sensed a structured approach from staff, scheduling length of stay and daily supportive meetings. Participants appreciated the admission conversations where the contract with jointly agreed terms and individual requests were reviewed together with a nurse or nurse assistant. Being asked to express individual requests for each admission gave them a sense of true commitment from staff. Sensing that staff did not view their help-seeking as unjustified or exaggerated was important when self-admitting to BA. Feeling welcome made it easier to take contact and arrive at the ward, as well as being ready to leave after only three nights. Participants sensed that the latter could potentially change negative perspectives on them as being hopeless attention-seekers.

> When you arrive as a patient in compulsory care or if you seek help through the emergency unit, I feel that people sigh in annoyance because I am seeking help again or because I have ended up in long admissions. And when I have arrived for a BA, people have come up to me and hugged me and said, "It's amazing that you are seeking help. How good of you to come". (I6)

Learning to use BA as intended was perceived to depend on being able to individually adapt the method, by for instance influencing how to be approached, who to talk to or how to ask for help. Staff's ability to approach participants with flexibility and engagement was crucial. There were examples of special arrangements, such as asking for help by putting up a sticky note on the door if a participant found it too demanding to physically approach staff for help. The renegotiation of the contract every 6 months became a process of learning to make use of BA for individual purposes while keeping it up to date with personal needs over time.

> We have signed a new contract a number of times. And each time, I have felt that there has been something new that I have wished for, or wanted to change, or wished that people would think of, and so on. And it has been received with open arms, they have noted it down and written it into the contract. (I1)

Struggling in early help-seeking

Taking the first step to self-admit was an effort of overcoming fear and shame, sometimes ending in failure. Learning early help-seeking within an emergency setting was a challenge.

Feeling shame and guilt

Participants perceived that the courage to ask for help diminished when approaching crisis, quickly narrowing the

window of opportunity to act in time. Support from others was important to avoid being trapped in hesitation or communicating through self-harm.

> The problem is that the worse you feel, the more it turns into "no, they don't want to have me there". Besides, you don't have the energy to act on it, to even leave from home at all. (I2)

> Going there is just up to oneself. If only I wasn't so damn ashamed of how I act. But I am very ashamed. (I7)

Questioning their own right to take up a bed simply because of having thoughts about self-harm or feeling tired, could result in trying to stay out of the way during BA or leaving early. They shared experiences of feeling abandoned, lonely and misplaced, of being left to themselves after being given a bed, a cover and a towel. One participant had reacted to such emotions by remaining in bed during BA and using the opportunity to eat at home while feeding the cat. Another participant had waited for four hours after arrival to be further recognized by staff, before leaving in disappointment.

> I could feel like: do I really need to be in psychiatric admission? And at the same time, I am still supposed to take responsibility for myself and my feelings. And yet, it was a new concept, being responsible. Not putting it on the staff, the way one feels and acts. (I6)

Not being regularly checked or controlled by staff like they were used to from other admissions sometimes made them feel as though staff were less engaged in them as patients, which in turn made them feel unimportant. Even with encouragement from staff participants could worry about being irritating when self-admitting. They expressed feeling guilty for causing extra work or disturbing staff. Needing help to seal up an old wound, caused a participant to dismiss herself from BA as she could not face having caused that much fuss. They felt embarrassed, describing themselves in terms of being strange, ill-functioning, difficult and uncomfortable.

> To be well enough to be able to take the initiative to ask for help. I guess that is the uncomfortable issue. (I2)

Participants talked about struggling to believe in their own ability to handle the responsibilities of BA. Having control sometimes made participants feel unguarded and unsafe, since admissions used to be a way of blocking self-harm by being locked in and controlled. Being able to leave the ward at any time and independently of current state of mood could result in feelings of BA as being pointless.

Facing failures and setbacks

Participants shared stories of having prepared for BA, such as organizing care for their dog and planning the journey to the ward, and then at times being rejected self-admission because the ward was full. This was tough to face since preparing for self-admittance demanded energy in situations of already being very tired. Also, having to explain yet another admission to a worried family member, who equated BA with acute care, could appear daunting. Therefore, it had happened that participants ended up self-admitting too late or not at all.

> If I am too sick, it will be like the same thing as staying at home, if I am just lying in my room all the time anyway and I get to go outside as much as I want. (I4)

Participants expressed how using BA or seeking acute admission was a difficult balancing act. The opportunity to use BA preventively was at times ruled out because of rapidly arising anxiety. Furthermore, understanding of their acute needs in the moment had occasionally been lost in staff's eagerness to implement BA as a crisis-management tool. Participants shared experiences of being rejected at the emergency unit because of having access to BA, as well as being persuaded to stay when wanting to interrupt BA to seek acute admission.

> At one point, I was assessed at the psychiatric emergency unit after a moderate self-harm episode. I had cut open veins in my leg and swallowed a scalpel. At that time, I was in such bad shape that I wished to be regularly admitted. I didn't tell the doctor, though, because I was afraid that he would think that I exaggerated. The doctor chose to let me go home, with the motivation that I had a place on BA that I was supposed to use first and foremost. (I2)

> At some point when I felt like I could not take care of my own medication, I have said that I needed to seek emergency care. And then they might have told me "no, you should think positive, and let's try this" and so on. And then I have ended up overdosing. And then you feel like, "yes, but I did tell you beforehand". Like, "listen to me". They are ignoring me saying that I can handle it. It is, in a way, both condescending and disabling, or perhaps not disabling, but you do feel a bit ridiculed. And not taken seriously. (I4)

Shaped by past experiences of coercion, participants were sensitive toward rigidity due to the frames of BA such as being denied over-the-counter pills against headache, refused help to dress a wound or not being given a toothbrush if forgotten, with reference to the responsibility of bringing personal items. Participants had perceived unnecessary exercise of power from staff in situations where they thought it would have been reasonable to make exceptions. Participants had also experienced that staff themselves sometimes did not follow the contract.

> I am unable to ask for help when I need it, because I am, like, out of it. And then it has been part of the contract that they are supposed to check on me. But if they don't, then I might just as well lie around at home and be out of it. (I5)

Participants had sometimes perceived a harshness from staff unfit with the compassion-focused set-up of BA. Although recognizing that allowing for flexibility may be challenging in a method based on predictability and structure, participants expressed that sticking to the general rules, while being open to exceptions or at least justification should be possible. Otherwise they felt that they would end up relying on emergency care if not being able to adjust to BA *exactly*.

Being located in an emergency setting

The setting of BA offered in a ward together with patients receiving psychiatric emergency care was demanding. Using

BA to resist one's urge to self-harm was challenging when being exposed to actions of self-harming others, such as seeing a co-patient repeatedly throw cups in the day room to cut themselves with the broken pieces.

> I was on my way out for a smoke and there had been some kind of incident. So, there were traces of blood all over the floor and it stirred up a lot of memories. And then I had to go back to my room and wait until they had cleaned it up. You are in the mix with people who are feeling so bad that it might trigger negative thoughts in you. (I6)

They had struggled not to take part in precarious conversations with others who approached them, while overhearing how depth of cuts were compared and stitches counted.

> If you lump together a lot of self-harm-girls and -boys, then depending on what type of patient they are, it turns into a competition of who did the most. (I4)

Being less sick compared to co-patients in an acute environment was challenging. Participants were torn between understanding staff's need to attend to acute situations and their own rightful expectations to be attended to and have their contract fulfilled. Still, participants felt hurt when staff abruptly left and recommended having BA separated from acute admissions.

> If you ask for a conversation and then the alarm goes off from another room. Then everybody runs there. No one stays to finish the conversation; everyone must go there. And then it's like "okay, here I have been preparing myself and then this happens". It is no fun. You feel kind of small. (I7)

Returning to a ward on BA, where most of them had stayed as emergency patients before, was done with mixed emotions. Traumatic memories of mandated measures, such as restraints or having medication administered against their will, could make them hesitant toward seeking BA. In some cases, this required special measures, such as self-admitting just for practice or trying BA at different hospital. In one case any kind of psychiatric admission including BA became impossible due to the hospital environment triggering anxiety.

Resting and recharging

Participants described BA as an opportunity to combine short-term recovery with work on self-development. Key components were the opportunity to rest and to connect with others.

Getting a respite

Participants referred to BA as a brief therapeutic break from stressful situations. Within a few hours from calling, they could access a safe place to manage stress, racing thoughts or isolation. They expressed that BA offered predictability by being available regardless of whether they were using it often or seldom, a year ago or yesterday.

> Whatever happens within you or out there, this is like a stable place. Like, it becomes easier to … manage life, when you can take a break at times and come back to something that you know is always there. (I7)

Participants perceived that BA had prevented them from self-harming and attempting suicide. However, treatment against self-harm was not perceived as the primary objective of BA. Rather, the role of BA was to fulfill basic needs by providing "rest from real life" (I3) by letting go of daily duties or excessive thinking to do something relaxing, or just sleep.

> The healing is, first and foremost, not having to deal with everyday things. Not having to do the dishes, clean, cook, do laundry, go to work. To get to just be. To sink down and listen to some good music or read a book, or in my case, I do a lot of crafting. To allow yourself to do those things instead of all the requirements of everyday life. I guess that's what I mean by taking a break from everyday life. (I6)

The 3-day-limitation of BA served as a relieving guarantee against prolonged admission and the 9 days per month maximum was perceived as generous. Although, BA at times had turned out to be too limited, participants found BA to offer well enough time—in time.

> It has been good for me to have three days. On the first day when you seek [help] it is very stressful, on the second day I am a bit more down to earth and on the third day I feel like "okay, now it is okay to go home again". (I6)

Participants attributed BA to the improvement in their well-being, which helped them avoid escalating into self-harm. They perceived that BA had prevented other, longer, psychiatric admissions and supported ongoing treatments, such as DBT.

> Despite some complications, it has truly helped me. You know, it takes a while before you get better. And so, to have had BA at that department where it has worked, has been important for me to be able to move on. (I5)

Communicating with others

Participants stressed the value of BA as a place to tackle loneliness and isolation. Being together and sharing burdens with others, including co-patients with similar problems was said to be the core of BA. Thereby, times of crisis could be endured, moment by moment.

> To have someone to talk to twice a day about emotions and situations that arise. To be able to ventilate those things. Not having to carry it all by yourself. (I6)

Participants shared stories of how the challenges of mixing BA with acute admissions had been handled professionally by staff who had prevented them from self-harming by being attentive to their needs. A precise response like "in twenty minutes" to an appeal for help, could make participants persevere while staff attended to others. With the pre-booked daily meetings with staff participants sensed that they did not have to worry about ever being noticed. During those brief checkups of how things were here-and-now they could express needs so that staff could adapt accordingly. Sharing feelings with someone who listened with presence reduced anxiety, dwelling and withdrawal from others.

> Someone who listens and kind of checks on you and asks how it's going. I guess, it's just like what you do with your loved

> ones. You ask how it's going, what happened, and how they feel and so on. Then, at least, you feel a little bit seen. (I7)

All participants expressed close contact and trust with one or several professionals involved in their outpatient or inpatient care, some of which had lasted for more than a decade. However, being highly dependent on established relations with staff was perceived as shameful and problematic in relation to BA. Participants shared stories of deciding at the last minute not to self-admit, because an unknown person from staff answered when they called. Being familiar with staff when arriving at the ward was perceived as very valuable and important.

> The last few times that I have been admitted for a BA, the intake conversation has been led by the same nurse. That alone has been very positive. Because you don't need to explain or go over the same things again and again, something you might experience as a patient. I don't need to because she knows me, like, she knows who I am, she knows of my problems and wishes. (I1)

The social network around participants varied widely from very close contacts and involvement of partner or family to isolation and hiding of treatment and self-harm. Participants' complexity of problems had put close and important relationships at risk. With access to BA they had experienced being more open to advice from relatives about seeking help when approaching crisis. This, in turn, had made them feel less of a burden to loved ones.

> At some point, we have been in a tremendous crisis and talked about separating. And then it has been much, much harder. But when things are stable at home, it gets a little easier. And then you feel supported and you feel loved, and then I can also listen when my partner says that 'now I think you should be admitted for a while, so that you can get some air and breathe. (I1)

Developing self-care and consideration

Absorbing the full potential of BA to achieve individual goals was a learning process. Participants had experienced developing self-compassion and insight through small steps of practicing the method and gradually refining the contract to fit their needs.

> It is stated in the contract that if staff experiences or notices that I am not feeling well, then they are not allowed to stop me, however they are supposed to advise me to stay at the ward. And being aware of that is a positive thing for me, it is good that I know it. Because when I feel like that, like I said, I can't think clearly, and I might hurt myself. (I1)

Combining BA with therapy was perceived as promising, supporting participants during demanding therapies like DBT and PTSD-treatment. Participants emphasized the importance of staying proactive as well as realistic in relation to replacing other treatment with BA, saying that BA could replace some but not all admissions.

> Like, it is helpful concerning self-harm and suicide attempts. Then it is helpful. But it is difficult to ameliorate my eating disorder with this form of care. (I7)

Participants described BA as the halfway option to use when being unable to stay at home, while still not needing or wanting to be locked in or medically cared for. BA was allowing for a certain level of disability while promoting development of self-care. Support from outpatient care contacts was perceived as valuable to be able to self-admit in time.

> My physician is intimately familiar with BA. And so, she encourages me to use it. And says that I should use it as much as possible and not wait. So, I feel a sense of trust and I feel supported from the physicians' side also, regarding BA. (I1)

Participants perceived that BA contributed to a change of focus from something quite narrow and internal to a wider perspective. Despite not having bags or personal items checked at arrival, they resisted bringing dangerous items to the ward, to protect other individuals from harming themselves. Because of the focus on responsibility and consideration, they had sensed that BA contributed to distancing the person from the problem, potentially improving attitudes toward those with self-harming behavior.

> BA is very much about being considerate of other human beings, and also very much about being considerate of yourself. (I6)

Participants struggled to phrase why they tended not to self-harm during BA despite still feeling the urge to do so. They talked about realizing that their own will was the driver of self-harm, and not the level of protection or limitation. To be given trust and responsibility had made them think twice before acting on destructive thoughts.

> At a ward, there are always objects available that could be used for self-harm. You just have to be creative enough. But seeking BA feels like stepping away from harming yourself. Even if the urge still remains in you. (I6)

Comprehensive understanding

Interviews with individuals with severe self-harming behavior and a history of extensive psychiatric inpatient care revealed potential meanings of access to BA related to feeling worthy of rest and recharge during stressful circumstances when approaching crisis. To widen the understanding of the naïve first impression, findings were reflected upon in relation to ideas appearing to be congruent with the interview texts. Overall, access to BA alongside usual treatment appeared to have contributed to a shift toward a more patient-sensitive, comprehensive, and responsive care. Several aspects were in line with the concepts of person-centred care (Munthe et al., 2012; Price, 2006), recovery-based psychiatric nursing (Barker, 2001; Barker & Buchanan-Barker, 2010) and human rights. Charters such as the United Nations Convention on the Rights of Persons with Disabilities adopted in 2006 (UN Department of Economic & Social Affairs Disability, 2016) and promoted in the World Health Organization's comprehensive mental health action plan (WHO, 2013) reflect these values. These interdependent and interconnected ideas evolve around the basic principles of compassion, dignity, and respect in self-harm treatment (NICE, 2011; The Swedish National Self-Injury Project, 2016), as is illustrated in Figure 1.

Figure 1. Interrelated perspectives of the meaning of BA.

BA was experienced to provide an option to prevent a vicious cycle of gradually losing control when approaching crisis. In prior help-seeking attempts, this group of severely ill individuals had feared rejection and struggled to convince gatekeepers of the need for acute admission, in their efforts to prevent from further self-harm. These struggles had often ended in long psychiatric admissions in which participants described being completely taken over by a system of control and protection primarily focused upon keeping them alive. Decision-making power to self-admit for crisis management, made appropriate care accessible, so that a further worsening state of health could be prevented. Also, avoiding being pushed over the edge, potentially reduced the strain on important social relationships. This implies a compassionate and respectful move toward empowerment very close to the ideas behind the recovery-based Tidal model of psychiatric nursing (Barker, 1999; Barker, 2001). The Tidal model emphasizes empowerment of people to lead their own recovery rather than being directed by professionals. It is based on a basic belief in patient involvement also when approaching crisis with reference to each individual's own ability to know their needs, and on the value of offering needed support without requiring an explanation (Barker, 2001; Barker & Buchanan-Barker, 2010).

The ability to individualize the intervention with regular renegotiations and refinement of the contract based on personal wishes and needs fits with the idea of continuity within a person-centred approach, where problem-solving is an ongoing multidimensional process requiring interaction and reinterpretation over time (Munthe et al., 2012; Price, 2006). It is also in line with the Tidal model of providing individually tailored care in a respectful and flexible approach (Barker, 2001; Barker & Buchanan-Barker, 2010). Allowing for a certain level of disability, while serving as a brief break from stress to manage life and connect with others was perceived to gradually facilitate the development of self-care and consideration. This notion is also supported by other findings indicating that recovery in relation to self-harm is a personal and prolonged learning process consisting of finding alternatives to self-harm, having basic physical needs fulfilled and learning to welcome and receive support from others (Tofthagen et al., 2017).

Results of the study highlight the complexity of person-centred care concepts, such as autonomy, shared decision making and collaboration (Munthe et al., 2012). The participants in this study struggled with deep feelings related to self-criticism, low self-esteem and shame, known to be associated with and even induced by self-harm behavior (Daly & Willoughby, 2019; Forrester et al., 2017; Gilbert et al., 2010). Avoidance had sometimes prohibited individuals from trusting in their own ability and right to use BA proactively, which had resulted in seeking BA too late. Experiences of being perceived as manipulative and less deserving of care are known main issues upholding stigma against individuals with symptoms of personality disorder which will typically create avoidance and delay in help-seeking behavior (Knaak et al., 2017). On a general note, according to the UN Human Rights Council (2018), stigma within mental healthcare needs to be prevented so that existing barriers to care are not worsened. Indeed, the participants in this study shared a history of having faced attitudinal barriers during help-seeking and care. The ability to communicate needs and wants, which is a key component in a person-centred approach (Munthe et al., 2012), was impaired from a history of not being heard or met with consideration and recognition in prior help-seeking.

Findings confirm the importance of attitudes and knowledge among staff, which was also recognized from experiences of BA during the implementation phase of BASRCT (Helleman et al., 2018). Benefits of the structure and predictability of BA, including brief pre-booked supportive meetings, became effective through the supporting attitudes and actions from the staff. For this group of severely ill individuals, relationships were very helpful when existing and sometimes a hurdle when lacking. Experiencing encouragement and understanding was crucial in the efforts to learn early help-seeking. Perceptions of having individual needs considered not only in relation to BA, but in relation to all options, is parallel to how the Tidal practitioner is to enable people to 'get going again' by assisting them in identifying and describing personal issues and difficulties (Barker & Buchanan-Barker, 2010). Findings point toward the significance of qualities recognized within person-centred care, such as staff acting with presence, while balancing flexibility with consistency and integrating the task-based with the relational (Edvardsson, 2015). In other words, this implies benefits of staff demonstrating good situational awareness; a combination of social and cognitive skills related to the perception and comprehension of the current situation, which may be used to anticipate proper action (Stubbings et al., 2012). In relation to experiences of BA in the present study this could consist of an individual from staff being highly attentive to participants' needs in critical situations, such as remaining present during a stressful triggering situation or taking a few seconds to provide a well-needed precise response before tending to an emergency. Participants had experienced how staff reactions provided in the right moment had prevented them from destructive behaviors. This supports the idea of a pragmatic and flexible approach for recovery (Barker & Buchanan-Barker, 2010) and of autonomy-building as a complex process depending on support

from caregivers (Munthe et al., 2012). Participants brought forward examples where they were convinced that failure during BA could have been prevented had staff been more attentive to their behaviors and more supportive of their expressed needs. Being able to trust staff to follow the contract was important for the contract to serve as a placeholder for participants' own stable voice when absent. This in turn would potentially reduce the dependency on existing relationships with staff and further support the quality of the contact with staff; a known key aspect of BA (Helleman et al., 2014).

Being allowed to try, learn from mistakes, and demonstrate progress in the ability to handle responsible autonomy was perceived to promote a highly needed positive image for this group. Hence, BA may be a potentially innovative strategy of using empowerment to reduce the risk of facing stigma in mental health, which is also suggested by the UN Human Rights Council (2018). Interestingly, patients' worries about seeking BA too early may be compared to perspectives among psychiatric staff of how crisis management with BA becomes effective through individual stepwise learning in a trial-and-error approach (Lindkvist et al., 2019). Mixing BA with acute admissions was a challenge for patients on BA when they found themselves to be relatively stable compared to other admitted patients. This resulted in worries about irritating others, feelings of guilt for causing work and doubt regarding the right to use BA to take up space at the ward for preventive purposes. This relates to the underlying assumption of a needs-based system where giving access to self-admission for prevention may seem unfair and unethical as fellow patients in worse conditions are subject to gatekeeping and limited control (Strand & Sjöstrand, 2019).

Experiences of BA as a substitute and complement to other treatment, including long admissions with perceived coercion, supports the notion of beneficial outcomes of being given voice and influence within a collaborative strategy (Masters, 2018). In line with conclusions of other studies on psychiatric self-referral models for patients with complex mental illness and a history of psychiatric admissions (see for example Moljord et al., 2017; Strand et al., 2015; Thomsen et al., 2018) there is a need to further study the value of increased patient satisfaction. This is consistent with the recommendations from the UN Human Rights Council (2018) on 'Mental health and human rights' stressing the need for approaches which restore and center around the voices and rights of persons with mental health issues.

Methodological considerations

All eligible participants were invited to participate, which due to criteria regarding severity of illness and more than 180 days of psychiatric admission prior to access to BA, was limited to only eleven individuals. Importantly, the seven participants who volunteered openly shared experiences in a way that resulted in rich data, despite a small sample.

The clinical trial on BA provided a rare opportunity to uncover experiences before the method was generally implemented (Westling et al., 2019). However, some experiences of perceived rigidity may be related to the strict manual necessary to follow in an RCT and minor changes and adaptations have occurred in the implementation that followed the trial. BA has, for example, been parted from other types of admission in separate BA wards at two of the included psychiatric clinics.

With respect to transferability, the context of Swedish mental health care is limiting. Eligible participants were recruited from three of the four hospitals offering BA in the Skåne region, ensuring findings to be related to BA as a method rather than to a certain nurse, ward or hospital.

To reduce the risk of subjective perspectives influencing results, two researchers (R-ML and KL) were involved in the analysis and discussed interpretations until consensus was reached (Graneheim et al., 2017). For credibility, the voices of the participants were aimed to be heard, supported by examples of representative citations in the structural analysis. The translation of all quotes from Swedish to English was reviewed by an individual fluent in both Swedish and English.

Conclusions and implications

The essential meaning of being able to self-admit to BA evolved around being worthy of support to control an approaching crisis. Human connection and the quality of responsiveness among staff had strong mediating effects on the perceived outcome. Results imply potential benefits of enhancing the use of participants' apparent self-knowledge in the written contract, to further strengthen the voice of the user and assist psychiatric nursing staff to provide care in the best possible way.

Increased autonomy was perceived to potentially substitute medical decision-making at times when these were not beneficial or necessary. Hence, the framework of BA may well be part of the needed shift from a medical model of disability to a social model focusing on overcoming barriers to equality with a respectful, predictable and balanced human rights-based crisis management (Sugiura et al., 2020). Future studies may focus on aspects on equity and efficiency of allocating psychiatric resources to BA to develop self-care for selected vulnerable groups within a broader needs-based system.

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Author contributions

Study design: R-ML, SW, SL and KL. Data analysis: R-ML and KL. Manuscript preparation: R-ML, SW, SL and KL.

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