Portfolio Volume 1: Major Research Project

A Speculative Design Study to Reimagine Crisis Care

Madeleine Kelly

21064528

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Abstract

Background

Compulsory inpatient care within the UK is subject to numerous critiques, relating to lack of safety and over-representation of people from the Global Majority. Numerous studies have understandably focused on service user experience, but few have looked at service users' recommendations for change. Since the establishment of the first recorded asylum in 1403, there have been numerous challenges and evolutions in crisis care, notably through the anti-psychiatry movement, the early psychiatric survivor movement and deinstitutionalisation. Current alternatives to inpatient care include crisis houses, Open Dialogue and the Soteria Network. Current research and policy rarely focus on recommendations outside of the arena of mental health, despite acknowledgements that many of the root causes are socio-political. Inspired by bell hook's love ethic, and utilising tenants from speculative design, this research seeks to explore how inpatient care can be reimagined, if human flourishing was the principle organising factor.

Methodology

This study has used a speculative design methodology, underpinned by a standpoint epistemology; with 13 participants taking part in three focus groups each. The participants were divided into two groups, seven in a staff group, and six in a service user group.

Findings

Reflexive Thematic Analysis was used to analyse the results, resulting in four themes; 'Conceptualising Crisis Care,' 'Glimmers of Imagination,' 'Barriers to Imagination and Change' and 'Societal Transformation.' Participants described their understandings of crisis, exploring the societal narratives around madness and how these influenced crisis care. They spoke to the power of imagination, and explored imaginative alternatives to care currently. However, participants also noted many barriers to the process of imagination and discussed the impact of institutional cultures, dominant financial discourses, power, the challenges of reimagining something that already exists, all resulting in a sense of stuckness and fatigue. Participants explored what could happen to move beyond this point highlighting the need for societal shifts in our understanding of madness, facilitated by meaningful connection with others.

Conclusion

The research points to the impact of bureaucratic systems on the ability to provide care, the machinations of disciplinary power and the challenges with recreating pre-existing systems. It highlights the need to focus upon and develop working utopias in response to harmful systems, alongside facilitating ways in which mad wisdoms can be shared and upheld.

Key Terms

Table 1 *Notes on Language*

Term	**Explanation**
Crisis Care	Crisis care is an expansive term that can be understood in a number of ways. NHS England, (n.d.) refers to crisis care as a broad range of services encompassing home treatment teams, crisis phonelines, mental health liaison teams in emergency departments, police and ambulance response, crisis alternatives (crisis cafes, safe havens, crisis houses) and inpatient services. Primarily, this thesis is focused upon crisis care as it occurs under Section 2 or Section 3 of the Mental Health Act (1983 c.20). However, crisis care can also be taken to mean what an individual might need when they are in crisis, and this additional understanding is also explored with participants of the research.
Madness	I have chosen to refer to madness in opposition to the biomedical phrasing of ‘mental illness’ or ‘mental disorder.’ In using the term madness, I hope to highlight the contradictions of medically coded terminology, which offer a veneer of certainty or scientific validity. In light of this, medicalised terms will be placed in quotation marks. How I have understood madness, and how I will be using it in this thesis, is as an expansive and shifting category. I acknowledge both madness and mental illness/disorder are loaded and disputed terms, and not every person who has experienced madness may identify with the term.
Mental Health Act [MHA]	The MHA (1983) is a piece of legislation that relates specifically to the assessment, treatments and rights of people experiencing acute mental health crisis.
Section 2	This term refers to Section 2 of the MHA (1983). This is an “admission for assessment" (MHA, 1983 s.2 (2)) which enables a person to be detained for up to 28 days whilst being assessed.
Section 3	This term refers to Section 3 of the MHA (1983). This is an “admission for treatment” (MHA, 1983, s.3 (2)), which enables a person to be detained

for up to six months. This can be renewed by another six months, and after that by a year.

CHAPTER ONE: INTRODCUTION

1.1 Chapter Overview

This chapter explores the context of the research. To do this, I[1] first explain the epistemological position I am taking for the research, alongside my connection to it. Then I look at the current context of crisis care within the UK, considering the background, evolution, and challenges of inpatient care. The section concludes by thinking about how we can reorientate the discussion around crisis care, and how speculative models might support this.

1.2 Epistemological and Personal Position

Everything you touch you change. All that you change changes you.

Butler (1993)

1.2.1 Epistemology

Epistemology refers to the study of knowledge and how we acquire it, or more simply- how we know what we know (Crotty, 1998). In my research, I sought to have discussions about alternatives to compulsory inpatient settings, and the context that would allow those alternatives to exist with those who experienced compulsory inpatient settings (service users [SU]), and those who worked within them (staff). In doing this, I chose standpoint epistemology (Collins, 2000; Haraway, 1988), which ties understanding both to social identity and proximity to experience.

This approach is in opposition to positivism. Collins, (2000, p.253) draws attention to the "Eurocentric knowledge validation process," underlining the verification of knowledge claims is not separate from the politics and context in which claims are made. Therefore, claims that uphold or reinforce the narrative of those arbitrating are more likely to be validated, resulting in epistemic injustice (Fricker, 2007) by which certain knowers are dismissed due to prejudices relating to the validity of their knowledge claims. The concept of researcher neutrality has also been drawn into question, with Smith (2016) positing that the notion of the impartial observer rests on a false western idea that an individual can be successfully decontextualised. She argues this leads the researcher to believe that due to their distance and separation from the so called 'object' of their study, they will neither influence them nor be influenced by them.

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[1] I have made a conscious choice to write in the first person. Given years of academic training instructing me otherwise it has felt somewhat unusual to talk about "I" in this context. However, in line my epistemological stance, it feels important to highlight that there is an I behind this research, and at every stage I made choices about what to include and not include, based on my own beliefs, judgements and assumptions. These are informed by my standpoint, and therefore I hope to remind the reader, with every "I" and "my" that my research does not, and could not, come from a point of neutrality.

My understanding of standpoint epistemology comes predominantly from Black feminist theory (Collins, 1990; hooks, 2014; Lorde, 2017), and its subsequent influence within disability justice theory (Ben-Moshe, 2020; Piepzna-Samarasinha, 2018; Sebatindira, 2023) and Mad Studies (Bruce, 2017; LeFrançois et al., 2013). Central to this epistemology is a critical focus on power and the structures that maintain it. Standpoint epistemology does not dismiss the idea of objective truth; it just critiques positivism's understanding of how it is obtained. It highlights the unique vantagepoint of those at the margins (hooks, 2014) to understand how power operates, and envisage alternatives.

This position aligns with my research goals of asking those who have lived experiences of systemic injustice to give their perspectives on what needs to change to ensure they receive the care they need in crisis. I feel this lens lends a vocabulary to talk about the potential differences in perspective and solutions provided by the SU and staff groups, as well as examining shared experiences of mechanisms of the power to which they are both subjected.

1.2.2 Reflexivity

Reflexivity refers to the positioning of a researcher in the context of others, and how their own standpoint will necessarily impact the research process and outcome. While reflexivity is often referred to as a tool to increase the rigor or validity of research (Jootun et al., 2009), there are some conflicts with this framing. If we understand reflexivity as a tool which enables us to quantify and contain the degree to which the researcher influences the study, we fall into the trap of believing there is such a thing as 'pure' data. As a researcher, while I view it important to attempt to describe my own standpoint (variable as it is), this in no way removes the influence it has on the research, nor will it allow the reader to do so either. Instead, Pillow, (2003) suggests researchers endeavour to adopt "reflexivities of discomfort" in which reflexivity is used as a tool to critique the notion of 'truths' with an acknowledgement that the construction of knowledge is always imperfect. Reflexivity can be a method in which we remain "vigilant about our practices" (Spivak, quoted in Pillow, 2003 p.177), acknowledging where our knowledge ends and how and when our practices might marginalize and exclude (Bolton & Delderfield, 2018). As part of my own process throughout the research, I used a reflective journal to support this 'vigilance' and critical reflection relating to my own subjectivity, especially where I noticed my own views were different to my interviewees or research team.

1.2.3 My Relationship to this Research

This project developed in response to my increasingly ambivalent relationship to the psychology profession. My starting point in the profession stemmed from my love of people and my desire to work towards a kinder world. However, the further I wade into the profession, the more I wonder about the profession's ability to be the thing that enables me to do this, given its racist, (hetero)sexist, ableist, and classist origins and its (and by extension my) continued role in upholding and entrenching these inequalities.

As a white, middle-class, able-bodied person, I was able to remain naïve to many of the ways in which psychology has, and is, causing harms. While through my own experiences of mental health distress, therapists, and voluntary admission for inpatient treatment, I sometimes found these systems frustrating, inefficient, and ineffective, I never experienced them as harmful. They were designed with people like me in mind. It is only through becoming increasingly politically engaged; through reading, dialogue with friends and working with those who have been harmed by these systems, that I have begun to increase my awareness of these inequalities.

I wanted to make sure any research I undertook moved away from an individualising narrative of mental health distress. In my understanding, the impact of structures outside of individuals (racism, (hetro)sexism, cisgenderism, capitalism, ableism) cannot be removed from individual or community expressions of distress. I chose to focus my study on inpatient care because I believe this is where psychology is at its most carceral, and where the workings of power are most concentrated. I also feel that those most exposed to these systems will have the clearest insights into the workings of this power, will already be thinking of alternative solutions, and because as Sebatindira, (2023 p.91) states, "we begin at the margins precisely because the marginal often finds a way of concerning everyone."

In deciding on a research project, I was wary of taking extractive accounts of systematic oppression. While understanding the impact of systems is important, I am suspect of the need to repeatedly 'prove' what is wrong for change to occur, and the implicit requirement for people who have been marginalised to perform their pain for others to listen or learn. In the end, I was inspired by the reading that I was doing at the time, which was largely Black feminist and disability justice thinkers, abolitionist texts and science fiction. Although the authors clearly articulated the challenges and inequalities existing at the time of writing and historical context for this, noticeably there was also a prominent focus on what could be. In fact, the need to imagine an alternative was of unequivocal importance. Using this approach felt like a way that I could engage proactively in topics of inequality, while also holding hope for a future in which people are able to receive the care they need.

All of this is to say, the contradiction of my working within mental health systems while also thinking about collective care and liberation is not one which can be ameliorated. It is a necessarily uncomfortable contradiction, and not one that can be resolved by this position statement or my research. However, it is a great privilege to be in the position to think with people who have been negatively affected by discriminatory systems about how they might envisage a better world that meets everyone's needs, and my hope is that reading it encourages others to reflect and be inspired to bring these worlds into being.

1.2.4 Insider Outsider Researcher

The concept of insider and outsider status is a false binary, as how we are positioned and perceived by others differs depending on our context, and is influenced by our social identities, as well as our experiences. In this research, I will have some shared experiences with all the participants taking part in this research, as I am both someone who has lived experience of madness and inpatient treatment, and a mental health professional.

However, even within the similarities there will be differences. Although I have 'lived experience,' Voronka, (2016 p.197) highlights the challenges in a blanket understanding of the term speaking to how "madness lands and is graphed on bodies differently." My experience of madness has been sanitised by the years that distance me from it, and of course my privilege. This is not something that was lost on my participants, and I was aware of being perceived as 'other' by the SU group. I was not at the extreme end of other, but I felt I was being positioned as a researcher first, someone with some experiences of madness second, and mental health professional third.

Within the staff group, I think I felt more aware of my otherness than with SU. I am relatively new to the field of mental health (only three years in the NHS), as most of my career has been spent in advocacy roles in the charity sector, and I have never worked in an inpatient unit. There was no one unifying staff experience, as participants ranged from health care assistant to psychologist. Considering this, there were a range of power differentials at play, from which I, as a trainee clinical psychologist, was not removed. Similarly, while I may have shared professional experience with some staff members, this was also modulated by our relative recourse to privilege.

1.3 Background

1.3.1 Current Landscape

Between 2023 and 2024, 52,458 people were newly detained as inpatients under the MHA (1983), though these numbers are quoted as an underestimate (National Health Service [NHS] England, 2024). Detention under the MHA, also known as being under section or sectioning, refers to when an individual is involuntarily admitted to hospital or an inpatient unit, due to the perception that they are at risk of harming either themselves or someone else. Whilst under section, an individual is prevented from leaving and cannot refuse treatment. The amount of time an individual can be held under the MHA can vary in length; Section 135 refers to an assessment period of between 24-36 hours, while a treatment section (Section 3) can last up to six months.

There are numerous critiques of compulsory detention and treatment of people in crisis, ranging from rights-based critiques (Kelly, 2014; Ogunwale, 2019), to concerns regarding over-representation of people from the Global Majority (Halvorsrud et al, 2018; Nazroo et al, 2020; Singh and Burns, 2006), to lack of safety within services (Care Quality Commission, 2023). As well as criticism from those outside of institutions, research has explored the experiences of those who have been detained in inpatient care, highlighting feelings of not being listened to (Chambers et al, 2014), lack of autonomy (Akther, 2019; Berzins et al., 2020; McGuinness et al., 2018; Walsh & Boyle, 2009; Wyder et al., 2016), lack of dignity and respect (Chambers et al, 2014; Hughes et al, 2009; Oflofsson and Jacobsson, 2001), over-medication (Hughes et al, 2009; Olofsson & Jacobsson, 2001), staffing issues (Berzins et al., 2020; Hughes et al, 2009) and safety concerns (Berzins et al., 2020; Wyder et al., 2016). Understandably, most of the research into SU experience focuses exclusively on their experiences of detention and compulsory treatment, rather than on what changes should take place, leaving the researcher to draw together recommendations for change.

In 2018 an independent review (UK Government, 2018) was conducted into rising rates of detention, concerns around SU experience and disproportionate detention of people from the Global Majority. Following this, a Draft Mental Health Bill (2022) was published to update the MHA. Although the draft bill sought to act upon the 2018 review's recommendations of increasing autonomy, reducing detention, increasing focus on therapeutic benefits of any intervention and individualising care, the Joint Committee Response (2023) questioned the efficacy of the Bill. The Committee questioned the role of reforming legislation "focused on coercive powers rather than patients' rights" (Joint Committee, 2023, p.15), arguing the bill should only act as a stopgap in a wider process of reform. It underlined concerns around lack of resources to meet the Bill's proposed objectives, alongside concerns that provisions to reduce inequalities in mental health care were not sufficiently robust.

The Mental Health Bill 2025 was introduced to build upon the Draft Mental Health Bill (2022). There were notable additions such as ending the use of police cells and prisons as places of safety, including statutory care plans for people detained, introducing a 28-day limit for detention of people with learning disabilities and/or autism (without additional mental health needs), expanding rights of appeal and strengthening detention criteria. However, while the Mental Health Bill 2025 is a crucial step, the dialogue around crisis care, and those who require it, is notably depoliticised.

Recent NHS England (2024) data shows that little has changed since the independent review (UK Government, 2018) as Black British people remain 3.5 times more likely to be detained under the Mental Health Act than their white counterparts. While within the UK people of Global Majority make up 18% of the population (Office for National Statistics, 2022) they make up 30% of people detained (NHS England, 2024). However, there are not just racial inequalities; the data (NHS England 2024) shows how the people from the most deprived areas on the deprivation index (IMD) are around 3.5 times more likely to be detained. While numerous studies acknowledge the impact of socio-economic factors in the development and perpetuation of poor mental health (e.g. Berry et al., 2021; Williams, 2021; Kivimäki, et al., 2020; Ridley et al., 2020; Ventriglio et al., 2021) UK reforms fail to mention them.

1.3.2 Origins of Inpatient Detention in the UK

To detail the history of inpatient detention in the UK is to speak to centuries of evolving thought and shifting ideology relating to madness or 'mental illness.' Madness is an expansive category, and its expressions are ubiquitous to the human condition. For as long as humans have been able to record and detail their experiences, they have spoken of altered states, voice-hearing and emotional distress. However, how we have understood, responded to, and attempted to control it has changed and evolved. To fully document this is beyond the scope of the current study, however a brief overview is provided.

Although Bethlem, the first British asylum, became an institution predominantly housing those labelled 'mad' from 1403 (Andrews et al, 1997), asylums were not commonplace until the nineteenth-century. Pre-enlightenment views of madness were wide-ranging from demonic possession (Ossa-Richardson, 2013) to "divine madness" (Scull, 2016). While a minority of people considered mad were institutionalized in this period, before the eighteenth-century the majority of people in crisis remained within their family environment, or within the community (Porter, 1990; Scull, 1977). The idea of developing a segregated environment for people who fell outside of society's norms (be that due to differences in physical ability, those with learning disabilities, those viewed as 'mad,' unhoused people, or those who committed crimes of survival) was not adopted on a larger scale until the early nineteenth-century (Chapman, 2023). This is not to romanticize the experience of existing outside of society's norms prior to this, nor to overemphasize the level of support received. It is to instead underline that there was no specific systematic discrimination against people termed 'mad.'

The move towards more widescale institutional care, dubbed 'The Great Confinement' by Foucault (1965), has been attributed to Enlightenment Era values and societal shifts brought about due to the emergence of capitalism as the dominant mode of production (Chapman, 2023; Frazer-Carroll, 2023). While Foucault's timelines may be disputed in a UK context (Porter, 1992; Scull, 1977), a number of so-called called 'mad-houses' were opened across the country. However, the number imprisoned within them was still comparatively small. Into the eighteenth-century, conditions within asylums were often dire, with people held in chains, and subject to bloodletting, purging, burning, and piercing to expel the humours perceived to be at the root of individual expressions of madness (Chambers, 2009; Kendler et al, 2022).

The Enlightenment Era brought about a valorisation of logic and reason, positioning madness as their antithesis. As the Industrial Revolution began, Enlightenment ideals fused with the increased demand for production required by the new capitalist system, prompting a fixation on productivity, further excluding those who were considered 'idle,' or unable to work in the increasingly inhospitable working conditions required (Oliver & Barnes 2012). Some, such as Scull (1977) argue that during this period, not only were those experiencing madness becoming surplus to the demands of capital, but their families also became increasingly unable to care for them given their own stringent working conditions, and emergence of capitalist social relations. Those deemed mad were often sent to workhouses and prisons until the Asylum Act 1845 mandated each county establish and maintain their own asylum, (The National Archives, n.d.) when they were subsequently syphoned off from the working-poor and those deemed 'criminal.' From this point, numbers increased dramatically, from 7,140 people held in public asylums in 1850 to 148,000 in 1954 (Adler-Bolton & Vierkant, 2022, p.63).

‘Moral treatment,’ pioneered by figures such as Philippe Pinel and William Tuke, gave way to psychiatry at the dawn of the twentieth-century. Moral treatment was presented as an alternative to the neglect, unhygienic conditions and physical punishment and restraint of the past, inspired instead by Enlightenment Era values, with the aim of “help[ing] the patient gain enough self-discipline to master his illness” (Digby, 2018 p.53) and regain their supposedly lost reason. This was done though a focus on education, entertainment (drawing, painting, music), and importantly, ‘work therapy,’ so those detained could make a “contribution to the general benefit of the community” (Park & Hamilton, 2010, p.103). Overcrowding and the advent of the bio-medical model led to its demise, though arguably its impact can be felt throughout the subsequent developments in psychiatry and into the present day.

Psychiatry rose to prominence in the twentieth-century as science that sought to categorize and understand the biological world. The human mind, like the animal kingdom and the natural world before it, became something to be studied, mapped, and quantified. The eugenicist Francis Galton’s paradigm of pathology inspired the work of Emil Kraepelin (Chapman, 2023), who developed specific and discrete disease categories for madness (previously an amorphous category). This shift sought to reify ‘mental illness’ as a primarily biological phenomenon, removing expressions of madness from their social and economic context (Esposito & Perez, 2014), therefore “obscur[ing] the social processes that produce and define deviance by locating problems in an individual biology” (Moncrieff, 1997 p. 63). Kraepelin’s work laid the groundworks for the development of the Diagnostic and Statistical Manual (DSM), (American Psychological Association, 1952), seeking to categorize all experience of distress into standardized diagnosable ‘disorders.’ Current iterations of the manual form the bedrock of modern psychiatry, and shape how distress is understood and responded to professionally.

Although these changes occurred outside the asylum, their impact was felt within. Increasingly, madness was analogized with physical health, something that required medical intervention. At a purely linguistic level, the influence of these developments brought about the Mental Treatment Act 1930, introducing a slew of medicalised language, and “lunatics officially became patients, and asylums, mental hospitals.” (Hilton, 2020). At a practical level, ‘treatments’ such as electric shock therapy, lobotomy, and insulin injections were adopted in the early twentieth-century before these were largely usurped by the advent of psychiatric medicine in the mid-century (Frazer-Carroll, 2023).

1.3.3 Alternatives

Alongside developments occurring in crisis care, there were parallel movements relating to alternatives to inpatient detention. These took several forms; from the anti-psychiatry movement and the survivor movement, to deinstitutionalisation, and alternative care models. While it is beyond the scope of this thesis to review this in depth, an overview is discussed below.

1.3.3.1 Anti-Psychiatry Movement.

Given the context of wider social movements pushing towards liberation and human rights (e.g. Black Power, gay rights, women's liberation movements) inpatient care became a key area of focus in the latter part of the twentieth-century. In broad terms, the anti-psychiatry movement provided a critique to the institutionalisation of those deemed mad, and the increasing bio-medicalisation and categorisation of 'mental illness.' The anti-psychiatry movement, the so-called "revolt from above" (Crossley, 2002 p.172), began around the 1960's led primarily by psychiatrists. However, the movement was united neither in politics nor aims. For example, key figures within the movement ranged from the right-wing libertarian Thomas Szasz (Chapman, 2023) to Marxist-influenced Franco Basaglia (Mollica, 1985). While some sought to analyse the way in which power and social control could be exerted through psychiatry (e.g. Foucault, 1965; Goffman, 1961), others were focused upon the specific meaning within expressions of madness, such as schizophrenia (e.g. Laing, 1975)

1.3.3.2 Early Psychiatric Survivor Movement.

Considerable resistance to psychiatry also came from within the psychiatric survivor (those who had lived experience of inpatient detention) population. It seems probable that resistance against inpatient detention has existed as long as there have been facilities that detain those experiencing madness. For example, in 1620, a petition was made to the House of Lords by those detained within Bedlam about their ill-treatment (Cowan et al., 2011). However, by the late twentieth-century there were multiple survivor-led groups and organisations campaigning against overuse of medication, compulsory detention and treatment in the UK. The Scottish Union Of Mental Patients was founded in 1971 by detainees of Hartwood Hospital, Scotland (Gallagher, 2017), followed shortly after by the establishment of the Mental Patient's Union in 1973 at Paddington Day Hospital (Spandler, 2006). A network of unions developed, alongside organisations such as the Manchester People Not Psychiatry/People Need People (1971), Protection of the Rights of Mental Patients in Therapy (1976) which became Campaign Against Psychiatric Oppression (CAPO) (1985), Survivors Speak Out (founded 1986), and the Hearing Voices Network (1988) (Baldwin, 2018; Frazer-Carroll, 2023;

Jackson, 2008; Martin, 2000). Early survivor unions and groups understood care and the context for distress as deeply political, and therefore prioritised collective action and mutual aid, seeking to provide a critique of, and in some cases alternative to, state-based provisions.

1.3.3.3 Deinstitutionalisation.

Foreshadowed by Powell's (1961) Water Tower Speech[2], deinstitutionalisation was the move to close large-scale asylums (largely complete by 1980) and the introduction of a community care model, cemented by the NHS and Community Care Act (UK Government, 1990). While theoretically this was a positive move, in line with many of the aims of the survivor and anti-psychiatry movement, arguably, the way it was operationalised left much to be desired. As the asylums closed, deinstitutionalisation "masked the growing depletion of real services for mental patients" (Sedgwick, 1982, p.216). In part the decision to close asylums was due to mounting public pressure and awareness of institutionalisation (this was due to the movements discussed, but also to press exposes of scandals existing within institutions). It has been argued, however, that a significant factor was cost-cutting and financial reasons (Chapman, 2023; Scull, 1984).

It is not insignificant that a move towards deinstitutionalisation occurred in parallel to the global rise of neo-liberalism. Szasz's approach to anti-psychiatry, centring around his belief in individual responsibility, mental illness as a construction, and view that those experiencing madness "pretend to be disabled by illnesses that do not exist," (Szasz, 2019 p.110) helps to explain some of the ways deinstitutionalisation did not provide the radical transformation many hoped. Given the desire within Thatcher's government to cut public spending and reduce 'dependency' on state services, it is possible to see how Saaz's approach to deinstitutionalisation provided justification for existing policy goals. Instead, those who had previously found themselves within asylums were "moved repeatedly between hospitals, care centres, other local facilities and family homes, as well as within a growing sector of 'for-profit' care" (Ikkos & Bouras, 2021, p.4-5). Equally, compelling arguments have been made for the link to growing prison populations with deinstitutionalisation. For example a study by Wild and collegues, (2022) showed that while NHS psychiatric beds decreased by 93% between 1960 and 2018, the prison population increased 208%. Instead of abolishing psychiatric detention, it appeared that populations were merely dispersed, in a process of "reinstitutionalization."(Wright et al., 2008 p.233).

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[2] Enoch Powell's 1961 Water Tower Speech spoke to a desire to reduce the number of psychiatric beds available, and to close a number of institutions to within a time span of 15 years.

Additionally, while the NHS and Community Care Act 1990 enshrined the involvement of those with lived experience into community care planning, it has been argued that this facilitated the neutralising of more ‘radical’ agendas by absorbing them into the mainstream (Cowan et al., 2011; Wallcraft et al., 2003). Instead of campaigning and building independent networks, ‘SU involvement’ focuses on reforming state services. This process is analogous to the co-option and subsummation of the more radical anti-racism movement into an individualised rights-based agenda (Kundnani, 2023; Shafi & Nagdee, 2022). For both the SU movement and anti-racist campaigners, inclusion into mainstream organisations left them with less power to control their focus, and subsequently people often found themselves redirected from more ‘radical’ aims. Where previously groups might have explored socio-economic roots of struggle, these were depoliticised and redirected to apolitical and procedural processes, such as reducing stigma through awareness trainings or proving the existence of discrimination through bureaucratic reporting procedures.

1.3.3.4 Current UK Alternatives to Inpatient Detention.

There are several current alternatives to compulsory inpatient crisis care in the UK. The legacy of historical approaches, such as attempts to build radical therapeutic communities, like the short-lived Kingsley Hall or Villa 21 (Spandler, 2006), can be seen in current alternatives to inpatient detention. Some examples of these include crisis houses, Open Dialogue [OD], and the Soteria Network. Prioritized in these approaches are several key values; autonomy, limited medicalisation and community.

The promotion of autonomy is ingrained in many of the alternative approaches to inpatient detention. For example, a network of crisis houses exists across the UK, providing a safe space that those in crisis can attend for short periods of time, be supervised and have access to 24/7 support. The overarching aim is that people feel able to identify their need for support and choose to access it - the service is totally voluntary; someone can leave if they want to and will not (with few exceptions) be forcibly medicated or restricted (Sweeney et al., 2014). Although similar in principle, crisis houses can vary greatly in how they are run and the support delivered, from NHS run and managed houses, to those run by independent organisations or charities that may be staffed by volunteers (Mind, 2018). However, spaces for support are limited, and for houses that require professional referral, the threshold can be high and exclusionary of those who might not be accessing mainstream services. Equally, across the board there might be certain expressions of madness which are deemed unsafe for a crisis house, particularly where risk to others may be (perceived) to be high, or if someone is managing their distress using substances in a way that might be a risk to themselves or others (Howard et al., 2010; Sweeney et al., 2014).

OD is an approach to psychosis conceived in Finland, inspired by systemic family therapy, which seeks to build and strengthen the network of support around an individual (Tribe et al., 2019). Like crisis houses, autonomy is a central theme for OD, as the client is placed at the centre of the decision-making process, with all treatment plans (including medication and diagnosis) developed collaboratively (Haarakangas et al., 2012). OD values the role of community connection, and so the incorporation of a network of support around an individual is essential. Unlike many mainstream approaches which focus on 'treating' the individual in isolation, OD recognises the role those around someone play in aiding (or hindering) their recovery and therefore seeks to work with everyone together, giving equal weight to the opinions of everyone within the network (including medical staff) (Gidugu et al., 2021). A randomized controlled trial of OD in the UK (ODDESSI) is soon to be published, however until then, there are questions relating to how well OD can be scaled to a UK health system (Mosse et al., 2023) which is under resourced. OD requires a radically different approach from the UK status quo, prioritising long-term involvement with clients, as well as being able to respond within 24hours to requests for support (Gidugu et al., 2021). Equally, there are concerns that OD, developed in a single homogeneous region in Finland with significantly more state infrastructure than the UK, may not be well suited to areas where there are higher levels of poverty, trauma or systemic inequalities (Buus et al., 2021; Haarakangas et al., 2012).

Finally, the Soteria Network, although not a current alternative that can be accessed by people in crisis, is an advocacy organisation named after the Soteria House project developed in 1970's California, which was a crisis house promoting the importance of autonomy, limited medication, and community (Balbuena Rivera, 2024; Joseph, 2013). The Network's aims are to promote alternatives to mainstream psychiatric care, and campaign for non-coercive, relational care (Soteria Network, n.d.). They seek to support with "[creating] networks of support for people in their own homes; …. seeking alternatives to coercion; …. co-creating 'coming off medication' groups; …. supporting mental health professionals to avoid medicalization." (Soteria Network, n.d.). While a recent review of the Soteria Network (Yeo et al, 2024) highlighted how the service and architectural design characteristics (the home-like atmosphere), it also noted the issue of long-term funding.

1.3.4 Case For Change: Imagining Alternatives?

Current research and policy focused on improving crisis care rarely makes recommendations for change outside the arena of mental health and current mental health systems and frameworks.

While the UK Parliament Joint Committee (2023, p.22) acknowledge that where mental health policy is reformed without “social care, housing, the criminal justice system and all the other elements of our society…we still have a problem,” these additional elements are rarely foregrounded. Perhaps understandably, policy is restricted by concerns around what seems possible, or reasonable. In this study however, I aimed to take an alternative approach. Inspired by Black feminist, disability justice and abolitionist frameworks, I wanted to think about the interconnectedness of crises in care and crisis more broadly, in economic systems, environmentally, politically. I hoped to understand, if we could dream our wildest dreams, what we would imagine as an alternative, as it should not be outrageous or unrealistic to hope that people experience care that meets their need.

Care is an expansive topic, and in the context of crisis, often thought about in terms of a professional service, a unilateral action from service provider to SU. In setting out her concept of a “love ethic” (hooks, 2016 p.87). hooks (2000, pp.87-88) argues “everyone has the right to be free, to live fully and well” and to do this, we need to embrace a “global vision wherein we see our lives and our fate as intimately connected to those of everyone else on the planet.” hook’s understanding of care is therefore more expansive, suggesting that care might be bi- or even multi-directional in its process.

In the worlds of abolition, disability justice, and Black feminism the focus is not only on the structures that must be destroyed or removed, but also about imagining and rebuilding a world that allows people to live with dignity, safety, autonomy and joy (Aviah Day & McBean, 2022; Hill et al, 2020; Piepzna-Samarasinha, 2018). Within these frameworks, there is a tacit understanding that “the future must be intentionally built, and that it must be built today” (Sebatindira, 2023 p.102) irrespective of how impossible it might seem, because survival is a necessity that depends on a future different from the present. Wilson-Gilmore (Gilroy & Wilson Gilmore, 2020) speaks of the need to “rehearse the future, rehearse the social order coming into being,” invoking a prefigurative politics that involves creating the necessary change within the present. However, part of enacting change relies on the ability to create a vision of a future to work towards, and currently, there is little that explores what this future would look like. Therefore, the purpose of this study is specifically to explore how crisis care could be reconceptualised, and what would need to change societally and structurally for those changes to occur.

1.3.5 Speculative Design

Speculative design originates within the discipline of critical design and is primarily concerned with imagining different futures. While traditional design often seeks fixed solutions, Dunne and

Raby (2013, p. 2) explain speculative design “aims to open up new perspectives on what are sometimes called wicked problems, to create spaces for discussion and debate about alternative ways of being, and to inspire and encourage people’s imaginations to flow freely.” Methodologically amorphous, speculative design seeks to provoke critical dialogue about what we accept as ‘normal’ and ‘how things are’ through a range of imaginative prompts. As Dash N’Dem (quoted in Mitrović et al., 2021, p.25) put it, the goal is to “develop collective strategies to engage people in confronting and rethinking their social reality.” The primary focus of speculative design is to encourage discourse, a helpful tool in the context of re-thinking systems which seem immutable.

1.3.5.1 Case Study: MadLove – A Designer Asylum.

The UK-based artist *the vacuum cleaner*[3] whose work spans across disability justice, environmental justice and direct action, has undertaken a project since 2014 to design an asylum that would provide a positive experience for those within it. Over a series of workshops, *the vacuum cleaner* has asked a range of participants including those within inpatient settings, academics, designers, mental health professionals and those with lived experience of madness to reimagine the asylum. In their workshops, *the vacuum cleaner* prompts participants to draw, build and discuss what an asylum might look, smell, taste, feel, and sound like. Data from these workshops has been compiled over the years and can be viewed online.[4]

1.3.5.2 Challenges with Speculative Design.

While speculative design can offer valuable tools for imagining futures, it is important to consider the impact of who imagines, and how the current world impacts these imaginaries. Speculative design has been critiqued as being a notably white practice (C. N. Harrington et al., 2022). Projects are often situated within institutional contexts, making them inaccessible to the wider public and limiting their reach (Malpas, 2017). When Morrison (quoted in Benjamin, 2024 p. 81) cautions against “all paradises, all utopias are designed by who is not there, by the people who are not allowed in,” she described how most utopias are inherently built to exclude, therefore entrench inequality and injustice. Martins (2014, p.4) expands, stating “ignoring issues of race, class or gender…is surprisingly easy” when futures are imagined by people in positions of privilege. Therefore, we need to understand that dependent on who builds them, utopias are not necessarily inclusive. Instead, we need to be critical and question who a utopia has been designed by and for. Levitas (2013) speaks to how the architecture of the future is explicitly shaped by that of the

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[3] Website can be found at: https://www.thevacuumcleaner.co.uk/

[4] Data accessible at https://www.thevacuumcleaner.co.uk/madlove-data/#data

present, and therefore unless the embedded ideas and ideals within the current society are made explicit, we risk replicating and reproducing the same issues.

Given these possibilities and contradictions of speculative design to provide ways of thinking about alternative futures, the focus of the scoping review is to consider how speculative design can be used to further social justice aims.

CHAPTER TWO: SCOPING REVIEW

2.1 Chapter Overview

This chapter discusses the aims, methods and findings of a scoping review looking at how speculative research methodologies can be used to support social justice aims. Through the review, I identified ways in which, although outside of the discipline of psychology, speculative design methodologies were being used to think about social justice issues.

2.2 Rationale for Scoping Literature Review

Due to the total absence of publications within the psychology discipline discussing or using speculative design methodologies, I decided to undertake a scoping review, as opposed to a systematic literature review. Scoping reviews generally allow for a wider overview of data, which can highlight gaps in research, lending them to emerging fields of research (Munn et al., 2018), in contrast to systematic literature reviews, which are often more specific, seeking to synthesise all pre-existing empirical data available to answer a specific research question (Aromataris & Pearson, 2014; Pollock & Berge, 2018).

Scoping reviews allow for a broader literature inclusion – including case studies, theoretical and opinion pieces found in peer reviewed journals, as well as ‘grey’ literature (Chandna et al., 2019), referring to “information produced outside of traditional publishing and distribution channels.” (Sumon Fraser University Library, 2018). Given speculative design methodologies originate from within the design community, the conventions for articles are different from those within the scientific community. Therefore, it was important to be able to include a wide range of papers from across diverse fields, leading me to conduct a scoping review. This enabled me to capture the breadth of pre-existing thought on the matter and include data, which on account of coming from a range of disciplines, did not conform to the conventions of psychological studies.

2.3 What Else Has Been Done on This Topic?

To my knowledge, limited research has been conducted within the psychology research community using speculative design methodologies, or exploring how speculative design methodologies could be used to advance social justice aims within mental health. While ‘social justice’ is a broad term, I am interested specifically in questions related to equity of human experience, for example: racial equality, capitalism, ableism, and sexism. Whilst social justice is a common theme found in psychological literature, especially in tenants such as liberation psychology (Martín-Baró, 1994; Watkins & Shulman, 2008), arguably discussions of social justice often fall into theoretical think pieces rather than empirical research.

Within the design-sphere, there is a large body of research discussing speculative design. Much of the current research relates to technology (e.g. Auger, 2013; Lukens & DiSalvo, 2012) or human-computer-interaction (e.g. Wong & Khovanskaya, 2018; Zhu et al., 2024). Speculative design is often a-political, using speculation to negotiate challenging dilemmas or pre-empt design malfunctions. However there is a growing number of articles looking at how speculative design methodologies can support utopian or social justice orientated thinking and design. Given the focus of imagining alternative futures, where the 'experiment' is "primarily to construct images of future realities or opportunities in contrast to present realities" (Knutz et al., 2014 p.8.3) it lends itself well to these aims.

2.4 Aims and Research Question

I wanted to explore the pre-existing scope of literature on speculative design methodologies, seeking to understand the reasons why, and ways that people were using these to further social justice aims. Therefore, the guiding research question of this scoping review was:

How have speculative design methodologies been used to contemplate issues relating to social justice?

To answer this, I was interested in the following:

- The rationale for why speculative design methodologies have been chosen
- How speculative design methodologies were used
- The challenges in using speculative design methodologies

2.5 Scoping Review Method

To complete the scoping review, I used the steps outlined in Mak and Thomas (2022) detailed below:

2.5.1 Identifying Research Questions

Developing a research question, I undertook several exploratory literature searches on Google Scholar to understand the landscape of literature about the topic (Arksey & O'Malley, 2005). During this, a decision was reached with my supervisors that I might be best placed to undertake a scoping review due to the nature of available literature. Research questions were then developed in conjunction with my supervisory team and university librarian who assisted in refining the focus of my final questions (Mak & Thomas, 2022).

2.5.2 Identifying Relevant Studies

The next step involved an iterative process to refine and develop my search terms to identify relevant studies. I consulted the university librarian who supported me to refine my search terms (Mak & Thomas, 2022). Table 2 illustrates the search terms used for most of the databases (search terms for J-Store can be seen in Appendix A). While my preliminary searches were on Google Scholar, I tried to look for literature directly from within the scientific community, using Scopus and Medline. However, due to limited responses, I consulted the librarian again to discuss which databases I should use for non-scientific research. JStore, a large social sciences database was chosen because they publish a wider range of journals relating to architecture, futures and design. Finally, I expanded my search to Google Scholar where I had found related articles previously, but not in database searches. Concerns around replicability led me to search Scholar using ‘incognito mode,’ ensuring cookies did not affect my search results *(Google Chrome Help*, n.d.).

Table 2 *Search Strategy*

Medline, Scopus, and Google Scholar Search Terms Example	
1	“speculative design”
2	“social justice”
3	“racial justice”
4	“disability justice”
5	“restorative justice”
6	“transformative justice”
7	“economic justice”
8	“reproductive justice”
9	“structural justice”
10	"distributive justice"
11	"design justice"
12	Or/2-11
13	AND/1,12

Scoping reviews inclusion of grey data (Munn et al., 2018), enabled me to include research papers presented at conferences, theses and dissertations. There was limited empirical research published in peer reviewed journals. However, conference papers and theses provided opportunities to see speculative design methodologies in practice, as they often featured case studies, or detailed original empirical research within them. I also used hand search methods, looking at bibliographies of related articles to identify additional papers.

I developed initial inclusion and exclusion criteria, running a search to see the types of papers available. Through an iterative process and discussions with my supervisors, I further refined my exclusion criteria in response to the types of papers that were coming up. For this specific study, my conception of social justice related to equity of human experience, therefore, I excluded studies that did not focus on human issues. Similarly, while Human Computer Interaction (HCI) and technology plays an important part in speculation, I was interested in HCI and technology only where they could be used to facilitate speculative thought, rather than as ends in themselves. Finally, I found a significant number of papers relating to social justice within education. While undoubtably important, I was more interested in social justice at a societal level, rather than thinking how specific professions could be made more equitable. My supervisors and I then further developed and finetuned additional criteria to ensure I was not unnecessarily excluding or including anything. The final criteria can be seen below:

Table 3 *Scoping Review Inclusion and Exclusion Criteria*

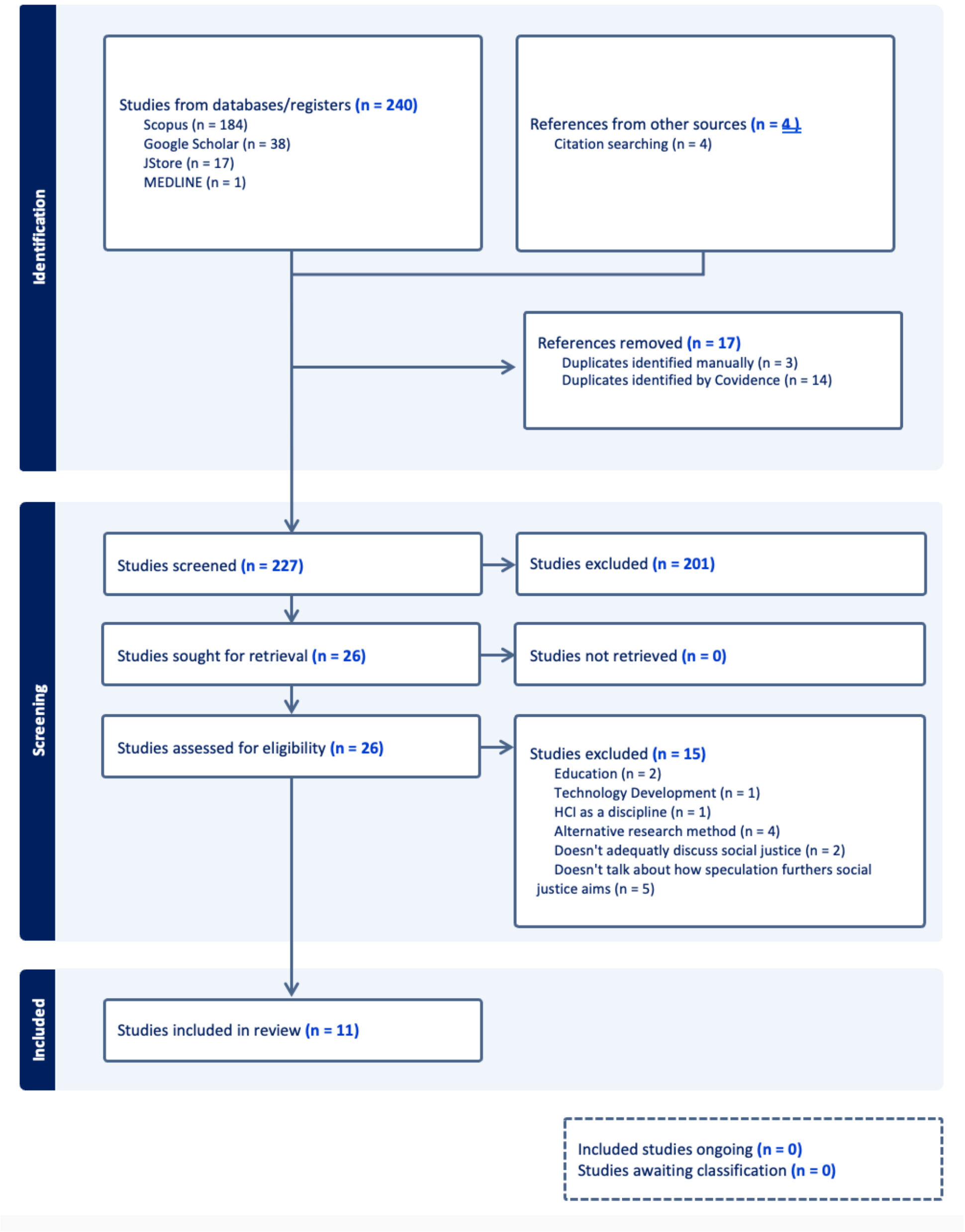
Inclusion	Exclusion
• Case Studies, empirical research, conference papers that featured case studies/practice examples, theses and dissertations	• Panel discussions, systematic literature reviews, bulletins, editorial introductions, book chapters, workshops
• Discusses why speculative design methods (e.g. design fiction, speculative design, design futures) have been chosen	• Development of technology: AI, robots, smart technology, AR, NLP and machine learning, without a focus on social justice
• Speculative design used to further social justice aims	• About HCI as a discipline rather than a tool

• Discusses social justice	• Texts set in exclusively educational contexts/ about education (courses, specific disciplines)/ how design is taught/ solely about improving education • Centres animals or nature • Urban placemaking/architectural focus alone • Focus on sustainability alone • Using literature as a prompt for a theoretical discussion

2.5.3 Selecting Studies

Once I had finalised my search criteria, I searched my four selected databases (Scopus, Medline, JStore and Google Scholar) on 09.11.24 along with four additional hand searched papers. The results were then uploaded to Covidence enabling me to check through and screen my papers according to my eligibility criteria (Mak & Thomas, 2022). I enlisted the support of a second reviewer to ensure I was screening my papers consistently. Overall, we had a 95% concordance rate, suggesting my inclusion/exclusion criteria were clear. Any disagreements we had were resolved through discussion. The process of study selection can be viewed below in the Preferred Reporting Items for Systematic Reviews and Meta-Analysis for scoping reviews (PRISMA-ScR) flow diagram in Figure 1 (Peters et al., 2021).

Figure 1 *PRISMA-ScR Flow Diagram*



2.5.4 Charting the Data

Once the papers had been screened, I began to extract the data needed to answer the research questions, using a table (Mak & Thomas, 2022). The table records information under the following categories; author, year, location, participants, outcome, and limitations/improvements suggested by the author (Mak & Thomas, 2022). Following conversations with my supervisors, and to gather the necessary data to answer my specific research questions, I added categories looking at the type of speculative design methodologies used, justifications for these, solutions they inspired, and challenges using speculative design methodologies.

Table 4 *Data Extraction Table*

Author, Year & Location	Title	Type of Publication	Research Type	Population	Social Justice Aim Approached	Speculative Methods Used	Justification for these methods	Solutions reached/What ideas did people had	Challenges with the methods	Outcome of using speculative methods	Limitations/suggested improvements from author
Bosley, B, Harrington C., Morris, S. and Le Dantec, C (2022) USA	Healing Justice: A Framework for Collective Healing and Well-Being from Systemic Traumas	Conference Paper	Online workshops- Closed Study	10 Black/ African Americans living in Southeast USA	Police Brutality	Afrofuturism and Black Feminism inspired individual and group methods. Introduction of key texts to familiarise participants with ideas. Creative methods and imaginative prompts. Collective workshop followed individual activities, allowing for further group discussion/participants to build on each others ideas	Using these methods allowed for better engagement from communities often excluded from research. Allowed for critical thinking about "wicked problems" like policing. Support to engage with notions of difference, deal with societal and politically minded issues, and find community focused solutions. Move beyond surviving to ideas of flourishing	Led to a range of different ideas and solutions. Thought about systemic issues via defunding police and reallocating the funds to community wellbeing (mental health, jobs, educational services) outside of the government services inspired by Black Pather breakfast programmes. Neighbourhood app to counter surveillance of Black and Brown children. Healing Justice Black party. Non-profit to support those who had experienced police brutality.	Stretch to use the speculative to eradicate police brutality- so far from current reality- too utopian. Prompt relating to how to generate joy following a traumatic incident was disliked by participants. Materials developed to support understanding of concepts like Healing Justice or Afrofuturism were complex, and not concise- inhibited participants ability to access them.	Felt it successfully enabled participants to envision community safety outside of current policing practices, and instead in ways grounded in community safety and healing. Noticed that solutions rarely incorporated joy, and participants owned experiences played a crucial role in shaping what individuals were able to imagine.	Make sure materials are accessible. Don't try and get participants to create/imagine joyful things to counterbalance suffering- participants responded better to thinking about how the suffering could be avoided in the first place
Bray, K.E.; Harrington, C.; Pa	Radical Futures: Supporting Community-Led Design Engagements through an Afrofuturist Speculative Design Toolkit	Conference Paper	Closed Study - online individual interviews	27 Community Design Practitioners	Supporting community members working in historically oppressed communities to support their inclusion in community development and design	"Building Utopias toolkit" - explained different design methods and offered lots of speculative prompts	Spoke about how speculative design can often be white washed, so focusing on Afrofuturist speculative design because of the discussion of race and power dynamics within the desire to push for social change. Allows people to engage with futures that are often constrained by daily realities, and boarded the scope of design. Supports people to think about how they want their communities to be , without there being a correct answer. Supports people to connect with each other and design equitable futures.	Interviewees felt these methods would work well in workshops and to facilitate conversations that spoke to community members hopes for the future. Felt the toolkit would also broaden the lens of designers working with communities.	Challenges with thinking abut the future when the demands of the present exist. People spoke about it feeling like escapism, and the struggle to get community members on board. Future imaginations can get suck in the realities of today. Feeling of responsibility linked to speculative design- speculation without commitment furthers ideas that it is a waste of time/overly idealistic	Enabled people to break out of the trap of what is possible- allowed for generation of new ideas, stoked the imagination of participants, removed the barriers of present expectations and allowed for open conversations. Noted it also enabled people to engage with and incorporate multiple elements of identity into the conversation.	Plain language definitions of concepts on cards were helpful. More prompts in the workbook offering examples- allows for an understanding of the process without strict example
Carey, H. (2023) USA	Social Design Dreaming: Everyday Speculations for Social Change	Journal Article	Online, 8 open workshops	College students, staff, professors	Racial equity in the USA	One workshop introduced idea of long term visions using future-backwards (Cynefin) and 'Thing from the future: (Candy and Watson, 2015). Another workshop was inspired by 'Future Workshop' defined by Jungk and Müllert in 1987 - acknowledging the past, acknowledging how its impacting now, what do we want more/less of, describe a better/ridiculously hopeful worked, summarise in 3 statements, back cast to reveal new perspectives.	Important to have a worldview to work towards. Acknowledgement that current racist worldview has been constructed, so we need space to tell different stories, and build an alternative, not seen in the current normative imagining of the world. Also allows for challenges to status quo.	Range of alternative world views. Thought about development of various organizations promoting change. Discussions about how to create ways for everyone to feel a sense of belonging, challenging harmful societal norms. Involved changes to current societal structure- brought in thoughts about economy and political spheres.	Worried about them feeling too idealistic or disconnected from the work on the ground. Felt there could be pushback. Felt visioning only became powerful when prefiguring used to see how futuring activities could be made tangible	Allowed participants to focus on the creative process. Participants spoke about how helpful it was to reframe thinking about change, and allow in new perspectives, as well as evoking agency in the here and now.	Found that when the breadth of questions was too big, people became overwhelmed- best to limit scope to allow people to become fully engaged, rather than finding stumbling blocks that they are unable to overcome (e.g. global capitalism).

Author, Year & Location	Title	Type of Publication	Research Type	Population	Social Justice Aim Approached	Speculative Methods Used	Justification for these methods	Solutions reached/What ideas did people had	Challenges with the methods	Outcome of using speculative methods	Limitations/suggested improvements from author
Dillahunt, T., Lu, A., and Velazquez, J. (2023) USA	Eliciting Alternative Economic Futures with Working-Class Detroiters: Centering Afrofuturism in Speculative Design	Conference Paper	Closed Study- 5 online workshops	22 Black and Brown Working Class Detroiters	Racially just alternatives to capitalism	Used "Building Utopias" workbook. Spent time introducing speculative design as a concept. Idea of imagining how technology will support the economy in 10/100 years in the past/future. Creative task to envisage utopian and dystopian futures (Who, What, When, Where, Why, and How?). Storyboarding alternative economies and the tools required to manifest them	Argued methods were a way to create space for debate and discussing alternative ways of being. Referred to "visioning" as a crucial part of imagining alternatives as it allows the present to be left behind. Useful tool to critique current design. Felt Afrofuturist lens to speculation would challenge uncritical design approaches.	Three key ideas of community capitalism, childcare collectives and Village Based children. Community capitalism was the idea of an alternative economy where any profits are redirected into the community and individuals own the means of production. Childcare collectives were focused on getting elders involved in looking after children, and incorporating learning about growing and cooking nutritious and culturally appropriate food into education. Village Based Children looked at shared childcare - a village raises a child. Focused one economic issues within this, so idea of coop housing, free childcare, nappies etc. All focused on values of love, care, inclusion and trust.	Discussed how previous studies noticed peoples futuring was limited by the realities of the participants day to day challenges	Particularly helpful for identifying areas that require more political education, community engagement and reflection. Argued that methods supported participants to develop 'futures literacy,' which supports agency in and preparation for changes that might occur and how they might be part of them. By understanding power structures and allowing space to reflect, it allowed for people to explore and work out a number of different options and find alignment in their values.	Suggested that it was important to identify individual values and community strengths prior to considering opportunities for technology to support these. Also recruiting from established organisation where trust had been established with the community.
Gerber, A. (2018) USA	Participatory Speculation: Futures of Public Safety	Conference Paper	Open workshops - in person	Residents of Ferguson USA	Police Brutality/Criminal Justice System/Reimagining Public Safety	In person, various street fairs. One asked people how to keep communities safe without policing. Another asked people how a different system would respond to a number of scenarios that might typically get a police response. Activity with a dice role to describe the future they landed on. Built the three worlds devised in these sessions into a reality	Focus on the use of speculative methods for non-reformist reforms. Argues that reforms often tweak a failing system, so need to totally reimagine- speculative tools allow for this to happen. Spoke about the role of provocation within speculative designs to question the underlying assumptions in the current system. Aims to create debate. Cites the use of imagination in non-western perspectives.	the Future of Public Service (the police are replaced by social workers to check that each person eligible for and receives public services), the Future of Hearts and Minds (religious organisation manage public safety) , and the Future of Grassroots Cooperation (neighbours protect each other) Through recreating the scenes for people to interact with, people engaged with what would be needed to make the scenarios tangible, and it allowed for further critical engagement	Often these techniques don’t succeed because the people with insight not invited to take part/those most effected by the issues less likely to take part - effects what is possible to imagine. Need to incorporate individuals effected to have an impact. Depends on public participation and investment, imagining and enacting systematic change will take along time. Critiques around what imagination can change/purpose of imagining alternatives.	Bringing speculations 'to life' allowed for a greater debate about alternatives. Allowed for multiple understandings of the future to be endowed upon the same object, leading to further discussion.	Lack of financial support meant that is was difficult to organise the public engagement with the project. Also having one designer represent/materialise people's visions reduced the scope as all created within that designers lens/worldview. Important to look at the politics of speculations- who gets to speculate.
Harrington, C and Dillahunt, T (2021) USA	Eliciting Tech Futures Among Black Young Adults: A Case Study of remove Speculative Co-Design	Conference Paper	Online closed six-session workshop series	6 young people at Chicago summer design program	Racially just futures	Developed a design workshop which gave an overview of speculative design. Speculative design prompts via Black Mirror episodes. Envisaging utopian vs dystopian futures. What the world would look like with different technologies developed. Collaborative storyboarding.	Allows people to suspend their disbelief and imagine and speculate freely. Collective speculation allows for people to build on each others views and ideas. Having set speculative probes helpful to prompt peoples imagination. Using Afrofuturistic lens encouraged design decisions to be more inclusive and impactful- broadens the scope and ensures that everyone gets to imagine a future	Three key themes- the need to address social conditions, how the restrictions from COVID would generate a more dystopian future, and concerns that technology development would be used to further police Black and Brown people and prevent social unity	Utopian visions were not absent from existing societal challenges. Techniques developed and practiced largely within privileged groups, so need to explicitly mention impacts of oppression.	Speculative design ideas supported young people to come up with ideas of alternative futures. Allowed space for collaborate discussion and to build on each others ideas. The design workbook was especially helpful as it reduced pressure to respond immediately. However, the authors noted that what Black and brown young people noted as utopian were existing realities for other groups.	Design workbooks are helpful as they scaffolded speculative thinking, and reduced feeling of pressure to people. Designers need to ensure everyone feels able to take part - e.g. in this case Afrofuturist lens allowed for racially minoritised young people to see themselves in the design. Suggested regular breaks within workshops.

Author, Year & Location	Title	Type of Publication	Research Type	Population	Social Justice Aim Approached	Speculative Methods Used	Justification for these methods	Solutions reached/What ideas did people had	Challenges with the methods	Outcome of using speculative methods	Limitations/suggested improvements from author
Lu et al (2024) USA	Contamination, Otherness, and Negotiating Bottom-Up Sociotechnical Imaginaries in Participatory Speculative Design	Conference Paper	Online,5 closed workshops	24 communtiy members from Detriot	Alternative economic systems	Adapted the "Building Utopias" toolkit. Used video clips, card decks and "thing from the future" to support thinking	Felt it allowed for a more complex concideration of the future. Allows for imagination of futures to challenge current oppressive status quo. Enables those effected by discriminatory economic policy to design and benefit from alternatives	Three themes: contaminating individual ideas- the idea that individual ideas become influenced by the others of those in the collective; negotiating visions amoungst alliances - building colelctive visions; weaving and acting upon a collective social technical imaginary - devleoping senarios such as collective child care	Specualtive senarios often devleoped by researchers 'expert' knowlede and thus are lacking relvence from those communities affected by the problem.	Being supported to navigate diffeences of opinion, and also to be introduced to another person's context and expereince through the wolds they generate. Supports bottom-up knowledge generation. Improtance of 'contamination'	Co-create a safe space via refexivity and negotiating norms. Used check ins and debriefs. Take discomfort as a place for growth and learning . Continue learning and contamination beyond the boundaries of the workshop setting.
Noel, L (2022) US	Dreaming Outside the Boxes that Hold Me In: Speculation and Design Thinking as Tools for Hope and Liberation against Oppression	Journal Article	3 separate closed in person workshops. Trinidad: Three weekly workshops. Puerto Rico: Eight weekly hour long workshops. Oakland: 30 minute interactive workshop	Black and Brown young people living in Trinidad (18 between 8-13), Puerto Rico (11 students in 20's) and Oakland California (around 45 teenage boys)	Empowerment of young people who experience marginalisation	All three case studies/sets of workshops used Critical Utopian Design Thinking- asking what is wrong, then utopian dreaming on where they wanted to be, then design that would help them get there.	Critical Utopian Action research allows participants to use an imagined utopia as a way of critiquing the current system. Framed as an emancipatory method allowing people who experience oppression to develop a deeper understanding of the structures around them, and support thinking about how change can be generated. The approach allows for exploration and experimentation. Argued that creating space to dream about a future allows those with identities who are often marginalised to imagine an alternative and change problematic narratives. Hoped it would encourage participants to feel a sense of agency and empowerment to act.	Trinidad: Imagined objects to make life better for people in their village- party buses, robots to help mothers in the home, apps to help bring people together. Puerto Rico: Came up with utopian ideas - Generators that can fly to where they are needed, Glasses that change peoples perspective, medical cyborgs who can provide medical help to those who need it, smart bridges that would notify communities that flooding imminent etc. Oakland- identified problems that effected the community and cocreated list of superpowers they would like to explore.	Critiqued that speculative design methods are often developed by and for white middle-class audiences and fail to depict diverse futures. Sometimes perceived as escapist and unrealistic.	In the Trinidad case study, young people felt their ideas were more listened to, and that they had more control and ownership over their ideas than in normal school. "A focus on utopia opens up the frame for people to dream and imagine without the constraints of the current times... People from underrepresented minorities and oppressed groups, such as Black and Indigenous people, women, and LGBTQ+ communities need imaginative frames from which to imagine futures where they are not oppressed and constrained in the ways they are in the present. Part of the act of liberation is in fact recognizing that one’s oppression is not a perpetual state and transformation is possible"	NA
Jamieson, K and Discepoli, M (2021) Scotland	Exploring Deaf heritage futures through critical design and 'Public Things'	Journal Article	Four collaborative workshops	Mixed- Deaf activists, artists, curators, Deaf historians	Supporting inclusion of Deaf people within the community and uplifting of Deaf culture	Speculative prototyping to develop models that allow for conversation between BSL and English speaking communities. Use of speculative probes and props to get a response from audience members	Role of what if scenarios in allowing resistance to the world as it is currently to surface. Embraces ideas of complexity and encourages multiple perspectives, whist supporting the political complexities and barriers. Use of probes can spark conversations that question he political status quo.	Development of protype Deaf museums, informed by a "Deaf-led activist aesthetic that symbolised oppression and a rejection of an oralist attitude and cultural system" (p.129). Discussed necessity in the telling of Deaf oppression as a significant aspect of Deaf heritage. Created roles/job descriptions for people within organisations who would develop Deaf inclusion	Some Deaf participants initially felt the "deaf merchandise" was demeaning and did not see how a souvenir could develop the conversation around Deaf culture in public life, but with prompting they began to design objects symbolic of Deaf culture or BSL inclusive objects (e.g. greetings cards)	Encouraged dialogue. Facilitated a collaborative process that enabled both Deaf and hearing participants to communicate- allowed for different knowledge forms to be present together. Brought the 'wicked problem' of Deaf Heritage and inclusion to life. Allowed participants to explore possible futures	Potentially challenging having non-signing researchers.

Author, Year & Location	Title	Type of Publication	Research Type	Population	Social Justice Aim Approached	Speculative Methods Used	Justification for these methods	Solutions reached/What ideas did people had	Challenges with the methods	Outcome of using speculative methods	Limitations/suggested improvements from author
Kafer, G (2023) USA	Speculating Surveillant Futures Past- a case study south side speculations project	Journal Article	Workshop format	Chicago based high school students, arts and humanities scholars, and practicing artists and storytellers	Rethinking political systems for social justice	Creating objects that might be found in a near future version of Chicago. Having brainstormed the various issues facing their communities, young people asked to design technology that could intervene/disrupt this. Finally asked to build fictional characters and build a story for them using the technologies they had invented. Use of the Use of Futures cone which looked at participants imaginings in 4 zones: the probable, the plausible, the possible, and the preferable.	Speculative design has often been used as a way to imagine more socially just futures. Opens up dialogue about anti-racist/anti oppressive futures. Allows for a critical alternative to the future to be developed. Suggested that there is a critique of consumerism and commercialism within speculative design as it is used to spark debate rather than solve issues.	Tackled a range of issues from housing to police brutality. Created design objects and short videos of the future technologies that would challenge thee problems. For example Clones and Protective wear that would allow young people to avoid police surveillance systems. Or Community Healing Pair which was a wristband and smart glasses that would allow someone to intervene in police violence, by recording it, and activating something that immobilises the police officer. It also had an inbuilt option for a restorative circle meeting to be established to look at routes to redress.	Highlighted the role of speculation in forecasting and securitization and how it's power can be used to give control over the future. Predictive policing, speculative finance etc. Who gets to speculate, for what purpose and for whom? Felt speculative design needed to emerge from the communities effected in order to support social justice goals	Showed non-linear nature of improvement- futures necessarily need to consider the past. Showed futures are not universal- so shouldn't be flattened to a generic future for all. Young people were able to use speculative design to use the resources of a university to think about legacies of inequality and create a sense of agency in their critical visions of a future.	Young people imagined futures with police brutality- highlighted challenges in creating an alternative future. Highlighted importance on engaging with the material conditions of the participants, as the speculative objects will exis in this frame. Constrained by 2 year project timeline - couldn't follow through on promise community building.
Walsh, A. (2023) South Africa	Towards Redress: the 'not-yet' future between harm and repair in Cape Town	Journal Article	Open workshops and individual semi-structured interviews	Young people from Cape Town	Redress in post apartheid South Africa	Exploring what a neighbourhood in a just future would look like using mapping- drawing out the new plan for the neighbourhood. Discussion facilitated around what this future would be like, what it would allow for	Discussed the importance of creating an future to stave off hopelessness. Specifically in this setting of post-apartheid, and discussions around 'forgotten" history and increasing marginalisation of people of colour creating a clear future is part of resistance to this. Where a group is marginalised their futures are also marginalised, and therefore imagining futures that include them is an important part of enabling people to ownership and agency to young people. Thinking about the future as a place of redress for past wrongs.	Imagined access to safe schooling, ample social housing, arts spaces, fruits and vegetables. Non-carceral alternatives to policing. Dragons who guarded and protected citizens from people who might do them wrong. Futures contained current barriers (neoliberalism, racial capitalism, individualism)	Can be critiques around utopian nature of futures methodologies- questions about whether it minimises the distances between the past, present and future. Runs risk of trivialising or forgetting things that are happening/have happened in an imagined future.	Sense of solidarity between the people taking part, across language and worldviews. Created space to imagine a different kind of future, and to discuss past injustices. Fostered hope in a process of 'worldmaking.' Showed need to resist fixed/pre determined outcomes.	Futures did not transend the norms of the present- hard to imagine futures outside of strong preexisting structures. Also need to be careful when designing futures that they do contain the past- i.e. need to build on injustice of the past when designing the future.

2.5.5 Data Analysis

This stage comprised of collating, summarising and reporting results of the scoping study (Arksey & O'Malley, 2005). Having extracted the data, I completed a reflexive thematic analysis (Braun & Clarke, 2006) to answer the research questions. Having uploaded the data into NVivo I created a series of codes reflecting the contents of the texts. These codes were then reviewed by my supervisors and I, during which we thought about how applicable a given code name was, and how they might relate to one another. This process enabled me to refine my codes, examine how they related to one another and identify patterns (themes) (Mak & Thomas, 2022). These are described in the findings section.

2.6 Quality appraisal

Before analysis, I will speak to quality appraisal (QA). QA is not always appropriate for scoping reviews, as the mixture of literature identified often does not neatly conform to the standards of empirical studies (Gough et al., 2012). Scoping reviews can include a broad range of data, regardless of the quality, due to their specific role in identifying areas for further research or generating hypotheses (Tricco et al., 2016). Given the lack of research from within the 'scientific' research community, and coming as it does from a range of different disciplines (HCI, design, arts and humanities), much of the literature does not follow the specific conventions for psychological research. Therefore, using a quality appraisal tool that might be used for a systematic review, such as the CASP appraisal checklist (*Qualitative Studies Checklist - CASP*, n.d.), would not be appropriate as it does not fit the approach taken.

From my epistemological position of standpoint theory, it could be argued that QA checklists exist to further validate norms for research designed to uphold truth claims of the powerful and marginalise those with less (Collins, 1990). However, understanding the researcher has acted with integrity, considered their participants' wellbeing, acknowledged biases within their thinking, and is using the data collected for a purpose that exists beyond publication is of utmost importance to me, and the wider research community, who frequently consider research quality and ethics. As a result, while not using conventional tools, it was still important to robustly consider quality. Considering that, and the varied data set appraised, I opted for a QA that allowed for a flexible approach, and whose appraisal categories were in line with my understanding of research values and integrity. The QA chosen is Tracy's eight Big Tent criteria (Tracy, 2010), the criteria for which are outlined below:

Table 4 *Tracy's (2010) Big Tent Criteria for QA*

Criteria	Description
Worthy Topic:	The research topic is relevant, timely, significant

Rich Rigor:	Explains theoretical constructs, data collection and analysis processes in detail. Methodology chosen allows for topic to be fully addressed
Sincerity:	Characterised by the researcher's reflexivity, their biases and thoughts as well as challenges they encountered conducting the research
Credibility:	Features thick descriptions, multivocality, and member reflection
Resonance:	Meaningfully reaches and influences the reader due to its evocative representations and transferable findings
Significant Contribution:	Provides a significant conceptual, practical, moral, or methodological contribution
Ethical:	Considers procedural ethics, relational ethics, and exiting ethics
Meaningful Coherence:	Achieved its stated purpose, uses methods that match their theories, successfully weaves literatures, research questions, findings and interpretations.

These QA criteria were devised with qualitative literature in mind. For the question of whether speculative research methods supported social justice aims, I needed to ensure all the papers I looked at involved some practical examples. Given I found no qualitative research articles in my search, I included published articles that spoke to practice examples through case studies (Carey, 2023; Jamieson & Discepoli, 2021; Kafer, 2023; Noel, 2022) one "meta-reflection" (Walsh, 2023 p.5), and conference papers; three followed the conventions of qualitative research papers (Bosley et al., 2022; Dillahunt et al., 2023; Lu et al., 2024), two followed the conventions of a methodology section (discussing recruitment, demographics and analysis in detail) without calling it such (Bray et al., 2022; C. Harrington & Dillahunt, 2021) and one took a more traditional case study approach (Gerber, 2018).

Table 5 *QA of the Scoping Review Papers Using Tracy's (2010) Big Tent*

Author and Year	Worthy Topic	Rich Rigor	Sincerity	Credibility	Resonance	Significant Contribution	Ethics	Meaningful Coherence
Bosley et al. (2022)	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓	✓✓
Bray et al. (2022)	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓
Carey (2023)	✓✓	✓✓	✓	✓	✓✓	✓✓	✕	✓✓
Dillahunt, Lu and Velazquez (2023)	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓
Gerber (2018)	✓✓	✓	✓	✕	✓✓	✓✓	✕	✓✓
Harrington and Dillahunt (2021)	✓✓	✓✓	✓	✓✓	✓✓	✓✓	✓✓	✓✓
Lu et al. (2024)	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓	✓✓
Noel (2022)	✓✓	✓	✓✓	✕	✓	✓	✕	✓✓
Jamieson and Discepoli (2021)	✓✓	✓	✓	✓	✓	✓	✕	✓✓
Kafer (2023)	✓✓	✓	✓	✓	✓✓	✓✓	✓	✓✓
Walsh (2023)	✓✓	✓	✓✓	✓	✓	✓	✓	✓

High Quality = ✓✓

Criteria Met = ✓

Criteria Not Met = ✕

While all the papers could be regarded as discussing a ‘Worthy Topic’ due to interest and relevance of empirical research and examples they documented, they did have certain limitations. Unsurprisingly, given only four of the eleven papers reviewed had named methodology sections (Bosley et al., 2022; Dillahunt et al., 2023; Lu et al., 2024; Noel, 2022), the approach to methodological ‘Rich Rigor’ was varied. Many do not discuss recruitment methods, decisions behind having open or closed groups, how the data was gathered or the types of analysis used (if at all). This made it challenging to understand reasons behind these decisions, or any problems that researchers had, or how they were overcome.

Participant data gathering was also limited; in some cases non-existent (Carey, 2023; Gerber, 2018), in others comprehensive, and in others mixed, (e.g. Noel, (2022) documented demographics for two of her case studies, but not the other). The absence, or partiality, of demographic details obscure which contexts speculative design methodologies have been most applicable, as well as my understanding of which communities get researched (Call et al., 2023). However, often the context and the community the individual participants are drawn was described in detail, making it possible to draw inferences around which contexts supported speculative thinking.

In most papers, the positionality of the researcher(s) was not spoken to, and therefore ‘Sincerity’ criteria were rarely met to a high quality. Positionality seeks to provide information about the lens with which the researcher(s) are approaching their topic, and how this can subsequently impact the research aims, researcher blind spots and data analysis (Darwin Holmes, 2020). Given positionality’s central role in meaning-making, it was surprising this was not more widely considered. Some papers demonstrated an understanding of the impact of positionality, for example, describing a multi-researcher analysis, the importance of building networks within communities they were researching, or including community organisations in the research(C. Harrington & Dillahunt, 2021; Jamieson & Discepoli, 2021; Walsh, 2023).

The QA also highlighted some mixed approaches to ‘Credibility.’ Neither Gerber, (2018) nor Noel, (2022) used any direct quotes from participants. Quotes allow for the participant’s voice to be heard in the research and increase (to some extent) researcher transparency (Eldh et al., 2020). Those papers appraised as high quality not only presented participant quotes, but discussed triangulation of themes (using member checking or multiple researchers) and in some cases provided additional photographs further illustrating participants’ contributions (Bosley et al., 2022; Dillahunt et al., 2023; C. Harrington & Dillahunt, 2021).

Notably, the reviewed papers scored low on the 'Ethics' criteria. Those that did not meet criteria spoke neither to which ethical board had approved the workshops or activities detailed in the papers, nor how participant wellbeing might be affected by the study, nor how the authors sought to support participants. Only three papers spoke to all three aspects.

Overall, papers scored well in 'Resonance,' and 'Significant Contribution,' suggesting the topics and findings were, in most cases, 'done justice'. Finally, most papers illustrated 'Meaningful Coherence' as findings were interwoven and contextualised well within the existing body of literature and met their stated aims.

2.7 Findings

2.7.1 Characteristics of included papers

All papers (n=11) used speculative design methodologies to explore or promote social justice aims. Most papers (n=8) focused on justice related to issues of racism; the other three were focused on rethinking political systems (n=1), alternative community economies (n=1) and the inclusion and uplifting of Deaf culture in the hearing community (n=1). Most papers (n=9) were based in the USA, with the remainder based in Scotland (n=1) and South-Africa (n = 1), though the researcher was based in the UK). In most studies, either the majority or entirety of interviewees were from the Global Majority. Participants, where age was given, ranged from 8 to 64.

2.7.2 Overview of Literature

This section provides a summary for the literature reviewed in the scoping review. All the papers spoke to the ways in which speculative design methodologies had enhanced the work they were able to do. Papers generally touched on three areas which can be further broken down into themes, illustrated below:

Table 6 *Areas and Themes*

Area	Theme
What Speculative Methodologies Enabled	Allowing For Complexity Communities Have the Answers Imagined Alternatives
Generating Speculative Thought	Group Process

Area	Theme
	Probes
Challenges	Exclusionary Practices
	Accessibility
	Barriers to Imagination

2.7.3 What Speculative Design Methodologies Enabled

2.7.3.1 Allowing for Complexity.

The papers all speak to a range of ways in which speculative design methodologies supported them to tackle so called "'*wicked problem[s]' that def[y].. simplistic solution[s]*" (Jamieson & Discepoli, 2021, p. 121). The social justice issues the papers are addressing are complex, multilayered issues, and many of the authors (Bray et al., 2022; Carey, 2023; Jamieson & Discepoli, 2021; Kafer, 2023) speak to the importance of not fixating on one set solution, but "*plural imaginaries*" (Mitchell & Chaudhury (2020), quoted in Carey, 2023, p. 2),

Whereas traditionally research might seek to find a specific solution to a 'problem,' speculative design methodologies encourage dialogue and debate, as the focus is on "f*ree idea generation rather than immediate production*" (Bray et al., 2022, p. 11). As speculative design methodologies are released from the pressure of providing immediate workable solutions, they instead allow for a different approach. Jamieson and Discepoli, (2021, p. 122) describe how this allows researchers to "*embrace the complexity of different perspectives, and endorse the importance of working with rather than against tensions*." Gerber, (2018 p.2) expands, it "*is not only a problematic mistake to avoid the politics of our imagined speculations, but also a missed opportunity to use speculative practices as a tool for political debate.*" She is speaking to the fact that imagination is not a neutral zone, that speculations will be imbued with politics. However, the imaginative realm is also a place where one can explore the outcomes of certain policy and action, without it having to taking place.

speculative design methodologies can be understood to enable complexity in a unique way. By moving the emphasis from doing to provocation, speculative design methodologies "*emphasizes exploration and experimentation over function*" (Noel, 2022, p. 2), opening up space for richness and interpretation. Arguably, as speculative design methodologies encourages people to imagine and construct a future that is not yet a reality, there is more space to hold multiple ideas in tandem with others. As Walsh (2023, p. 3) explains, speculative design methodologies “e*nable[es] what is ‘possible’ to be articulated and explored without dogmatic adherence to the ‘here and now.’*” By their very nature, speculative design methodologies stand in opposition to a more positivist understanding of ‘truth’ which seeks to synthesize and concentrate ideas into one workable ‘solution.’

However, this approach to speculative design methodologies cannot be taken for granted, and must be inbuilt, as Kafer, (2023, p. 210) warns against “*universalist accounts of the future, which often flatten social relations and ignore the political and cultural contexts in which design objects exist*.” This speaks to, and warns against the tendency to streamline and simplify, instead inviting and encouraging researchers to remain with complexity.

2.7.3.2 Communities Have the Answers.

All the papers described exclusionary processes in which solutions were developed on behalf of communities who were experiencing challenges, without consulting them on what they needed or wanted. Harrington and Dillahunt, (2021, p. 12) quote Francisca Porchas Coronado saying “L*ook for those who are the most impacted by this moment, and they’ll know what to do. If you show up and follow their leadership, you will most likely feel nourished, and know what to do next.*” This quote exemplifies a theme running throughout the papers, that those with lived experience are the best placed to understand the complexity of the issues which they face and to highlight how these can be tackled.

Speculative design methodologies puts communities at the heart of the process of ‘futuring’ creates space for people to dream, and allows them to own and acknowledge the “r*esources communities possess within themselves that can address problems*” (Bray et al., 2022, p. 11). Speculative design methodologies offer an opportunity to move away from professional expertise, creating space and tools for communities to use speculation without external professionals (Bosley et al., 2022; Jamieson & Discepoli, 2021). Noel, 2022, (p. 14) concurs, describing how the “*emancipatory nature*” of the methods “*meant that the power did not only lie with the facilitator or instructor, since participants drove the content by declaring their interests and concerns,*” allowing “*participants to bring their interests and concerns.*” Noel’s speaks explicitly to power, and although she does not speak about it in terms of “*redress*” (Walsh, 2023 p.10) she does consider how speculative design methodologies allow her participants to have their ideas heard and validated, and the impact this process has on community autonomy and agency.

The papers illustrated how speculative design methodologies enabled participants to understand the links between their imagination and reality. Bosley et al. (2022), Carey (2023) and Gerber (2018) spoke explicitly about imagination's role in a prefigurative approach to change. Speculative design methodologies seemed to enable participants to explore how what exists today was imagined by those before, e.g. a participant in Carey (2023, p. 4) described how "*I have to imagine that at some point my ancestors dreamed me into existence. I appreciate the opportunity to dream too.*" Here, we can see how the participants' understanding of their own agency shifts by realising their reality has been conjured by those before them, and they have the ability to conjure the reality of those ahead.

2.7.3.3 Imagined Alternatives.

All the papers are ultimately engaged in the pursuit of supporting people to imagine alternatives to the status quo, which are more in line with their and their communities' needs. Several papers discussed the concept of "*world building*" (Bray et al., 2022; Carey, 2023) and "*world making*" (Walsh, 2023 p.10), a constructionist approach linking to the prefigurative change mentioned previously. Central to this process of change is "*en/visioning*" (Bosley et al., 2022; Bray et al., 2022; Carey, 2023; Dillahunt et al., 2023; Gerber, 2018; C. Harrington & Dillahunt, 2021; Kafer, 2023; Lu et al., 2024; Noel, 2022). Visioning is a process where "*we forget how things are and imagine how things might be*" (Dillahunt et al., 2023 p.959). Different authors approach visioning in individual ways but Carey (2023 p.81) describes how it was in "*giving mundane form to the visions and describing how that future might look and feel in the everyday moments that communicated a vivid future possibility*." In this, we understand something about how speculative design methodologies allow ideas to become tangible rather than abstract imaginings, supporting enacting of social justice aims.

Speculative design methodologies play a key role in highlighting ways in which oppression can function. While oppression can be material, one of its key functions lies in the policing of imagination. Badiou, quoted in Gerber (2018 p.1) says "T*he power in place doesn't ask us to be convinced that it does everything very well [...] but to be convinced that it's the only thing possible.*" Noel, (2022 p.11) expresses a similar sentiment when she suggests "*liberation is…recognizing that one's oppression is not a perpetual state and transformation is possible.*" In supporting communities to imagine alternatives, speculative design methodologies challenge the perception the status quo cannot be upturned.

2.7.4 Generating Speculative Thought

Given the role that speculative design plays in allowing "*people to suspend their beliefs to imagine what can be, and to articulate these ideas to speculate*" (Harrington & Dillahunt, 2021, p. 2), all the papers took time to explain how they would facilitate and bring about speculative thought.

2.7.4.1 Group Process.

The majority of the papers used (or featured the use of) speculative design methodologies with closed groups who met over several sessions (Bosley et al., 2022; Bray et al., 2022; Dillahunt et al., 2023; C. Harrington & Dillahunt, 2021; Jamieson & Discepoli, 2021; Lu et al., 2024; Noel, 2022). Perhaps unsurprisingly, where groups followed a multi-session format sessions were often carefully designed to build upon the knowledge of the session before, slowly layering and adding complexity to the discussions that participants were having, increasing the 'futures literacy' of participants (Dillahunt et al., 2023; C. Harrington & Dillahunt, 2021; Jamieson & Discepoli, 2021; Lu et al., 2024; Noel, 2022).

Where groups met over a series of weeks, it appeared that more attention could be paid to pacing, either in interspacing time for "*reflections, meditations, and moments of rest*" (Bosley et al., 2022, p. 6) or by being conscious about "*breaks and spreading sessions out weekly*" (Harrington & Dillahunt, 2021, p. 12). Given that Dillahunt et al. (2023, p.973) states "*aspects of futures literacy depend on being reflexive,*" being able to build this time in might have added to the richness of the discussions.

While not all the authors relied upon group discussion, many felt group process was integral for the development of ideas (Bosley et al., 2022; Bray et al., 2022; Carey, 2023; Dillahunt et al., 2023; C. Harrington & Dillahunt, 2021; Kafer, 2023; Lu et al., 2024; Noel, 2022; Walsh, 2023). Lu et al. (2024, p.174) described this process as 'contamination' in which he speaks to "*transformation through encounters, embracing vulnerability with others, and thereby fostering collaboration across differences.*" Other authors built in collective process, for example Bosley et al. (2022) asked participants to present their work individually to the group, before the group completed the same task, drawing on all the ideas of the individuals, and weaving them into a collective vision.

2.7.4.2 Probes.

A 'probe' is a term borrowed from the design world that "*serve as an entry into creating community-led design tools, addressing complex topics that allow participants in research to interact with prompts that generate rich insights*" (Bray et al., 2022, p. 2) and to "*provoke*" (Dillahunt et al., 2023, p. 957) debate. Provoke is an interesting term, as it suggests speculative thought is not something that one does naturally, or arrives upon easily. Instead, the texts used a range of probes to support their participants to think speculatively.

Some authors used toolkits (Bosley et al., 2022; Bray et al., 2022; Lu et al., 2024), comprising of workbooks that had set activities for participants to progress through, either individually or collectively. Others (Dillahunt et al., 2023; Lu et al., 2024) used a card deck, developed by Bray et al. (2022). Other methods such a literature (Bosley et al., 2022), maps (Walsh, 2023) and story boards (Dillahunt et al., 2023; Lu et al., 2024) were also used. Some used specific prompts, asking participants to imagine certain objects or scenarios in the future (Carey, 2023; Kafer, 2023; Noel, 2022) and several referenced TV clips, notably *Black Mirror*,[5] which was frequently featured as a probe (Dillahunt et al., 2023; C. Harrington & Dillahunt, 2021; Lu et al., 2024).

Unlike the others, Gerber (2018) developed 'artifacts' as probes, developed from what participants had said to provoke further questions and debate. These were then shown to participants to encourage them to further reflect on issues relating to public safety.

2.7.5 Challenges

2.7.5.1 Exclusionary Practices.

All the authors, with the exception of Walsh (2023), described how traditional design methodologies can exclude those they are nominally said to be for. In the practice of speculative design methodologies, Kafer (2023, p.201) directly asks "*Who gets to speculate, for what reasons, and on behalf of whom?*" Authors felt that despite the participatory aspects to speculative design methodologies, where it is practiced ("*largely within the privileged walls of universities in wealthy countries*") leads to failings in how it thinks about "*diverse oppression in capitalist, heteronormative, sexist, racist and classist societies*" (Harrington & Dillahunt, 2021, p. 3). Noel (2022 p.71) agreed, arguing that often speculative design methodologies "*underrepresent minorities*" and as such, they are excluded from imagining, and therefore from their place in the future. However, even when people who have been minoritised are part of studies and encouraged to use speculative design methodologies to think about future possibilities, barriers exist. Bray et al. (2022) described the power dynamics between researcher and participants, and the subsequent need to not only acknowledge and consider these, but also the impact of wider systems of oppression on participants.

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[5] Black Mirror is a speculative science fiction series on Netflix, written by Charlie Brooker

As part of recruiting a more diverse cohort of participants, and to support with development of materials and sessions that did not perpetuate harmful norms, authors often linked with established community organisations (Bray et al., 2022; Dillahunt et al., 2023; Gerber, 2018, 2018; C. Harrington & Dillahunt, 2021; Lu et al., 2024; Walsh, 2023). Working with community organisations helped ensure the right people were in the room, as they had pre-existing links with the community they served. Connecting with such organisations was a method of refocusing upon community voice, and ensuring that the design *and* the practice of speculative design methodologies was centred on the community it was researching with.

Similarly, many authors mentioned additional frames they used when designing their research and materials. For example, several authors drew on the idea of Afrofuturism[6] (Bosley et al., 2022; Bray et al., 2022; C. Harrington & Dillahunt, 2021; Noel, 2022) to make their process of speculation relevant to the populations they were researching with.

2.7.5.2 Accessibility.

Authors reflected upon the accessibility of their studies in several ways. Much of the writing on the topic took place during the pandemic, and as such, several of the studies feature online groups (Bosley et al., 2022; Bray et al., 2022; Carey, 2023; Dillahunt et al., 2023; Lu et al., 2024). This meant authors had to be particularly mindful of how to engage participants, given the challenges with online engagement. Lu et al. (2024, p. 176) describe how they "c*ollectively brainstormed ways to make the online session inclusive, such as providing prompts in the chat, using polling functions, creating small breakout groups, assigning roles in each group*." Dillahunt et al. (2023) approached this in a similar way, giving roles to participants, and encouraging the use of chat, poll and emoticons, both to facilitate engagement and to support those who were less confident speaking.

They also touched on how to make the workshop materials more accessible. Bray et al. (2022) spoke to the importance of a tool kit "*that was less text heavy and free of jargon*." Dillahunt et al. (2023, p.960) discussed how they practised sessions, and ran them past key stakeholders to "*identify any points of confusion*" as well as asking participants for feedback. However, others struggled with this balance, Bosley et al. (2022, p.11) described that "*individuals expressed difficulty parsing through complex*

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[6] Afrofuturism refers to a vision of the future that explicitly incorporates and engages with Black culture, identity and history, with a focus on liberation and agency, reclaiming Black presence in the future. This can be seen as resistance and response to the erasure of Black people from dominant cultural visions of tomorrow (Womack, 2013).

materials" and that five of their ten participants had chosen to draw or use other forms of communication instead of writing.

2.7.5.3 Barriers to Imagination.

Despite the probes used to support people to imagine, several authors spoke about the challenges with this process (Bosley et al., 2022; Bray et al., 2022; Dillahunt et al., 2023; C. Harrington & Dillahunt, 2021; Walsh, 2023). Authors spoke to the fact that their participants were unable to imagine a future that did not feature the societal issues of the present (Bosley et al., 2022; C. Harrington & Dillahunt, 2021; Walsh, 2023). A participant in Bosley et al. (2022, p.7) describes challenges in envisaging "*a world without police brutality…That is what we as Black people fight for every day, but it seems like sometimes it's such a far-fetched idea, and thinking about it is harder than I thought it would be*." It appears, in this example, police brutality is the norm, to the point that even though the participant wishes it didn't exist- they cannot imagine an alternative. They also cast doubt on the validity or purpose of speculation when they describe it as "*far-fetched idea*" (Bosley et al. 2022 p.7). A participant in Bray et al. (2022) also spoke to this theme, mentioning the challenges they felt would exist with convincing community organisers to use the speculative toolkit, suggesting it might feel too much like a game to be taken seriously.

Both Harrington and Dillahunt (2021) and Walsh (2023) described how the utopian worlds created still featured racism or patriarchal systems. Harrington and Dillahunt (2021, p.11) point out that the "*utopian futures for Black and brown youth are the existing realities among other groups*" and reflect upon what it means that our society inhibits people's ability to imagine a different world beyond "*basic survival*."

However, while some authors highlighted the challenges with imagination faced by those experiencing minoritization and discrimination, they did not feel that abandoning the process was the answer. Instead, they spoke to the creation of design processes that were inclusive of e.g., Afrofuturism (Bosley et al., 2022; Bray et al., 2022; C. Harrington & Dillahunt, 2021; Noel, 2022). While Bray (2022) noted how hard it was to speculate when communities were needing concrete solutions in the present, Walsh (2023) appeared to be the only paper to explicitly respond to this. They spoke to the notion of redress and reparative futures, in which there is space to think about both the impact of the past and present and the need for this to be materially addressed, alongside a speculative imagination of the future to come.

2.8 Conclusions

2.8.1 Summary of Scoping Review

In summary, this scoping review explored three key areas when considering how speculative design methodologies have been used to contemplate issues relating to social justice; what speculative design methodologies enabled, generating speculative thought, and challenges.

speculative design methodologies were seen to encourage complexity across the papers chosen, allowing for multiple answers to 'wicked problems' rather than fixating on one solution. Similarly, speculative design methodologies allowed for communities to generate answers to the problems or challenges they were having. Using speculative design methodologies facilitated a process in which communities were able to reclaim their expertise from academics and policy makers, and instead envisage futures that worked for them. Finally, speculative design methodologies allowed for participants to imagine alternatives to the status quo, prompting participants to question the immutability of the present conditions.

Papers spoke to two key ways in which speculative thought was generated. Firstly, most papers referred to group process, and how understanding was built and developed between participants. Secondly, all papers used probes to help facilitate speculative ways of thinking, using a range of mediums from film, reading, workbooks and cards.

Finally, papers spoke to challenges experienced by researchers and their participants. Many explored the exclusionary nature of mainstream design, and in some cases speculative design methodologies, as they are predominantly used by academics who have little experience of marginalization. They also described the challenges with accessibility and how they navigated this, both online and through ensuring there were a range of ways for participants to engage in the research outside of writing alone. Finally, several authors explained the limits of speculative design methodologies when participants are experiencing challenges in the present. They explored how these can alter participants' ability to imagine alternative worlds without the challenges of the present being represented in the future.

2.8.2 Research Implications

This is an emerging, but, especially within psychology, under-used research approach that supports for a nuanced and multivocal approach to 'wicked problems' relating to social injustice, exclusion and inequity. The scoping review has highlighted speculative design methodologies use a range of tools to co-create alternative futures, typically focusing on the imaginings and wisdoms of those most directly affected. On account of this, speculative design methodologies is potentially a highly relevant approach for the research undertaken in the fields of mental health and clinical psychology, where the aim is to focus upon addressing the social determinants of challenges to mental wellbeing, or where researchers have social justice aims.

2.8.3 Rationale and Implications for this Research

The idea behind the scoping review was to explore the ways speculative design methodologies can be used to explore social justice aims. The scoping review has highlighted speculative design methodologies can be helpful to draw out and explore complex issues, whilst allowing participants to debate and hold different positions. By using imagination, it is possible to move beyond the often-limiting constraints of the day-to-day and facilitate alternative solutions. Turning to the current study, given the emotive context of inpatient care, it indicates that speculative design methodologies might be a helpful medium for me to explore this further.

The scoping review indicated that people's imaginings were often influenced by their current context and real-world concerns. I therefore felt it would be interesting to think about how participants in my study would respond to prompts around imagining. Having acknowledged the role of imagination as something that can enable change, I believe it is important to understand the mechanisms by which imagination is either facilitated or hindered.

The scoping review has also highlighted some of the main ways in which speculative design methodologies can be maximised in their efficacy. It speaks to the role of group process, and how to support participants to adopt a speculative approach. From the scoping review, it appears that speculative design methodologies worked best when used over a series of weeks with the same group. This allows for time for participants to become familiar with the methodology (and each other), as well as giving ample time and space to utilise several probes. This is an important methodological consideration for the present study, highlighting the need for me to ensure a closed group, with several sessions, allowing participants to get to know each other.

2.9 Research Questions

My research seeks to understand how crisis care can be reimagined in a way that promotes human flourishing. To explore this, I broke this down into four questions:

1. What is crisis care?

2. How do people reimagine crisis care?
3. How do people respond to prompts about reimagining?
4. What would need to be different about the world to enable this?

CHAPTER THREE: METHOD

3.1 Chapter Overview

This chapter outlines the method used to answer my research questions. I seek to explain my research design; the use of qualitive research methods, focus groups, and Reflective Thematic Analysis (RTA). I also describe my recruitment process, participant demographics and ethical considerations I had undertaking the research. The chapter concludes by describing the data collection and analysis process.

3.2 Design

3.2.1 Why Qualitative?

This research aims to support group-members to explore what care means to them, and how crisis care can be reimagined with that in mind. In asking group-members to do that, I am asking them to imagine an alternative to our current system. Given quantitative research lends itself to quantifying and measuring phenomena, and not imagining or generating novel ideas (Sofaer, 1999), a qualitive approach was necessary. Instead, qualitative methods allow me to explore group-members subjective imaginings.

3.2.2 Why Reflexive Thematic Analysis?

I chose reflexive thematic analysis (RTA; Braun & Clarke, 2019) as it fits my research aims and epistemological stance. Although Braun and Clarke are not the sole originators of thematic analysis (TA; e.g. Boyatzis, 1998; Joffe, 2011) RTA is a rearticulation of their earlier discussions of TA (Braun & Clarke, 2006). RTA acknowledges my active role in knowledge production, by explicitly focusing on "centrality of researcher subjectivity and reflexivity" and "the importance of methodological scholars locating their stance and acknowledging their position(s)," (Braun & Clarke, 2019 p.590). Given that a core tenant of standpoint epistemology relates to situated knowledge (Haraway, 1988) (the idea that different knowledge is available to different people dependent on their social identity) RTA's focus on researcher subjectivity and reflexivity aligns well, allowing me to acknowledge where my views will influence my approach to the data. Braun and Clarke, (2019 p.592) describe researchers as constantly thinking and reflecting, "*journeying*, not arriving," aligning with Spivak's (quoted in Pillow, 2003 p.177) reminder to be constantly "vigilant" in our practices.

As an analytic tool, RTA is a "method for reorganising and organising patterns in content and meaning in qualitative data" (Braun & Clarke, 2006 p.84) to generate a collective meaning. For my research, I hope to explore SU and service provider imaginings and alternatives. This is not to form them into one homogenous view, but to create a patchwork "joining of partial views and halting voices into a collective subject position" (Haraway, 1988 p.590). RTA allows the researcher a degree of freedom that is not experienced in other analytical styles. For example, unlike Interpretive Phenomenological Analysis which focuses on the meaning individual people make of their experiences (Alase, 2017), RTA can compare ideas between group-members. As this research is speculative, it makes sense to have an analysis method that can be used flexibly, not only about experiences, but ideas.

Approaches to data analysis within RTA can take two forms, inductive ('bottom-up') and deductive ('top-down'). Given I am focusing on people with lived experience of compulsory inpatient services, and my epistemological standpoint specifically preferences the situationist knowledges, especially those whose knowledge is often subjugated, it would not make sense for me to approach this deductively. While the aim is primarily inductive, of course, neither an entirely deductive nor inductive approach is possible (Clarke & Braun, 2013). I developed themes based on a close link to the data, rather than trying to fit it into a pre-determined coding frames or my own preconceptions. However the quotes that stood out did so based on my own subjectivities, therefore my influence can never totally be neutralised.

3.2.3 Focus Group

Focus groups are often used as a way of exploring new areas and collectively generating new ideas (Wilkinson, 1998). Similarly, focus groups are often a data collection method of choice in participatory research, as some argue they have the potential to "empower" group-members (Bagnoli & Clark, 2010 p.104). They create a space where people with shared experiences can discuss and share topics of collective importance and devise collaborative approaches to these.

Given the scope of the question, having a place where ideas could develop iteratively felt important. Given the traumatic experiences experienced by some SU at the hands of staff, and the risk of retraumatising or triggering people, I chose to have two separate groups for SU and staff. Due to the power differentials, I was concerned how I would manage safety within a mixed group, how able or safe SU would feel to share their experiences in a mixed group, and whose voices would dominate the space.

3.2.4 Increasing Participant Agency as Part of Design

When considering alternatives to the current system of crisis care, I thought it was important to speak to those most affected by it - namely people who had experienced section. I felt, due to their experiences within these systems, they would be best placed to reimagine alternatives. In keeping with my epistemological position, and borrowing from Participatory Research (PR), I sought to prioritize insider knowledge and the lived experiences of those close to the topic, rather than situating the 'expert' position with me, the researcher (Vaughn & Jacquez, 2020). PR involves those most affected by the topics studied in the process of the research itself (e.g. shaping questions, being co-researchers, consultants, supporting with theme development) (Vaughn & Jacquez, 2020). The hope is that by doing so, the research can be used to bring about action or meaningful change for those most impacted by the topic studied (Cargo & Mercer, 2008). Borrowing from PR approaches aligns well with RTA as both acknowledge the importance of subjectivity and the role that researcher and participant will play in the generation of knowledge (Liebenberg et al., 2020).

Especially given the profoundly disempowering nature of being sectioned, I wanted to prioritise the autonomy and dignity of the group-members to be involved in the research. I felt a way to do this was to take steps to share some of the power within the researcher-participant relationship, shown below:

Table 7 *Involvement in the Research*

Area of Involvement	**Description**
Consultant Involvement	Two people with lived experience of being under section were recruited as consultants via the NSUN bulletin. Experts by experience were paid £20/hour[7]. Met three times. Consulted on research design, recruitment, focus group content, and theme checking. For example, I trialled a speculative prompt with the consultants who highlighted bits that felt confusing and needed reworking. The consultants gave feedback on my recruitment posters and participant information form, specifically relating to

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[7] See Appendix B for Consultant Payment Form

Area of Involvement	Description
	font, overlaying of images (visual accessibility), as well as language. Optional involvement in dissemination.
Advisory Input	Received advice from a range of audiences: research team, academics (e.g., in Mad Studies/lived experience), peer support facilitators, decolonial writers, and third sector professionals.
Payment for Participation	All research group members were paid a London Living Wage for focus group participation, to value their time and expertise.
Participant-Generated Questions	Group-members, once introduced to the speculative, were invited to create their own questions about speculative thinking and crisis care to shape future sessions.
Theme Presentation and Co-construction	At the start of focus groups two and three, previously constructed themes were shared. Group-members were invited to respond with agreement, divergence, or alternative suggestions. Emphasized relational, co-constructed meaning-making.
Final Session Engagement	In the final session, group-members identified the most salient points discussed and reflected on who they wished to inform.
Creative Expression	Participants were invited to submit creative responses to the topics, offering varied means of engagement and expression.
Transcript Review	After transcription, group-members reviewed transcripts to redact quotes or add clarifications.

These steps by no means indicate power was equalised. Notwithstanding identity privileges, and unease my professional title might hold for people with experiences of the coercive experiences of the psych system, my role as a representative of an academic institution means I hold power that creates significant barriers to equity between myself and the group-members involved in my study (Malone et al., 2006). Also, undeniably, to paraphrase the title of Felner's (2020) article "You Get a PhD and We Get a Few Hundred Bucks," - I get a PhD, and group-members get £62.33. Therefore, my ability to comprehensively share power is limited, and I have to acknowledge the areas in which my ease has overridden further power sharing, specifically where I have made certain research decisions (e.g. number of focus groups, consulting rather than developing with people with lived experience, not including group-members in theme development post transcription etc). As such, I have decided not to refer to the project as participatory action research (PAR) or even as participatory research.

3.2.4 Speculative Design

Speculative approaches have been used for design (Galloway & Caudwell, 2018), Human Computer Research (HCI) (Bardzell et al., 2012) and public policy (Tsekleves et al., 2022). To my knowledge, they have only been rarely used when thinking about crisis care alternatives.[8]

While psychological research often focuses on past or current experiences, it very rarely focuses on the 'what if'. Using speculative design methodologies, group-members are encouraged to think about and critically engage with the future (Dunne & Raby, 2013; Wilkie et al., 2017). As outlined in the introduction, current research has successfully highlighted the problems and made the case for change within crisis services. However, there is a gap when it comes to thinking about how this change could occur. As the scoping review has shown, speculative design methodologies can support social justice aims by allowing for the impossible to be imagined in a way many other methods do not. By focusing only on what is perceived to be possible, the opportunities for change are limited: "what we don't see, we assume can't be" (Butler, n.d. quoted in Russel, 2017). Therefore, it felt appropriate to apply a speculative design approach to the question of alternatives to crisis care.

3.2.5 Structure of groups

Due to the very nature of speculative design, it often lends itself to a more participatory research process (e.g. Tsekleves et al., 2022). I was aware that many speculative projects follow an iterative process (Dillahunt et al., 2023; Harrington & Dillahunt, 2021; Jamieson & Discepoli, 2021; Lu et al., 2024; Noel, 2022), allowing for ideas to change and be built upon, and wanted to reflect that in the group structure. To encourage this, each group met three times, weekly, for an hour and a half.

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[8] A notable example of this is in *the vacuum cleaner*'s work, who uses art to support creative research speculations into alternative mental health provisions (see https://www.thevacuumcleaner.co.uk/#madlove)

I anticipated a level of diffidence when first inviting participants to think speculatively, and therefore I structured the group to allow for speculative thinking to be introduced before it was applied to the context of crisis care. I wanted to allow adequate space for participants to get to know each other, explore speculative ideas and the contexts they had been used in before being asked to develop ideas themselves. Therefore the first session is dedicated almost entirely to this. For the subsequent groups, while there was some structure, the sessions are very much guided by the group-members. The session plans were developed in conjunction with, and piloted to, my consultants. A plan of the sessions can be seen below, in Table 9, 10 and 11.

Table 8 *Plan of Focus Group 1*

Activity	Detail	Timings
Intro	Madeleine introduce themselves. Housekeeping - Jessica here to support. Discuss options if distressed.	5 mins
Group Intro's Icebreaker adapted from (Benjamin, 2024)	Round of names, and icebreaker: if we were stranded on a desert island, what skill would you bring that would help the group survive and build.	10 mins
Group Boundaries /Expectations	What community values do we have for how we wish to work with one another? Agreement about how everyone would like to work together over the weeks.	10mins
What is the Speculative	Aim to create group definitions of terms. What do people understand about the speculative? Or imagination? Acknowledge challenges with being imaginative. What do dreams mean to you? Are they tied to reality? Are they silly? Are they important? What role does imagination play in everyone's life?	10mins

Quotes on Screen[9]	Ask participants to take some time to remind themselves of the quotes. Which stands out most? Any that are interesting? Any that they disagree with? What images come to mind? Where do the quotes transport them to?	15 mins
An adaption of 'Thing From The Future' Adapted from Candy & Watson (2015), via Michelle King, cited in Benjamin (2024)	Looking at the slides[10], ask participants to choose something from each level, to build an object from the future.	15mins
Bring speculative to inpatient services	Ask participants: Are there questions you would like to focus on for next few sessions? Explain we are going to think up questions relating to imagination and care, and imagination and mental health services. How do they think thinking about and imagining might be applied to the context of care and impatient services? Are there any questions that they want to make sure we discuss next week?[11]	15 mins
Invitation	Invitation to participants to write/draw/audio record the future they imagine - can be a task they work on between sessions or up until a deadline of 3 weeks after last session. If completed while sessions are still taking place, they are welcome to use it as a prompt or tool in the session's discussion.	5 mins

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[9] See Appendix C for full list of quotes and Appendix D for the quotes participants chose

[10] See Appendix E for 'Thing from the Future Slides"

[11] See Appendix F for questions participants chose

Check out	Ask participants: How are you feeling, one word to describe.	5 mins

Table 9 *Plan of Focus Group 2*

Activity	Detail	Timings
Intro	Check in, what do they remember most from last time/session? Any thoughts or reflections from previous meeting?	10mins
Feedback Tentative Themes	Researcher will share tentative themes from rudimentary analysis of first session. Ask people if they agree? Are there other themes people would add? What do they think was missed? Any they think are wrong?	15mins
Discussion	Start discussion with questions participants identified. Then look at researcher's discussion points (if not already covered). What do you need when you are unwell? If you could invent anything that would help when you are unwell, what would it be? For these things to exist, how would the world need to be different?	50mins
Summary	Summarise session, explain we will continue the conversation next session. In between sessions, task to think about who they would like to hear this conversation? Prompt about drawing/audio recording/writing the future they imagine if people want to take part in that.	10mins

Check out	How are people feeling? One word to describe the session.	5mins

Table 10 *Plan of Focus Group 3*

Activity	**Detail**	**Timings**
Intro	Check in, what do they remember most from last time/session? Any thoughts or reflections from previous meeting?	10mins
Feedback Tentative Themes	Researcher will share tentative themes from rudimentary analysis of first session. Ask people if they agree? Are there other themes people would add? What do they think was missed? Any they think are wrong?	15mins
Discussion	Continue thinking about the questions from last time/questions unanswered last time. Can use their creative pieces if they wish.	30mins
Reflection	Key themes/points. Key stakeholders they want to know these things.	25mins
Summary	Thank everyone for taking part. Explain I will give them the transcripts for them to read and remove anything they don’t feel comfortable with. Potential opportunity to support with future presentation of the information if interested once project finished. Remind people that they have up to three weeks to submit any drawing/audio recording/writing on the future they imagine, if they would like to.	5mins
Check out	Something they didn’t expect.	5mins

3.2.6 Contradictions

Within my study I made the decision to include both SU and those who have worked on inpatient units as staff. This choice was made because I felt both SU and staff were closest to the experience of sectioning and therefore best placed to give their viewpoints on it. Given all group members are in proximity to the same harmful systems, it is likely that all are harmed by it, though in different ways to different degrees. As Fanon, (1967) describes, it is not only those at the blunt end of oppression who are harmed, those with power to do harm to others or who exist as part of harmful systems are also negatively impacted. However, in including both, I risk positioning both as equal, something Haraway, (1988 p.584) refers to as a "denial of responsibility and critical inquiry," and potentially decentring the experience of those more likely to be in the margins (hooks, 2014).

This contradiction continued through the study and into the analysis. I believe the inclusion of both groups helped to provide a deeper, more nuanced understanding of the topic, for example, illustrating the institutional barriers to imagination that might not have been so apparent had they not been included. Although relating to staff experiences, several of the topics staff raised had a direct impact on the crisis care SU experience and therefore need to be considered in any reimagining of crisis care that occurs.

3.3 Group-members

3.3.1 Participant Criteria

This study had two sets of inclusion criteria (see below); one for people with experience of section, and another for staff working in inpatient services.

Table 11 *Participant Inclusion Criteria*

SU Inclusion Criteria	Service Provider Inclusion Criteria
Experience of treatment under section 2 or 3 in a London-based service within the past 10 years	Minimum 1 year's experience in a London-based service/team providing emergency inpatient care
Have not been discharged from an inpatient service in the last month	Experience of a client facing inpatient role within the last 5 years

Aged 18+, English speaking and UK based	Aged 18+, English speaking and UK based
Have access to video conferencing software, feel comfortable using it, and have a confidential space to do so	Have access to video conferencing software, feel comfortable using it, and have a confidential space to do so

There were several universal criteria for group-members. All group-members needed to be able to communicate in English. Due to the design, it was important that people were able to communicate with each other unhindered within focus groups. However, this decision may have excluded the viewpoints of people who would had a unique insight into the impact of language exclusion on mental health.

In devising criteria for people with lived experience of section, it was felt that an understanding of the longer-term workings of inpatient units and treatment whilst under section would be helpful. I decided not to include people under 36-hour assessment sections, and focused on people who had experienced compulsory treatment under Section 2 and Section 3. Due to the changing nature of inpatient services, and the effect of distance from an experience, I only included those who had experienced Section 2 and 3 within the last 10 years. Due to my concern around being able to adequately support people within a group environment, I only included people who had been discharged over a month ago.

The criteria for staff members stipulate they should have at least one year's experience in an inpatient service. This duration was chosen to ensure a substantive understanding of the service, whilst also accommodating those who may have left due to burnout, incompatibility with the service, or other reasons. To ensure participant's experiences remained relevant to the current context, I only included those whose experience was in recent memory, as both systemic changes and the passage of time influence how experiences are recalled. I chose to recruit from a range of professional background within inpatient services, as I felt their perspectives and understandings would vary dependant on their roles.

Those who identified with both a user and provider role were given a choice of which group to join.

3.3.2 Recruitment

Purposeful sampling techniques were used to recruit group-members. This technique refers to the selection of individuals who are “especially knowledgeable about or experienced with a phenomenon of interest” (Palinkas et al., 2015 p.2). Given the proximity of both groups to crisis care, this approach felt appropriate. Recruitment took place between January - March 2025.

Group-members were identified in several ways; via NHS, through charities, and the research team’s professional networks. NHS recruitment was supported by a preexisting contact working across two NHS Foundation Trusts. While the plan was to recruit from both sites, one site dropped out at a late date due to service pressures.[12]

Table 12 *Recruitment Processes Through London-Based NHS Foundation Trust*

Staff	Inpatient
Contact emailed poster[13] and participant information form (PIF) to relevant staff heads	Email with poster and participant information form (PIF) circulated in SU/peer support mailing lists
Meetings with staff heads to explain further about the project, who would then circulate details through their staff teams	Meetings with staff heads to explain further about the project, who would then circulate details through their staff teams to circulate to their SU if appropriate
Several teams allowed me to attend meetings for a portion of time to discuss the project/recruitment	SU contacted me directly on the email address given on the poster and information sheet
Staff either contacted me directly on the email address given on the poster and information sheet, or consented to their managers passing their details to me	

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[12] Given the topic of the thesis, this cancellation felt prescient- a clear example of an overstretched service.

[13] See Appendix G for posters

I contacted NSUN who circulated information in their weekly bulletin. Interested people contacted me directly via the email address provided. Group-members were also recruited via my research team and professional networks, and via word of mouth and snowballing.

Once people made contact, I booked in a screening call over Zoom or telephone, depending on the person's preference. Before this call, I sent over a link to a secure OneDrive file including easy read and long versions of the PIF, consent form, demographic questionnaire, and participant payment form (see Appendix H, I, J, K, L). The screening call process is briefly outlined below, with more details under ethical considerations. I encouraged group-members to ask questions throughout this process.

Figure 2 *Screening Call Process Flowchart*

After the screening call, the participant had a week to fill in the relevant forms. If no forms were completed by this date, I emailed people once more to follow up, after which I assumed they were no longer interested in taking part.

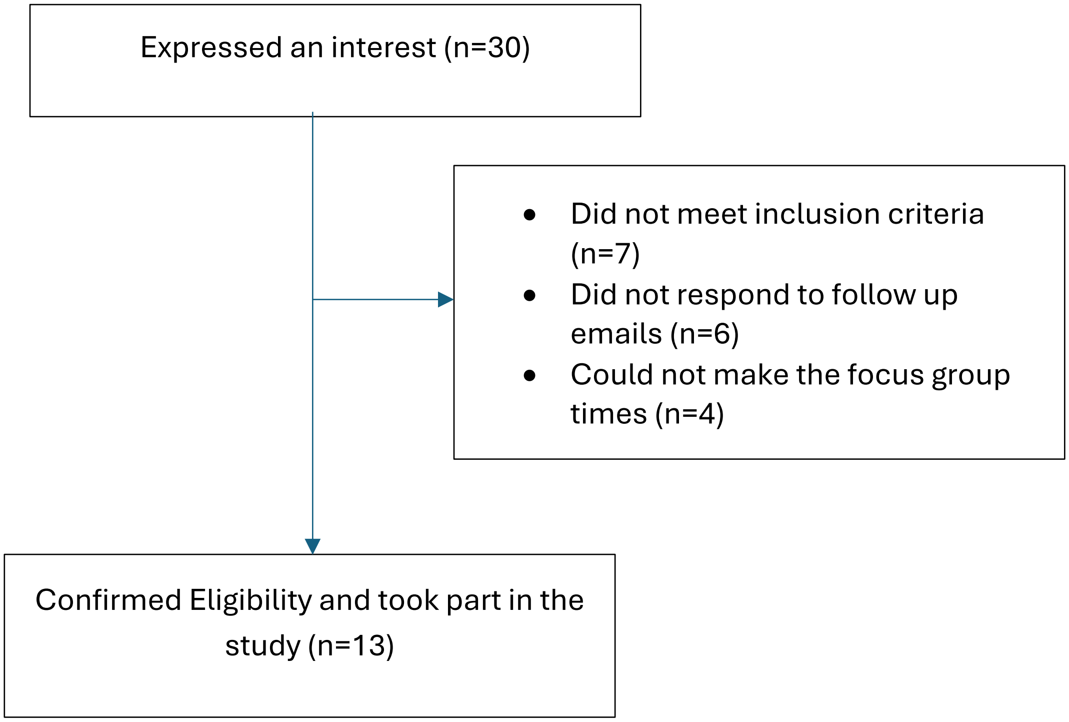
3.3.3 Sample Size

I recruited thirteen participants in total, making up two separate focus groups of seven (staff) and six (SU) participants. Plummer-D'Amato, (2008) suggests that the recommended focus group number is between six and eight. The group size allowed for rich discussion, but also felt small enough that it was possible to include all members of the group.

3.3.4 Participant Information

31 people expressed interest in the project, and 18 were eligible for the process after screening. See below:

Figure 3 *Participant Flowchart*



A summary of group-members demographic information is detailed in Table 13 below. Given my epistemological stance, it felt important to explore the social identities held by group-members within the study, given the different insights people from different perspectives/positionalities might be able to access. Therefore, my demographic form asked questions relating to age, gender, sexuality, disability, religion, language and class. As the form allowed people to write in their own demographic descriptors, this is reflected in the language below.

Table 13 *Participant Demographics*

Demographics	N	%
Age		
20-25	3	23
31-35	1	8
35-40	4	31
41-45	2	15
51-55	1	8
60-64	1	8
Not disclosed	1	8
Ethnicity		
Black British- African	1	8
African	1	8
Somali	1	8
Chinese	1	8
British Born Tamil Sri Lankan	1	8
Mixed (white and Asian)	1	8
Magyar	1	8

Mixed	1	8
White British	4	31
White (British-American)	1	8
Gender		
Cis- Woman	9	69
Cis - Man	3	23
Non-Binary	1	8
Sexuality		
Heterosexual	6	46
Asexual	1	8
Queer	3	23
Bisexual	1	8
Disability		
Yes - Uncategorised	2	15
Yes- Mental Health	2	15
Yes- Autispeculative methodologies	1	8
Yes- Invisible	1	8
None	7	54
Religion		
Islam & Sufi Spiritualism	1	8
Christian	4	31
Spiritual	2	15

Not religious	6	46
First Language		
English	10	77
Hungarian	1	8
Somali & Dutch	1	8
Cantonese	1	8
Language of Thoughts		
English	10	77
Hungarian - English	1	8
English -Tamil	1	8
Somali & Dutch	1	8
Social Class		
Lower Class	1	8
Working Class	5	38
Lower-Middle Class	1	8
Middle Class	4	31
Middle Upper class	1	8
Free School Meals		
Yes	6	46
No	5	38
Unsure	1	8
Not Disclosed	1	8

Housing Situation		
Private Rented	3	23
Homeowner	3	23
Temporary Accommodation	2	15
With Family	3	23
Council Tenant	1	8
Not Disclosed	1	8

3.4 Ethical Considerations

3.4.1 Ethical Approval

As I recruited NHS staff and SU, ethical approval was required from the NHS Health Research Authority (HRA) and Research Ethics Committee (REC). IRAS project ID: 344006. The REC granted a favourable approval with conditions on 07.10.2024 (Appendix M), and confirmation that these were met on 09.10.2024 (Appendix N)[14]. I received my HRA approval on 14.10.2024 (Appendix O).

Having received this, I applied for registration from the Research and Development (R&D) teams of two London-Based the NHS Foundation Trusts. I obtained confirmation of capacity from one trust (Appendix Q) and a withdrawal from the other based on lack of capacity (Appendix R). I requested full sponsorship from the University of Hertfordshire Ethics Board. Protocol Number LMS/PGR/NHS/02319 (Appendix S).

3.4.2 Addressing ethical considerations

In a project concerned about human flourishing and care, it was important to me that ethics were a key consideration, rather than a checkbox in my study. I undertook the steps below:

3.4.2.1 Informed Consent.

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[14] Two amendments were made can be seen in Appendix P

Informed consent is the cornerstone of ethical research. I ensured that all group-members had copies of the information sheets prior to our screening call. These sheets outlined why I was doing the study, how I would use and store the data gathered, and their right to withdraw. During the screening call, I went through the consent forms with people to ensure they were clear about the study, and to give space for any further questions or clarifications. Group-members were given a week following the call to reflect before signing to the consent form, to ensure they were making the right decision for them. During this time, I made it clear they were free to contact me if they wanted any clarifications. It was important to me that participants did not feel observed or pressured to fill in the form.

3.4.2.2 Confidentiality.

The information sheet (provided to group-members prior to the screening call) explained how I would maintain their confidentiality. Demographics forms were anonymous and stored in a separate OneDrive folder to group-members' completed consent forms (which hold their identifiable details).

To maintain group-members anonymity, I asked each participant to provide a pseudonym. When I sent out the transcripts to group-members to check, all names were replaced with these pseudonyms. Any additional details which would identify a person were also removed. Any quotes are attributed to the group-members' chosen pseudonyms.

Due to the nature of a focus group, ensuring complete confidentiality is not possible, as I am not able to police what others say outside of the group. I made group-members aware that they may know others within the group during the screening call, and instructed people to only discuss what they felt comfortable with. As part of the first session, the group developed group agreements, which included not sharing personal information about others from the group.

3.4.2.3 Data Handling.

All the sensitive data (consent forms, demographic questionnaire, interview recording, digitised creative pieces and transcripts) were stored on the University of Hertfordshire's OneDrive network, in line with the university's data management policy and the General Data Protection regulations. Only I had access to identifiable participant data and interview recordings. I only shared anonymised transcripts with group-members, consultants and research team once the data was anonymised, and identifiable information removed. Identifying information was kept until the study was complete, after which it was destroyed.

3.4.2.4 Right to Withdraw.

Group-members were made aware that their participation in the study is optional on multiple occasions. They were told they had the right to withdraw at any point, for any reason. They could also request for their data to be removed from the project, at any point up until after the final transcripts were agreed. This deadline was in place because I could not remove their transcribed data from the analysis once it was included in codes and themes.

Participants were informed that if they left before analysis their data (consent, demographics, participant payment information forms) would be destroyed. Anything they contributed during sessions they attended would not be directly quoted though I could not delete their speech from the transcript due to its contribution to the overall conversation.

3.4.2.5 Safety Measures.

Although the research is related to a potentially upsetting topic, the focus was not on past experiences, but future alternatives. During the initial screening call, I was checking to see how comfortable group-members were with the topic, and were sure of what they were going to be talking about. However, it is never possible to rule out the potential that someone might be triggered or upset. Following consultation with the Make Space Collective (an organisation who facilitate online peer spaces for people who do or have self-harmed) I built in several additional safety features to my protocol. They recommended check-in calls (to which I also added the option of email depending on participant preference) a day before and a few days after the focus group. On their suggestion, I also made group-members aware that they could book in a half an hour debrief the week following the focus group if they required. I made sure to explain this was not a crisis service. Finally, they also suggested I have a second facilitator to support in case anyone became upset, or dropped off the call (see Distress Protocol[15] – Appendix T). Participants were also given a list of emergency or crisis numbers, and details of phone lines to make use of if needed (Appendix U).

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[15] The Distress Protocol was a requirement of the REC. I looked at several examples while developing mine, and wanted to be very considered in how I approached it. While I was aware of the need to maximise the safety of those involved, I wanted to balance this with group-member autonomy and not wanting to replicate harmful

As with any group, it was important to establish a group contract during the first session to support the safe attendance of all involved (BPS, 2021). We spoke about guidelines of how everyone would like to be treated within the group, and impacts of dynamics within the group, specifically relating to safety and confidentiality. It was also explained in the case that someone felt upset and needed to leave, that they were free to just exit the call, and that the cofacilitator would call them to check they were ok.

3.5 Data Collection

Once I had enough group-members who had been through the screening process, I sent each participant an email to arrange the focus groups. I made the decision that focus groups would take place online using video conferencing software (Zoom). The use of online video conferencing tools was considered carefully. While they can be more convenient, reduce travel costs, and potentially increase accessibility (Gray et al, 2020), they can hinder rapport, exclude those experiencing digital poverty, and can be harder to ensure safety and confidentiality (Piacentini et al, 2021). Due to the time commitment required from group-members, I decided online groups might be preferable, making sure to maintain an awareness of the challenges described in the BPS guidelines for ethical internet-mediated research (Kaye et al., 2021).

With participant availability considered, I emailed each participant an invitation to three Zoom meetings. All focus groups took place in March 2025. The day before each meeting, I called or emailed (depending on preference) group-members to check they had received the link and were still happy to attend. Each focus group lasted 90 minutes. The group discussions were recorded visually online via the inbuilt software and audibly using an encrypted dictaphone**.** This was to ensure the conversations were recorded correctly and the information would be available in the event of any technical issues. The video recordings were checked, and once I was sure they were good quality I stored them on an encrypted drive, deleting the audio recording. Zoom software was used to transcribe these. I checked the transcriptions and anonymised the scripts to use as data. Group-members were sent the anonymised transcripts. Once they confirmed changes they wished to make to the transcript and sent it back to me, NVivo 14 (Lumivero, 2023) was used to analyse the data. Following the completion of each

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systems (often they suggested notifying people's care-coordinators). I wanted to make sure there was no difference in protocol for service-user or staff member, and that I was not unfairly discriminating against service-users by overreacting or over-policing their (potential) distress and underestimating their own ability to self-sooth and cope.

set of focus groups, the group-members were paid London Living Wage for the sessions they attended, in cash or BACS depending on preference.

Some group-members shared a creative piece with me, and these were uploaded to an encrypted OneDrive file. As a minority completed a creative piece, they were not analysed, however they can be seen in Appendix V.

3.6 Data Analysis

Although the staff and service user focus groups were conducted separately, I analysed the data as a whole. I used the six phases described by Braun & Clarke, (2006) to complete my RTA. While presented as six chronological stages initially, they later stated they wanted to "disrupt that sense of a rigid or stepped process" (Braun et al., 2022 p.426). In my process I found I often moved between phases. For ease of comprehension, the phases I moved through and between are shown below.

Table 14 *Six Phases of RTA (Braun & Clarke, 2006)*

Phase	Process
Phase One: Familiarizing self with data	RTA encourages "immersion" (Braun & Clarke, 2006 p.87), i.e. researchers to become as familiar as possible with their data. On finishing each of the focus groups, I noted down any observations or reflections in my journal (Appendix W). I rewatched the focus groups several times as part of the process to check and correct the Zoom AI generated transcript, which also aided my familiarity. During this process, I made notes of any specific points during the transcript that provoked particular interest.
Phase Two: Generating Initial Codes	I used NVIVO 14 (Lumivero, 2023) to code the dialogue from the transcript. Having familiarised myself with the data, I then began to work systematically through the data to produce some initial codes. These codes referred to certain features of the data, both sematic and latent (Braun & Clarke, 2006). Semantic codes referred to descriptive codes which described the data at face-value, whereas latent codes sought to understand the underlying meaning beneath what people were saying. To enhance reflexivity, I checked my codes with a team

	of other clinical psychology trainees and my supervisors. The aim of this was not to verify or validate my own coding choice, but to explore areas of difference and reflect upon how my assumptions and language might be influencing my coding choices and labels. Appendix X gives an example of part of my coded transcript.
Phase Three: Searching for Themes	At this phase, I began to start grouping my themes together under common sections. This was done in two ways. One way was to merge code names that almost overlapped e.g "sense of solidarity" and "shared experiences." The other way was to create wider group headings such as "Imagination" under which all codes relating to imagination could be grouped (see Appendix Y for an example).
Phase Four: Reviewing themes	At this point, I had to be ruthless with my initial themes. I was guided by a series of questions from Braun & Clarke, (2012). These prompted me to think about what themes I had an emotional attachment to, but were not supported by as much data as others. I also had to think about overlap and internal coherence, or if themes could be grouped under a larger umbrella theme. I also reflected upon the ability of each theme to respond to the research questions. Once I had developed a list of themes, I then rechecked these against my transcripts to ensure they spoke to the whole data set.
Phase Five: Defining and Naming Themes	During this phase I sought to sum up the essence of each theme in a few words. As a whole, I was looking for themes that provided a "coherent overall story about the data" (Braun & Clarke, 2012 p.66). I also developed sub-themes at this stage to ensure that theme names gave clear impressions of what I was hoping to convey about the data. I tested theme names with members of my research team and clinical psychology colleagues to again check for implicit assumptions I was making in my languaging and understanding of the themes. The result of this process is the final analysis, which is detailed subsequently and illustrated by a thematic map (Appendix Z).
Phase Six: Producing the Report	In this section I aimed to tell the story of my data in a clear and compelling way that does justice to the contributions of all the group

members. I used quotes to justify each theme and bound the themes together with a narrative that explained the story of the larger data. The write up is presented in the following chapter.

CHAPTER 4: FINDINGS

"Whatever contested images of a better future emerge, they will… necessarily fail- partly because of the limits of our imagination, partly because of the limits of our power. Even as they fail, they operate as a critique of the present and a reconstruction of the future. Utopia must continually be reinvented as one crucial tool in the making of the future"

Levitas (2013)

4.1 Chapter Overview

In this chapter, I present the findings from the TA in four main themes. These themes and their subthemes can be seen below, and trace the trajectory from current understandings of crisis care, to the efforts of participants to imagine something different, to the barriers to imagination, and finally the possibilities for transformation.

Table 15 *Themes and Subthemes*

Theme	Subtheme
Conceptualising Crisis Care	Attempting To Define Crisis
	Stigma and Othering Shaping Care
	Crisis in Care?
Glimmers of Imagination	The Power of Imagination
	Reimagining care
Barriers to Imagination and Change	Institutional Constraints
	The Prominence of the Ward
	Dominant Financial Discourses
	Power and Epistemic Authority
	Stuckness and Fatigue

Societal Transformation	Redefining Madness Building Connection and Collective Imagination

4.2 Theme One: Conceptualising Crisis Care

This theme explores the ways participants sought to articulate crisis and crisis care. Participants' understandings of crisis care were shaped by three key factors; what they understood crisis to mean, the narratives relating to madness and how they experienced crisis care through working or as an inpatient.

4.2.1 Attempting to Define Crisis

Across the groups, participants sought to explain and understand the term crisis. Although I did not ask them to, each group spent time thinking about what crisis was, and it appeared to be a key step in thinking about how crisis care might be conceptualised. Participants' understanding of the term crisis shifted, and as a result, so did their solutions to it. Carrie (staff), reflected on the limitations of the term in current mental health discourses:

> *I think the word [crisis] has become so unhelpful now, like… obscuring, even?... I don't think it's actually matching up with how people are experiencing their own moments of crises… how can we imagine a system, or a supportive network... if we're not even talking about the same things?*

In this quote, Carrie speaks to a disconnect between staff and SU conceptualisations of crisis. The lack of a shared definition, she suggests, risks undermining the development of effective support, as the people involved may be operating with conflicting assumptions and goals. Another staff member critiqued the dominant service framing of crisis as an isolated, acute event. She emphasised the importance of recognising the historical and contextual build-up to experiences of crisis:

> *When people mention crisis, they make it sound like it's acute…But when you look at people's histories… you can see there's a pattern, or there's a theme there*. (Zahira, staff)

Zahira's point resonated with several SU accounts. Lizzie (SU), described how experiences of delusions, viewed clinically as 'acute symptoms,' were often linked to recent life events, and so, while they *"may not literally be true…maybe link to some experience that you have just gone through."*

Therefore suggesting although a crisis may manifest acutely, crisis is often rooted in longer term psychological or social factors. Therefore there can be meaning within what are often described as ‘symptoms,’ though medicalised terminology can strip them of this. Similarly, Clara (SU) conceptualized crisis as *“a sense of being stuck,”* a cyclical experience in that she “*may climb out of only to fall back out of again*.” This framing supports Zahira’s assertion of the frequent “*pattern*” and recurrence of crisis.

Participants also reflected on what care in response to crisis entailed. For Ify (staff), care for someone in crisis depended on the individual’s manifestation of crisis. She felt some people in crisis “*just need some sort of respite*” and so heavy restrictions or mandated medication were not always necessary. However, she also felt crisis sometimes necessitates control:

> *I know someone who will tell you “If you don't put me on CTO [Community Treatment Order], I will not take my medication” and we know what that means…. he's going to relapse, and when he relapses he becomes a risk to himself and to others. So for someone like that, it is appropriate for him to be in a controlled environment*

Ify’s comments clearly draw upon a bio-medical framework of understanding madness, where medication holds a central role, and subsequent expressions of distress are understood through ideas of “*relapse.”* Josh (SU), with experience of CTO’s, held an opposing view “*I don’t think it [CTO] should be allowed… if they’re… a non-violent person, and… they feel the side effects are too much, they shouldn't be forced to*.” While Josh's stance is firmer than Ify’s, both acknowledge the complexity of care during crisis, particularly regarding the threshold for coercive intervention. Each suggest that crisis responses may require difficult trade-offs, though their interpretations of when such measures are justified diverge significantly. In contrast, Annette (SU), described that, for her, care meant “*mutually agreed… co-designed, co-produced, agreed.”*

This subtheme explored how the definition of crisis, and the shifts between individuals and services, is a foundational point of clarification. Participants felt that without understanding what was meant by crisis, care could not be appropriately matched. Where some participants drew on dominant frameworks of medicalised care, it also spoke to the differences that exist relating to the removal of autonomy and the boundaries of coercion.

4.2.2 Stigma and Othering Shaping Care

Many SUs reflected on the ways in which madness is perceived within broader society. Arpad described how “*stigma*” was something that has “*been going around for…centuries*” affecting “*how we [SU’s] understand so-called mental illness, and how people see it in general*.” His comments highlight the enduring nature of stigma and negative impact on both individual and collective perceptions of madness. Clara (SU) elaborated, noting that society "*shames people [experiencing madness], because there's something within that's afraid of anything that's different.*" Clara describes how madness is presented as a deviation from the norm, something unfamiliar and therefore to be feared or rejected. Lizzie (SU) also reflected on "*shame*," contrasting the response between physical and mental health. She observed that, unlike with physical illness, where someone might be met with expressions of concern and support, experiences of madness often elicit a "*weird silence."*

SU's often linked societal perceptions of madness with treatment approaches, including medication. Lizzie (SU) critiqued the dominant recovery narrative, arguing:

> *often the focus is just on repairing a problem that's perceived by others, which you may not experience as a problem yourself, necessarily, and getting you back to what is normal for society…. what will make me more palatable*.

She highlights how 'treatment' can be seen as a tool for social conformity, rather than focusing on individual flourishing. Arpad (SU) offered a similar critique, describing that, "*even though I'm treatment-resistant, I still have to take medication which isn't helping me*". He explained how "*now I have kidney disease because of mental health medication."* His experience underscores a troubling implication: madness is seen as so undesirable that even life-limiting side effects of treatment are considered acceptable, as is it better to be concretely physically unwell, than mentally unwell.

At times, experiences of madness were othered within the staff group. For example, when speaking about the challenges of providing crisis care when someone was very unwell, Amma stated "*they're not normal…, normal as in- because they're unwell*." Similarly, Ify noted "*we all have days where you are very depressed... But… you are still able to function even with this crisis, is what makes the difference between ourselves and them*." Although not representative of all staff views, these comments illustrate a difference in perception between SUs and certain staff who view themselves as 'normal.' This difference carries with it implicit value judgments, reinforcing hierarchical distinctions between staff and SUs.

This subtheme has looked at how narratives around madness influence crisis care. Participants spoke to how stigma and othering shape 'treatment' approaches, whether consciously or unconsciously.

4.2.3 Crisis in Care?

Across the groups people spoke to concerns around the current state of crisis care. Many described harm caused by crisis care, such as Matt (staff), who reflected "*I feel angry… thinking back to the harm that's happening all the time*." Zahira (staff) spoke to the inherent contradictions within current crisis care, describing how services are:

> *constantly reproducing harm, and then pinning all the blame onto the victim. It almost feels like an abusive relationship…The narrative is "Oh, I'm the hero trying to save you from this." But I'm also using abusive measures throughout it, like restraining, force feeding.*

Indeed, many SU spoke to instances in which treatment or protective measures became sources of distress. People described their horror at witnessing the "*brutal ways*" (Annette, SU) in which people were restrained, while others described their own experiences. Lizzie (SU) explained how she was "*restrained in my own bedroom, and the pillow was positioned under my face, and I actually couldn't breathe*." People spoke about medication in similar terms, for example Annette (SU) described "*being given a medication which just reduced me to an absolute zombie when I was at crisis point... I couldn't physically move. It was absolutely frightening, and actually made my mind worse*." These experiences led SUs to reflect "*sometimes crisis care… feels like it's not very care focused*" (Mary, SU) and more about "*control*" (Arpad, SU) in reflection of the embedded assumptions relating to madness and risk.

Staff were generally acutely aware of how services were perceived by those that used them. Amma (staff) reflected:

> *the complaints keep rolling in, and that's relating to a lot of how they don't feel cared for, how they feel that the service is against them, that we're against them, that we're not really helping them.*

While the quote illustrates Amma's awareness of the SU sense that their care is inadequate, many staff described feeling limited in the care they could provide on account of the system they worked in, reflecting on how "*boundaries that are put in place make that [care] difficult and restricted*" (Chris) "*bureaucracy*" (Zahria), "*set barriers*" (Amma) and "*restriction as to how much of care we can give*" (Ify). For staff in this position, understandably, there was a sense of frustration in being caught between the care they could provide, and the care they wished to provide. Staff frustration presented an interesting point of comparison. While SU reported experiencing direct coercion and removal of choice and autonomy, staff spoke to restrictions on how they were 'allowed' to care, by the system.

There was a sense from both groups, to different extents, that they were prevented from acting how they might wish by systems larger than themselves.

This subtheme has outlined the main concerns that participants had when speaking to how crisis care currently operates within the UK. Participants spoke to the inadequacies of care, especially focusing on the harm justified under so-called care, and the limitations of choice experienced by staff and SU.

4.3 Theme Two: Glimmers of Imagination

This theme looks at the glimmers of imagination that occurred within focus groups, presenting imagination both as a tool of transformation and a site of struggle. This theme explores the ways participants perceived imagination and the role it played, before looking at what they envisaged.

4.3.1 The Power of Imagination

This theme speaks to how participants perceived imagination. When introduced to the speculative nature of the project, participants spoke at length about their understanding of imagination, and its central role in sparking change.

Overall, people conceptualised imagination as a positive and powerful force. Several participants described imagination as a "*very powerful tool*" (Ify, staff), essential to "*survive or improve your situation*" (Josh, SU). Mary expanded on this, explaining "*if you don't have imagination, you can't think of change… you're just in what you are*." Therefore, it appears that participants viewed imagination as the mechanism methodologies for envisaging a range of alternatives to the present. Zahira (staff) linked imagination to being "*creative and open-minded*," as it was a "*realm where everything is possible… you're not necessarily thinking about if it's feasible*." In this view, imagination stands at odds with rigidity and the status quo, creating space to explore a range of possibilities, without the pressures of finding the 'correct' solution. Carrie (staff) described imagination as a form of survival, in bleak moments, when wondering "*How can we survive?*" especially when everything "*feels so oppressive… "there is this strange optimism," even though I see myself as pretty much a pessimist*." Carrie thinks about imagination as something that is resilient and can be found in moments of desperation.

However, a few people also described challenges with imagination. Arpad (SU) described imagination as "*a double-edged sword*" as he believed imagination was affected by one's state of mind. Therefore, he cautioned about how "*if you're not well… you're probably speculating on things that are going to happen to you in a bad way*." Lizzie (SU) described a similar occurrence, stating that "*sometimes that [imagination] can take us down routes that can be potentially harmful to us.*" While on balance, both felt the positive force of imagination outweighed its potential shortcomings, it showed an awareness that imagination could, in certain circumstances, bring about worse possibilities.

Finally, Matt (staff) spoke to how sometimes, in the wrong context, imagination "*feels just like another layer of toxic positivity*." In this, they spoke to the conflation of imagination with "having to pretend everything is fine." While imagination, as others described, can be a source of hope and potential for change, Matt's perspective reminds us that it can also be misused, becoming a means of denial, rather than empowerment. This underscores the importance of context in shaping whether imagination is experienced as liberating or limiting.

This subtheme has looked at how participants understood the potential power of imagination. Although imagination was viewed as something favourable that supported hope, it was also seen as fragile and could be negatively influential, as some participants also highlighted how imagination is not always positive and can at times be a guise for toxic positivity.

4.3.2 Reimagining care

There was a distinct difference in how the groups reimagined care. Although both groups found reimagining challenging, SU immediately had several ideas and found it easier to describe the care they would like to receive. Staff appeared to find the task of imagining much harder, thinking less of the care that SU might receive, and more towards ways that might alter or improve their own roles providing care.

Within the SU group, one idea, envisioned by both Arpad and Annette, captured the group imagination:

> *not a respite home, but a holiday home… in the country where people could go who were having a crisis, who could be with nature… All sorts of novel things that could be introduced… not just medication.* (Arpad, SU)

Arpad and Annette's vision served as a conceptual anchor to which others attached their own. Many SU highlighted the importance of "*embodied*" care. Elsewhere, Clara described experiences of madness as a profound dislocation from self, and therefore this quote speaks to how embodied care is something that can be grounding and restoring, helping to bring someone 'back to themselves.' Others proposed body-based therapies such as "*massage*" (Annette, SU), "*yoga*" (Arpad, SU), and "*aromatherapy,*" a "*menu of different sensory interventions*" (Lizzie, SU) and "*physiotherap*y" (Clara, SU).

Nature was a prominent feature in SU imaginations, as a symbolic contrast to institutional spaces. Josh (SU) suggested support "*should be out in nature somewhere*" while Arpad (SU) situated his imaginings in a "*large forest with a lake.*" Other participants frequently evoked nature through references to smell and atmosphere: like "*fresh grass, flower, pine trees*" (Annette, SU), "*warm and smells of summer*," (Clara, SU) or "*clean like fresh air*." (Mary, SU). Nature was therefore associated with a sense of calm and wellbeing, in stark opposition to traditional controlled and contained crisis settings.

Connection featured heavily in SU imaginings. For some, this took the form of a trusted individual; Lizzie (SU) hoped for "*people who can act as Doulas, or guides… to nurture you through [crisis]*," while Arpad (SU) described the role of someone who could offer flexible companionship:

> *somebody who will sit with you and not force you to talk. But just be there. So you're not alone*

Annette (SU) also spoke about connection, describing the soothing presence of others within a collective. She imagined a communal sleeping space where being in silent community was healing in itself:

> *presence of other people…it makes you feel better…. I just think that connection again with other human beings in a room, nobody's saying anything, but the presence.*

Implicit in SU comments about connection is a critique of current care where connection is absent, and SU feel a profound sense of isolation and loneliness. These imaginings point to a deep desire for relational, human-centred care.

SU often foregrounded choice and agency in the things they imagined. Arpad used the metaphor of a "*buffet, so that you could take up the food any time you wanted*" as a way of underscoring the autonomy within the imagined setting. Lizzie extended this metaphor to spiritual guidance, envisaging a "*spiritual buffet*" as she "*wouldn't want to be prescriptive*" when thinking about what guidance people in crisis should receive. Similarly, Annette, though she felt strongly about the importance of feeling like she was not alone, acknowledged the need for individual options: "*it's very important at times for your own room…some people much prefer that*." The focus on choice reflected a nuanced and relational imagining of care that emphasised flexibility, autonomy, and responsiveness to individual differences.

SU also spoke to altering material conditions. Lizzie described how "*a citizen's Advice Bureau [is needed] for mental health related legal challenges and other situations we find ourselves in*". Lizzie also imagined changes to incapacity benefit, so that the employer was responsible for paying for someone's sick leave and would receive sanctions if there was a clear pattern with employees becoming unwell. In Arpad's imagining, the centrality of food and shelter are significant, speaking to how, without considering basic needs, crisis support cannot be effective.

It was notable that staff, on the whole, found it harder to think about alternatives. Some staff spoke about the role that technology might play in alleviating a stretched system. For example, Amma (staff) wondered, in the context of increasing automation and cuts to staff budgets, "*would there be a robot… giving that quality of care and service…so SUs would be able to have that holistic approach.*" Similarly, Ify (staff) suggested with improved technology, implants could be used to "*alert professionals…just before crisis stage*." Notably, several SU also spoke to the potential role of AI as something that could be there when they were "*without… access to a physical person who was available*" (Lizzie, SU). It is interesting to note how, in the absence of resource and actual human presence and connection, individualised AI is suggested as a solution.

However, most of the dialogue focused around changes to the existing system, and what they did not want. Matt described how they hoped that it would be possible to move away from "*medical… [and] dehumanizing language*." Carrie (staff) and Zahira (staff) both agreed, feeling that medicalised language was a way to alienate someone from their own experiences.

Staff spoke to the need for a future crisis care to support staff as part of the system. Ify (staff) asked:

> *Who looks after us when we are in crisis? … We have policies on paper, but how are our emotions taken into account in reality?*

This was echoed by all the staff, with Amma (staff) highlighting the need for "*genuine care*" for both staff and SUs. In their reflections, staff emphasised the profound emotional strain of constantly witnessing distress. Like SUs, they expressed a desire for a model of care that not only centres compassion, but also includes staff as recipients of that care. Staff appeared to suggest that the impact of a harmful system could be mediated by focusing on improving the situation for staff.

This subtheme has looked at the ways in which people reimagined alternatives to crisis care. SU created an imaginary 'base' which allowed them to speak to and reconceptualise different elements of crisis care, and begin to think about creating an alternative system. However, staff reimagining was more limited, focusing instead on specific elements within the current system, and thinking about how these could be changed, often without overall transformation.

4.4 Barriers to Imagination and Change

Although participants spoke of the transformative power of imagination, and the potential benefits it might bring, more often it felt like their belief that change was possible was being blocked. This theme explores the mechanisms that inhibit imagination and possibilities for change. Therefore, this section focuses on the role of institutional constraints, current models of care, financial discourses of cost and efficiency, power hierarchies and the subsequent state of stuckness in which many participants found themselves.

4.4.1 Institutional Constraints

As mentioned previously, those within the staff group found it noticeably more challenging to think about alternatives to the inpatient setting. While the SU group felt more relaxed with most participants expressing a sense of solidarity, the staff group was slower to build a rapport, and there were frequent silences. This sub-theme explores some of the mechanisms for this, looking at staff capacity, safety and feelings of 'enmeshment' with the institution.

Many staff described how challenging they found it to begin to imagine alternatives to the current crisis care model within their working environment. For example, Zahira explained:

> *when it comes to the NHS, imagination is a bit tricky, because you need the time and capacity to do it, and….to feel safe… to feel like you can actually now picture something different.*

Zahira highlights the need for space and safety to foster imagination, factors expanded on by other staff members. Carrie describes imagination as a "*luxury… if you have the time*," reflecting although innovation was meant to be part of the job, the time available was minimal and often deprioritised. From a SU perspective, Arpad reflected that, due to "*pressure…psychiatric nurses, they spend more time in the office doing paperwork, trying to keep up with all their targets*," concluding "it's a system thing." Within the sessions, a microcosm of this appeared to play out. Participants were invited to contribute a creative piece about an alternate world where crisis care had been completely reimagined. One staff participant submitted an AI-generated piece of text around the future of inpatient care. I wondered if (though cannot verify that,) they felt they lacked time or emotional bandwidth (whether the invitation became another task on an already long list), or if there was fear or self-consciousness about how their imagining might be received.

Staff frequently mentioned safety. Matt, a health care assistant, described the intense pressure to “*fit the culture of the group*” or risk “*severe and frightening repercussions, like bullying, like being ostracised*.” While Matt felt this pressure would be less acute for Occupational Therapist’s (OT)’s or psychologists on account of their increased relative autonomy, this was not always the case. Zahira, a trainee psychologist, noted individuals who highlight problems or attempt to work differently often become “*scapegoat[s].*” Amma, an OT, also reflected on how she had been shamed by her team members for trying to provide more compassionate care:

> *I want to move forward. I want to make changes. And sadly, being labelled myself difficult, not easy to work with, too soft…it's not very encouraging, actually puts a lot of my confidence down.*

These comments, illustrating staff’s need to self-police, make sense of some of the group’s reticence, particularly when it came to ideas. In the first session, participants were invited to engage in a series of speculative exercises. This proved especially challenging for staff, and while some had previously used their microphones, during these activities they chose to respond via chat or remained silent. This shift suggests staff may have felt vulnerable or self-conscious about how they would be perceived by colleagues. Their later reflections on being judged for speaking out or sharing ideas helped explain this reticence.

Staff members described how certain work practices limited their imagination. Zahira described how, in the NHS, “*it's about policing the imagination because it's so risk focused.*” Lizzie (SU) expanded on this, stating how, especially in the treatment of psychosis symptoms, psychiatrists were unwilling to do things differently as “*no psychiatrist is going to want any sort of “relapse,” … on their books, because it's a black dot against their name… therefore, they operate in a way that mitigates risk rather than aiming for that holistic well-being*.” Ify (staff) built on this, arguing within the NHS you are:

> *working in an environment where there are ground rules, regulations and policies that you have to work in…those confines. That means you're … limited as to what you can actually bring in*

While regulations and policies are important for ensuring a level of standardised care and safety, some of these quotes speak to how the environment can become stifling, or overly rigid and regulated. Amma reflects on how working in the context left her feeling like she had no agency:

> *we're kind of forced to think a certain way, we're not really thinking, are we? We're made to follow without having our say.*

Finally, staff spoke to how, as people working for an organisation "*we're so deep into it…we're in the jobs where we represent the system as wel*l" (Carrie, staff) it became challenging to explore alternatives. She highlights an uncomfortable contradiction between criticising the organisation, and realising by doing so she is implicitly criticising herself. It's ambiguous whether it is the proximity to the monolithic organisation or the need to preserve oneself within the organisation that makes envisaging challenging. Either way, the context does not prove conducive to imagination.

This subtheme has looked at the challenges institutional constraints created for people trying to imagine alternatives. It has examined how limited time, fear, habitation and organisational regulation constrain both individual and collective contemplation of alternatives to existing crisis care.

4.4.2 The Prominence of the Ward

This subtheme speaks specifically to how a medicalised model, in this case the ward, often created a block to imagination that participants struggled to overcome.

Zahira (staff) discussed the impossibility of recovery within coercive systems, referencing and paraphrasing Bulhan's (1985) work on Franz Fanon when she said "*like Franz Fanon said… you can't be in therapy unless both people are free in that space*." She went on to describe how the very experience of being trapped would leave someone "r*eally struggling to manage*." When asked what they might put in its place, staff struggled to conceptualise an alternative. For example, Ify described "*an online ward, so you're not in a physical hospital…it's a virtual ward*." Similarly, Carrie (staff) expressed confusion at what could happen instead of a ward:

> *what would these systems do when they get in contact with the person who's presenting with a lot of distress to them…. and they have nowhere else to put them? And they feel like they don't have the resources*

What feels apparent in both Ify and Carrie's comments is the immutability of the ward as the environment for crisis care. In both quotes, although imagining a fictional world, it appears that their framework for care has not changed. Within a bio-medical model, madness is managed through medicalisation and 'treatment.' Therefore, in the absence of the ward, no alternative could be imagined, unless, of course, it resembled and served the same purpose as a ward.

In thinking about alternatives to crisis care, it is striking that the most imaginative concept, in many ways, bears remarkable similarity to a ward – a location in which people experiencing madness are grouped together under the care of staff. SU also made this comparison, referring to the crisis location as a "*hospital*" (Josh, SU) or comparing it to "*a private ward*" (Mary, SU). This speaks to the limits of imagination, highlighting the challenges in reconceptualising the system around care.

This subtheme has illustrated how the dominant medical model of care and the primacy of the ward further reproduced or remodelled itself in the imaginaries of the participants. It suggests the challenges involved in remaking or reimagining something that already exists, no matter imperfectly.

4.4.3 Dominant Financial Discourses

This subtheme discusses how the wider financial landscape influenced people's imaginations through capitalist-informed discourses of finance and scarcity. These discourses were threads that ran throughout the focus groups, influencing how able SU felt to demand care that met their needs.

One of the most noticeable ways this emerged was through participants' need to justify public spending on mental health care by demonstrating its potential long-term cost savings. When Annette (SU) described the location for the crisis retreat, she also spoke to saving money:

> *Crisis prevention breaks…they will stop admissions on wards which have got to be costly… having a patient as an inpatient… is very intensive in terms of staff time. The NHS… is already under-resourced. So this is a preventative measure.*

Similarly Arpad (SU), having described the choice, autonomy and services available in his imagined crisis holiday retreat at length, proceeded to discuss how it could be cost saving:

> *I don't think it would cost that much, actually… because having a buffet… I don't think that would be that expensive… Sleeping bags aren't that expensive now, neither hammocks… It doesn't need bricks. It can be made out of wood… like a log cabin, except on a bigger scale.*

This quote, in which Arpad breaks down how each element of care can be made to cut costs or save long term, shows how swiftly a utopia can be brought to reality, and how even an imaginary world is impacted by, and needs to be justified to, current scarcity narratives. Relatedly, when SU were talking about the nature lodge, Annette (SU) expressed trepidation in referring to it as a holiday home:

> *These respite homes, or... we don't call it a holiday home, do we? Because the whole disability haters will jump on- we're being pampered*

Annette described a persistent sense of self-policing that accompanies advocacy for those experiencing madness. When asked about why financial concerns were so prominent when designing services, Arpad and Lizzie reflected that often they were made to feel guilty for simply using services. Arpad explained his GP had told him "*you are a very expensive patient*," a statement that shows how economic discourse can shape self-perception. Lizzie reflected on the decision to prioritise other spending over health care:

> *I think it's hard, because… there are plenty of other things we do spend on, and that's never questioned. So why is it that we're the Cinderella of services?*

In the absence of alternative dominant narratives, discourses around who is deserving or underserving began not only to impact how participants imagined alternatives, but also how they imagined themselves. There were a few times when participants sought to distance themselves from the 'bad patient' who are (the paradigm dictates) deserving of restriction, coercion and medicalisation. For example, Lizzie spoke to how, in being restrained, she was "*treated like a criminal…and you know, I'm not a very tall young woman, and I wouldn't be a physical threat to anyone*." Although understandably Lizzie feels her treatment is unjust, her sense of injustice appears to rest on the idea that the treatment she received would not be unjust if she were someone tall or male or criminal, holding on to a relatable sense of self by separating from a stigmatized identity of 'dangerous mental health patient.'

This subtheme has examined how the financial discourses shape people's capacity to imagine. This sub-theme has sought to illustrate how cost-saving rhetoric becomes internalized and proceed to shape imagination.

4.4.4 Power and Epistemic Authority

Power, or lack-of, was a major discussion point. The groups spoke readily to how those in positions of power exerted their epistemic authority to silence those with less power, and maintain the status quo. In conversation, people discussed how often power was self-sustaining:

> *I think inequality and poverty is the driver of most crises… Everybody says, "There's always going to be world hunger. There's always going to be poverty somewhere." But…if you look at the statistics, we have enough food for the whole world, it's just the distribution is unequal… the solution is there- which is equal distribution- but we can never get there because of power being the only truth in the world if you like.* (Carrie, staff)

Carrie is critiquing power, stating not only that the powerful hoard resources, but they create conditions in which the unequal context is viewed as a natural fact, rather than a product of political decision. However, she also questions why, when power is so beneficial for the powerful, would this ever be given up? Therefore Carrie suggests that power specifically seeks to curtail or obscure an understanding of what could be possible. Zahira (staff) expands on why this is, reflecting because imagination "*fuels us to be able to live fulIy as we want to... it makes sense to oppress that, because that's the starting point of everything else*."

In acknowledging power was self-serving, people described how options for different types of crisis care were limited by how those who were in power imagine them. Frequently, people mentioned how those in charge of major decisions around health were ill-qualified. Ify (staff) reflected it shouldn't be "*politicians or businessmen*" designing care, stating instead it should be "*people who are knowledgeable in this area, people…who have experience*." Similarly, Arpad (SU) felt "*it would take an overhaul of governmental policies*" to improve care. Both quotes suggest those who hold the power are not acting in the interests of those who require care, and until their influence is removed, it will present a barrier in what was possible to be imagined.

Within a care context, participants spoke to the need for those in positions of power to control the narrative:

> *Psychiatrists have a God complex… and that comes down to their inferiority because they know…, "You are practicing a pseudoscience." "You don't understand how your drugs work." "There are no medical biomedical tests to prove what your hypotheses are…." anybody practicing that would probably feel a little bit embarrassed by these gaps and want to shore that up by projecting a heightened degree of perceived authority*. (Lizzie, SU)

In her reflection, Lizzie critiqued the operation of psychiatry, suggesting that psychiatrists' insistence on a singular truth often stems from a deeper insecurity about the validity of their profession. This rigidity can act as a defence, protecting professional identity at the cost of alternative perspectives. Zahira (staff) noted that change was perceived as "*very scary,*" which Carrie (staff) reflected it could be perceived as a direct challenge, or even threat, to some staff members' authority:

> *It could be more threatening for people [staff] to accept that, actually, people do have ideas about their own care, and they know themselves! They tried those things that maybe you studied all your lives for! But actually, this is the life that they've lived! For much longer than you studied for, etc*.

Carrie highlights how the need to assert their authority is linked to a desire to protect their position. In saying this, she also uplifts the lived experiential knowledge of SU's, reflecting that often their input gets minimised in comparison to academic knowledge. Several SUs echoed this, with Mary describing how SU were portrayed as "*not being 'reliable narrators*'" and had their concerns ignored.

This subtheme has explored how power acts as a barrier to imagination. Participants described how often people in positions of power acted in their own interests, controlling the narrative to ensure their position was maintained.

4.4.5 Stuckness and Fatigue

Across the groups, participants described feeling stuck and a sense of emotional fatigue. They readily acknowledged the negative effect this had on their imaginations and will to generate change.

Staff, in particular, described the frustration of attempting to make changes within services but feeling unable to. Many expressed a sense of powerlessness; either because they felt powerless to enact the changes needed, or the changes attempted had been ineffective. Carrie (staff) captures this below, indicating a sense of fatigue and disillusionment:

> *We just feel very ineffective, or… bigger systems out there that require us to be a certain way. Or we've… [b]een there, done that, tried that! But the underlying message is quite similar…it can sound very depressing, and very hopeless.*

Matt picked up on this sense of frustrated effort, and described how imagination was "*almost experienced… like a criticism, naivety. Like, "Well, we've tried everything. It doesn't work. So yeah, what is there to talk about?*" Matt suggested their team members felt that their efforts pushing for change were akin to criticism and threat. This was echoed by Zahira (staff) who stated "*Change in and of itself is a very scary topic within inpatient settings*," leading to feeling a lack of change that made her feel "*stuck….and more and more frustrated*." However, it appeared there was little relief from this stuckness; Amma (staff) reflected the lack of opportunity for a different type of experience providing care:

> *So even if you… think to yourself "Okay, let me just go and find something else." But you're actually going into another hamster wheel. It's just a different colour wheel, perhaps a new design. And but it's the same thing rotating, which is not very nice.*

The evocation of the hamster wheel, something that requires constant effort, and produces fatigue, with minimal returns is significant. The quote suggests that in Amma's view, whichever job she might move to, the feeling of futility would follow.

Feelings of stuckness did not exist only within the staff group. For example, Mary reflected that while she found it easy to acknowledge the

> *idea that things need to change but… being unable… [or] not quite aware of how the changes could be implemented. But… hearing other people's experiences … felt good.*

Mary speaks to her own feelings of overwhelm at where to start with thinking about change, despite being able to identify areas for change. The quote also suggests that thinking with others was a helpful process in 'unsticking' some of her thought processes.

Many participants found themselves critiquing the current model and reforming aspects of pre-existing structures of crisis care. The task of redesigning crisis care was emotive, and ultimately, perhaps this impacted the ability to reimagine a system that is currently unlikely to be radically reformed:

> *I feel a bit conflicted between… optimism and hope and imagination, and anger… at politics and… wider structures … And I feel a bit conflicted about… how to like hold those two things together, and how they work together.* (Matt, staff)

Matt explains how they are trapped between hope and anger, leaving them unsure of how much to imagine. Implicit in the quote is the fear of unrealised imaginations, and the pain that that might cause, having acknowledged the need for change. In this context, imagining can be seen as an interruption in the strategies people have developed for surviving within harmful systems.

This subtheme has explored how a feeling of stuckness and emotional fatigue across the groups inhibited people's ability to imagine. It spoke to how the emotional exhaustion of failed change and stagnancy led to a collective resignation and sense that change was not possible.

4.5 Societal Transformation

While many of the focus group conversations highlighted barriers to imagination, participants also discussed what might foster a world in which imagination is possible – one that could support alternative forms of crisis care. This theme explores how shifts in societal understandings of madness, alongside connection and collective effort, might enable imagination and transformation in crisis care.

4.5.1 Redefining Madness

This subtheme explores how people hoped madness could be reconceptualised. Many spoke to the need to broaden narratives and reintegrate madness into everyday understandings of what it means to be human. Many SU described an overall framework of spirituality to make sense of their experiences at a personal level. However on a larger societal scale Clara (SU) reflected:

> *I think we've really… lost understanding of what it means to be a human and experience those extreme states*

Clara suggests that madness is often understood as something 'other,' removed from normative human experience. Lizzie (SU) expands on this point, referring to people experiencing madness as:

> *the canary in the coal mine… saying there's something wrong in this family, or structure that is harmful…it's not necessarily you that's diseased. It's the system that is.*

Lizzie reattributes the origins of madness to the environment, rather than the individual, suggesting that distress can be an indicator of wider systemic dysfunction. Many participants felt this understanding should be shared more broadly. For example, Apad (SU) felt that there should be:

> *Education from an early age... discussing…not explaining what mental illness is, but just discussing how people cope with extreme emotions, crises and things like that….[and] to treat people as you would like to be treated*

Arpad called for a greater level of understanding of madness in context, and as an understandable response, rather than somewhat taboo and mysterious. Participants suggested this shift should begin early; in schools, in nurse training (Lizzie, SU), and among the public. Some staff (e.g. Carrie and Matt) acknowledged how difficult such a shift would be, and suggested that art could be a method to shift viewpoints:

> *The only way we could do it is by somebody completely outside of this world looking in on us…using art as a medium, as a tool… that would…get us out of… the practicalities of the*

> *everyday, to be able to reimagine in the first place. To be able to make a political commentary, to be able to change rhetoric, change narratives…. TV shows can do that (Carrie, staff).*

Carrie explained how she feels it would take a total shift in perspective, or a suspended reality, such as a TV show (or a "*musical*" -suggested by Matt), to transcend the barriers of day-to-day reality. Others reflected on how madness itself should be harnessed as the medium which allows people to think more creatively. For example, the "*creativity that can exist in mania, divergent thinking*" (Lizzie, SU), or how "*people have used extremes of experience…. To really and inspire... produce great art, and things which people can relate to or want to understand*" (Clara, SU). This thinking suggests madness can allow people to access patterns of thought and ideas that are not accessible to others.

This subtheme has focused on the centrality of changing the narrative of madness as something that will impact how crisis care is approached. Participants spoke to the role of education and the arts in creating this shift.

4.5.2 Building Connection and Collective Imagination

Participants often spoke of connection as an essential condition for transformation. This subtheme explores how these connections might be attempted, the impact of being in community and how community can influence and broaden individual perspectives.

Staff often felt a clear lack of community amongst themselves and felt unsafe suggesting alternative ways of doing things. Matt (staff) speaks to the need for community and the power of solidarity below:

> *everyone at every level of the hierarchy should be, and could be, using their imagination, and…doing things differently. And if we all… banded together with more solidarity and…implemented our imaginations things could maybe change from below*

Matt implicitly acknowledged the limits that exist when trying to create change alone. They speak to how, with a shared understanding, and a mutual desire to push back against concerns or harmful practice, change might be possible, or people might be more able to voice ideas. Within the SU group, who overall commented less on feelings of stuckness, participants spoke to the *"sense of empathy, mutual appreciation, and understanding, that sense of having that common experience*" (Clara, SU). This was not the case for staff, who spoke to how:

> *I… didn't anticipate this level of resistance or lack of safety, basically, to be able to break out of our own systems. (Carrie, staff)*

Carrie describes how feeling unsafe led to resistance in her own, and the group's, imaginings. Given the group was made up of individuals who had expressed a desire for change, this felt significant, making me wonder how networks of solidarity and support might be built between staff, but also between staff and SU to enable collective imagining (this will be returned to in the discussion).

SU spoke frequently to uniting in personhood, and the shared experience of humanity that transcended experiences of madness. Clara reflected "*Distress is part of the human condition, we all need to help each other more*" and Arpad described how "*we're all human… nobody is better than anyone else. We all start off equal and life changes us, and hopefully we change for the better.*" These quotes were emblematic of the SU group, who spoke often for their desire to uplift others, striving to bring about a fairer, more caring world, in which experiences of madness can be accepted and integrated into the fabric of our own conception of ourselves.

Finally, people spoke to the importance of having a view informed by a collective understanding and vision. The two following quotes describe this:

> *honouring as many different perspectives…as possible….the more voices that come into the conversation, the better it is* (Lizzie, SU)

> *it's been insightful hearing from other people…sometimes you think in a certain way, but when you hear other people's view about the same thing… it kind of widens, or broadens your own thinking* (Ife, staff)

These reflections suggest imagination can be a collective process, and how there is not just one imagined future, but multiple, which can all build on each other.

This subtheme has looked at how community and connection enable imagination and hope to be fostered. It explored how a feeling of shared experience and solidarity can enable people to question the status quo, and how imagination is a collective endeavour.

CHAPTER 5: DISCUSSION

"If we do act, in however a small a way, we don't have to wait for some grand utopian future. The future is an infinite succession of presents, and to live now as we think human beings should live, in defiance of all that is bad around us, is itself a marvellous victory"

Zinn (2004)

5.1 Chapter overview

In this chapter I provide an overview of the research. The chapter begins with a summary of my findings in relation to the research questions. Following that, I contextualise my findings in the pre-existing research. I will then consider the implications of my research, and critically appraise the research, identifying strengths and limitations of the study. I will then explore invitations for future research and conclude with my reflections on completing the study.

5.2 Summary of Findings

While there are many critiques of crisis care, there is very little that speaks to how it might change, and how it might be possible to reimagine a new crisis care going forwards. The project of reimagining, as participants experienced, is unwieldy, challenging and overwhelming. However, I think there are seeds of hope within the results. In identifying the barriers to imagination, we can work to overcome them, and in discussing alternatives and transformation we can speak to the values that must guide any developments in crisis care – community, choice and collaboration.

Overall, participants found the process of reenvisaging an alternative to crisis care a challenge. However, they did generate several meaningful imaginings. As part of the process, participants spent significant amounts of time contextualising their understanding of crisis and madness. This took the form of defining what crisis was, as they felt that how someone was supported though crisis depended on how the crisis was understood. For most participants, crisis was not something that just 'happened' but instead was part of a pattern, one in which SU reflected they sometimes felt "stuck." Notable in defining crisis was the push and pull between bio-medical and experiential understandings, leading to a divergence in how a crisis might be approached. In exploring how madness was perceived on a societal level, SU highlighted how often experiences of madness were stigmatised. Participants all readily acknowledged and described the harms that occurred as part of their own experiences of crisis care, from overmedicalisation, coercion and bureaucracy.

Participants sought to reimagine crisis care in a number of ways. When thinking about imagination, participants spoke about how they viewed it as something vital for hope and change. Several participants also highlighted how imagination is not always positive, as we can imagine harmful things, and how imagination can be coopted as a tool of 'toxic positivity.' SU created a collective vision of a space in nature that allowed them to be in community and access relational support on their terms, along with a range of body-based therapies. Emphasised within this vision was a sense of freedom, choice and agency, both in the space they inhabited, and the decisions they made about their wellbeing. In addition, SU also thought about more structural reforms, such as penalising employers who frequently had unwell employees. Staff, in comparison, struggled more with the task, focusing instead on changes to the preexisting system, such as a reduction in medical language and improved staff care. Staff also explored the role that AI and robots might play, suggesting a VR ward, or how automation might alleviate an overstretched system.

Participants also reflected upon just how hard imagining could be. In some cases, participants described how various barriers were impacting their imagination (e.g. institutional constraints, power and epistemic authority, or feeling stuck), but in other cases, the barriers appeared less visible, or the impact that they had on people's imaginations felt in some ways obscured to them (e.g. dominant financial discourses or prominence of the 'ward').

Within the focus groups, participants also discussed how these barriers could be overcome. Everyone agreed a change of perspective in health and madness was required, and both groups highlighted the role of art in this. SU also spoke to education and how incorporating mad wisdoms and knowledge could support both an increased acceptance of expressions of distress and more structural changes. Finally, the role of connection and community was highlighted throughout, whether negatively by the sense of fear and isolation felt by staff, or positively by the healing SU felt through the company and companionship of others. It is notable that my experience of the two groups was stark, whilst the SU group felt mutually supportive, warm and hopeful, the staff group felt atomised in comparison.

5.3 Links to Existing Literature

5.3.1 Crisis Care

Participants' descriptions of crisis care were largely negative. Participants criticisms, on the whole, fell in line with pre-existing literature relating to the challenges of inpatient care. SU spoke of overmedicalization, coercion, and restraint (Olofsson & Jacobsson, 2001; Silva et al., 2023), whilst staff described experiences of overwhelm, bureaucracy, and moral injury (Deady & McCarthy, 2010; Juneja et al., 2025; Laker et al., 2020), suggesting that the current model of crisis care fails both groups. When staff described the term 'crisis' as "*obscuring*" this can be understood within the framework of hermeneutical injustice (Fricker, 2007). The dominance of the bio-medical framework in crisis settings can limit the conceptual resources available for SU to articulate or validate their experiences in socially legitimized ways. When the bio-medical is presented as a singular explanation of madness, Armstrong (2023 p.13) states that SU are "undermined as epistemic subjects," suggesting they are systematically alienated from their experiences.

SU's linked their negative experiences of crisis care to a wider narrative that deems madness as 'other' and deviant. Participants spoke directly to 'treatment' goals that prioritized "*what is normal for society"* and "*control*" over SU own sense of recovery and physical health. Esposito and Perez, (2014, p.214) stated that "most current psychiatric treatments merge with neoliberal ideology" in so much as structural problems are ignored, and the focus is on an individual and their 'resilience.' Furthermore, they point to the role of medication as something that is "often designed to modify behaviours to fit normative patterns of neoliberal agency," (Esposito & Perez, 2014, p.216) which links to both SU understanding of being made more "p*alatable*" and a staff desire for SU to be "*normal*." One way to understand this is through the Foucauldian lens of 'disciplinary power' and 'biopower' (1975; 1978). Within healthcare these two work in tandem, by first seeking to create norms in order to exclude that (or those) which fall outside of it as 'abnormal' and subject to 'correction' and secondly by using these norms to manage and control the population, increasing productivity and economic growth through control enacted via professional groups (Lilja & Vinthagen, 2014).

However, while valuable, a Foucauldian lens analysis cannot be used to fully explain the state of crisis care, as both within my study and others, staff frequently spoke about their own perceived lack of power, feeling limited or like they lacked agency to work as they hoped (Laker et al., 2020; McMullan et al., 2018). This could be understood as a form of mirroring, in which staff subconsciously identify with the SU emotional experience (Johnston & Paley, 2013). However, I found Armstrong's (2023 p.13) focus on the NHS as an "accountable bureaucracy" more compelling. He speaks about how a bureaucracy requires documentation for every action taken to be auditable. In this context, parts of work that are harder to quantify become problematic, which in health care refers to immeasurable factors, such as building relationships and trust with SU (Armstrong 2023). Instead of focusing on providing meaningful relational care, like participants wished they would, staff were overwhelmed by bureaucratic procedures and managing risk which Graeber (2012, p.112) refers to as "ways of managing social situations… founded on structural violence." This reading makes sense of staff feelings of overwhelm and powerlessness, and SU feelings of impersonal and risk-averse care, without losing an overarching understanding of how market forces manipulate crisis care as it stands.

While deinstitutionalization had felt a promising process, moving crisis care in a different direction, it marked the start of the bureaucratisation of care. Although large numbers of people were being transferred from asylums, adequately funded community care was not forthcoming (Wright et al., 2008). Slow sales of the asylums, combined with a meagre mental health budgetary increase (1.8%) in the 1974 NHS reorganization meant the aspirations of a robust community care model were unobtainable (Gawron, 2019). Enquiries into early failures of the model led to "the creation of an audit culture with a focus on risk management" and the introduction of a number of new bureaucratic processes (Cummins, 2019 p.42). SU and staff within the study described how the focus on mitigated risk superseded the ability to provide holistic care. This prioritisation of bureaucratic and risk processes over genuine concern for SU and relational practice has been highlighted in pre-existing literature (Armstrong, 2023; Turner & Colombo, 2008).

5.3.2 Challenges

Similar to many of the papers within the scoping review (Bosley et al., 2022; Bray et al., 2022; Dillahunt et al., 2023; Harrington & Dillahunt, 2021; Walsh, 2023) I found asking participants to imagine alternatives was not without challenge. Within the scoping review, three papers spoke specifically to how their imaginings were limited or influenced by concerns of the present (Bosley et al., 2022; Harrington & Dillahunt, 2021; Walsh, 2023), linking to some of the challenges participants of this study had, imagining crisis care without stigma, financial constraints or wards.

Many of the barriers to imagination that the participants faced existed in response to systemic pressures, and the self-regulatory mechanisms through which SU curtailed their own imaginations could be understood through the lens of disciplinary power (Foucault, 1975). A clear example of this is Annette's invocation of the "*disability haters*," who although not present in the discussion, led her to modulate her imaginings. This sense of “observation” is described by Foucault in the account of Benthem’s Panopticon, where constant visibility to an unseen observer leads people to self-police and self-censure (Foucault’s 1977 p.170). In simpler terms, ‘observation’ is the mechanism in which stigma is internalised.

Extensive research has demonstrated the negative impact of stigma on individual wellbeing (e.g. Elliott & Doane, 2015; Markowitz, 1998; Sickel et al., 2014). SU described how experiences of stigma affected them, especially in relation to their sense of their own value in literal terms - how much money they felt it was acceptable to dedicate to crisis care services. However, stigma does not exist as a purely self-disciplinary process, stigma is enacted by those who exist outside of the individual deemed ‘other.’ Research highlights how stigma can operate structurally, influencing resource allocation and treatment even in domains such as physical healthcare (e.g. Corrigan et al., 2004; Thornicroft et al., 2007). In this study, such dynamics were visible, for example, when Arpad’s care provider referred to him as an “*expensive*” SU, or in some staff’s perception of SU as “*not normal”* or through the binary of ‘them and us’. Internalising negative narratives can also be understood in terms of System Justification Theory (Jost & Van der Toorn, 2012), which suggests that people often defend and maintain the current system, even when that is harmful to them. In this context, challenges in imagining alternatives, or perceptions of being burdensome, may not only reflect stigma, but the psychological investment in the perceived legitimacy of the status quo.

A significant part of my findings emerged not only from participants’ explicit responses, but from observing the process itself. While the scoping review indicated imagining alternatives might be more difficult than anticipated, the process made it abundantly clear. I, like some participants, was “*struck and surprised*” by how challenging the process was and unpicking this feels essential. The stuckness I witnessed led me to draw parallels between the perceived permanence of certain structures (such as the ward or the biomedical model as the only ways to manage crisis) and Fisher's (2009 p.1) concept of ‘Capitalist Realism’ in which “not only is capitalism the only viable political and economic system, but also that it is now impossible even to imagine a coherent alternative to it.” While the current bureaucratisation of care, and spiralling rates of madness in capitalist societies are arguably entangled with neo-liberal policies, Fisher’s framework captured me for broader reasons. He articulates how discourse, in a Foucauldian sense, renders “poverty, famine and war….as an inevitable part of reality, while the hope that these forms of suffering could be eliminated easily is painted as naive utopianism. Capitalist realism can only be threatened if it is shown to be in some way inconsistent or untenable" (Fisher 2009, p.22). The insight is echoed by Goode and Godhe, (2017 p.113), who remind us "discourses and ways of knowing are inextricably entwined with material forces (economics, institutions, violence, the biosphere and so forth). Again, the upshot is that both present and future may not be as easily 'loosened' as we might wish." In this sense, participants' difficulty in imagining alternatives cannot be reduced to a lack of creativity or will; it reflects the deeply embedded and materially reinforced nature of dominant structures. For example, Carrie's comment on the construction of poverty and hunger as seemingly 'natural' and therefore politically neutral, mirrors Fisher's analysis. But unlike Fisher, she admits she cannot imagine an alternative. Gramsci, quoted in Fiori (1970 p.106-7), explained this in the following terms "people hesitate and lose heart when they think of ... a radical change.. and fail to perceive the new order which is possible, and which would be better organized, more vital than the old one." This speaks to a broader tension - although participants often recognised the flaws of the current system, imagining an alternative felt like too great a task.

Participants described how their own hope was perceived as "*naivety*" by others, and therefore led them to feel increasingly "*hopeless*" contributing to a sense of feeling "*stuck*." The view of hope as something naive speaks to how its devaluation is a key tool for maintaining the status quo. In panel discussion Hartman (2020) echoing ideas of disciplinary power states "so much of the work of oppression is about policing the imagination,". Indeed, hopelessness, felt by many of the participants of this study, can be seen as synonymous with the sense of stuckness. As Wright (2010 p.16) suggests, "fatalism… reduce[s] the prospects for change" by shutting off alternatives. Instead, many writers seek to reconceptualise hope, not as something naive but as a "fight" (Freire, 2017 p.65), a "practice" (Weingarten, 2007 p.3) or a "discipline" (Kaba 2021 p.27) in which hope can be mobilised as an active survival strategy.

It was notable that although both groups found imagining alternatives challenging, staff found it considerably more so. One way this can be understood is through social identity theory (Tajfel & Turner, 1979) in which staff identify with their professional group and seek to further the perceived interests of the group to enjoy their relative proximity to power. In that reading, suggestions of change to staff practice can be read as threat, something multiple staff participants described. Alternatively, Herzfeld (1993 p.7) describes bureaucracy as a "secular theodicy" which functions as a "social means of coping with disappointment." In the face of evidence suggesting the central role of social inequality and injustice (Bell & Marmot, 2018; Nazroo et al., 2020) in experiences of madness, clinicians aware that they cannot make changes on these levels might use bureaucratic process to reassure them of their efficacy. As such, disrupting this might shake their own individual sense of purpose. However, for SU who might feel ostracised, like many other groups living within the margins, there is no choice but to imagine an alternative, as this is the only recourse to potential power.

5.3.3 Alternatives

It was striking to observe some of the similarities between participants' suggestions of alternatives to inpatient care approaches that have already been tried, or are still being tried. While in part this might speak to the challenges in imagining beyond those things already in existence, it would be foolish to totally dismiss them as such. Instead, arguably it speaks to common values relating to crisis care, such as the role of autonomy, connection and reducing medication use.

One of the prominent ways that SU reimagined crisis care was a "*holiday home*" in nature, that fostered a sense of community, with the option of additional support if people needed it. Central to this vision was SU freedom - to choose the care they wanted and not to be isolated from others. This emphasis aligns with recurring themes in research on SU experience, where autonomy (e.g. Katsakou & Priebe, 2007; Valenti et al., 2014) and connection (e.g. Eldal et al., 2019; Gilburt et al., 2008) are identified as vital components of meaningful care. It is easy to make links between this holiday home and some crisis houses. For example, Maytree (2022) in London provides a free "non-medical residential befriending service," staffed predominantly by volunteers. A key feature of such services is their relational approach within a non-clinical setting, which appears to resonate strongly with SU preferences. Similarly, within OD, the focus on creating meaning and understanding the context of the person's experiences (Sekkula et al 2001) and "unconditionally accepting and respecting" (Galbusera & Kyselo, 2018 p. 4) the individual experiencing madness linked to many of the participants' wishes for experiences of madness to be understood as part of, rather than other to, human experience. Equally, the Soteria Network which promotes community and is against coerced medication (Calton et al., 2008) also maps on to the ideas and values of SU within the study. However, the continued existence of genuine alternatives rests on uncertain ground. The very nature of crisis houses and the Soteria Network is to provide an alternative to mainstream, professionalised, biomedical approaches. However, in the current climate, this often leads to chronic underfunding, reliance on volunteer staffing and closure.[16] Instead, crisis houses are being increasingly professionalised, with the majority under NHS management

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[16] For example, the UK's only Soteria House, opened briefly in Bradford in 2015 for a 10-month pilot, and is still seeking volunteers and additional funding to reopen (Soteria Bradford, n.d). Due to similar challenges, there are very few independent crisis houses. The aforementioned Maytree is one, although it underwent a two-year closure, only opening again in April 2025, cancelling previous plans to liquidate the charity (Maytree, 2024).

(Mind, 2018) and operating through crisis team referral only (Dalton-Locke et al., 2021). There is a tension between precarious funding, whilst retaining the essence of a non-bureaucratised model, and continued existence on a more secure funding which loses the relational essence that facilitated change.

The process by which alternative models become absorbed into the mainstream warrants critical attention. The Hearing Voices Network (HVN), which began as a radical, survivor-led network of peer-run spaces, now faces the risk of "clinicalization" (Jones et al., 2016 p.116). Increasingly, HVN groups are run by NHS services or large national charities, and often require formal referrals (HVN, n.d). Several studies have explored the efficacy of the HVN model (e.g., Corentin et al., 2023; Longden et al., 2018) alongside its feasibility for use within NHS settings (Branitsky et al., 2025). A similar trajectory is evident in the ODDESSI trail, which asks if the OD model can "fit in with how existing NHS services operate" and "result in good clinical outcomes" (Open Dialogue Centre, 2022). In both cases, feasibility is tied to cost reduction for the NHS. While I am wary of being overly cynical, and recognise the value in mainstream services seeking to adopt more relational, holistic, or survivor-informed approaches, I remain concerned about the extent to which large bureaucratic systems can integrate alternative models without in some way compromising them. I believe the tension between institutional adoption and the preservation of radical intent is a crucial area in evaluating the future of these approaches.

5.3.4 Transformation

One way to understand the findings of this study is to view the crisis in crisis care as a symptom of a wider malaise. People spoke not only to challenges within services, but linked these to their political context, discourses within society, and capitalism. A crisis care that focuses on the chemical-biological roots of madness at the expense of the social and political causes is impoverished. For meaningful change to occur, many point to the need to radically rethink not only how services are run, but how the structures around them operate (Adler-Bolton & Vierkant, 2022; Foucault, 1965; Frazer-Carroll, 2023; Hemphill, 202). While it is far beyond the scope of this study to comprehensively explore exactly how this can take place, some ideas for how this might occur will be considered below.

Participants spoke to the need for a shift in perspective, greater connectedness and change in wider structures for genuine alternatives for crisis care to take place. In the context of what has been described as the current 'polycrisis;'[17] genocides in Sudan and Palestine, irreversible climate change,

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[17] Polycrisis is a term first coined by Morin and Kern, (1999 p.74) referring to multiple interlinking crises occurring at any one time

Trump's presidency, and rising global inequality, it can be challenging to hold on to the hope that transformation might be possible. Participants described a sense of powerlessness when confronted with what felt like immovable structures, such as the NHS, the UK government, or capitalism. However, in understanding the mechanisms of polycrisis, which exist due to the interconnected nature of our world (Lawrence et al., 2024) there is hope that action, even on a smaller level, will impact and create change on a larger level.

With the awareness that transformation rarely occurs instantaneously, but is instead the product of incremental changes over time, the abolitionist concept 'non-reformist reforms' coined by Gorz, (1968) is a helpful concept in thinking about the role of reform within transformation. Non-reformist reforms are any reforming process that seeks to "undermine the prevailing political, economic, social order, to construct an essentially different one, and build democratic power toward emancipatory horizons" (Akbar, 2022 p.2507). In this context, improvements to carceral ward cultures (i.e. better staffing or repainting wards) would not count as a non-reformist reform, as while these may create small improvements, they do not challenge the underlying structures, in many cases obscuring them, or further legitimising their practice (Ben-Moshe, 2013).

Where participants could imagine alternatives, this opened possibilities for change and supported a critical interrogation of the status quo, a process that helps "expand rather than shrink our horizons" (Goode & Godhe, 2017 p.118). Similarly, Spandler (2009 p.672) highlights the role of "imagined ideological and 'utopian' alternatives" that help "fuel and sustain…ideas about change." One enduring example is the Trieste mental health model. Franco Basaglia, an anti-fascist psychiatrist and director of the Trieste asylum, reimagined crisis care by closing the institution and establishing community-based, restraint-free services (Mezzina, 2014). He aimed to reshape the community itself, converting the asylum into housing with art studios, theatres, and cinemas, recognising that "much that is therapeutic comes from the arts… from eating, drinking and laughing together" (Asylum, n.d.). McLaughlin (cited in Spandler, 2020, p.16) observed that the core struggle was ideological: challenging exclusion's class basis and promoting the decriminalisation and depsychiatrization of distress; Trieste, he noted, revealed how "the sane only hold a temporary truce against madness." Although Basaglia had been inspired by UK TCs, critics, and even Basaglia himself (Burns, 2019) suggest that the model was context specific (Muusse et al., 2020), and could not be scaled due to population homogeneity, access to affordable housing and public support of deinstitutionalisation (Allison et al., 2020; Portacolone et al., 2015).

The model continues to spark inspiration and offer hope that an alternative approach is possible. Although not perfect, Crossley, (2002 p.813) describes Trieste as an “working utopia” which formed part of a “laborator[y] of experience.” This resonates with Levitas’ (2013 p.219) argument that all utopias are flawed, and that instead “utopian envisaging is necessarily provisional, reflective and dialogic” encouraging us to see experiments such as Trieste not as complete answers, but creative prompts for further envisaging. Within the scoping review, several papers (Bray et al., 2022; Carey, 2023; Kafer, 2023; Lu et al., 2024) reject the ideas of a universal solution, suggesting instead that there is no one way to imagine the future. Kaba, (2021 p.167) echoes this in noting to the generative nature of striving for change, “We’ll figure it out by working to get there. You don’t have to know all the answers.” Together, these thinkers remind us that we don’t need a perfect destination to begin moving; change begins in the act of imagining and trying.

A prefigurative approach, suggests “futures do not just happen; they are created by our actions” (Carey, 2023 p.2). When thinking about wider systems change, it can be challenging to think about what action needs to be taken. Silver, (2018 p.163) describes “everyday radicalism,” as the way “social action creates a rupture with the everyday,” linking this to Rancière’s concept of “dissensus…. the moment when the dominant discourse becomes disrupted.” Within the research, Arpad’s deceptively simple call to “*treat others as you would be treated,*” an ethic he tries to live by, can be read as a moment of dissensus. In a bureaucratic system governed by risk and medicalisation, his emphasis on shared humanity perturbs dominant discourse. It can be seen to challenge the dehumanisation (of both staff and SU) that can occur within crisis care, and points to a more relational practice. Moments such as these were emblematic of the SU focus on the collective over the individual, and against the dominant discourses. Moments such as these can be galvanised, and as brown (2022 p.2019) says, “by tapping into the potential goodness in each of us we can generate justice and liberation, growing a healing abundance where we have been socialised to believe only scarcity exists.”

5.4 Implications

The findings from the study illustrated that there is a problem with crisis care, illustrated both by participants’ eagerness to take part and their responses. However, the task at hand is complex, and wide reaching. Not wanting to fall into the trap of “economic reductionism” (Hall, 2006 p.34), whilst a significant increase in funding might alleviate some of the current issues, pouring funding into the same broken systems without considering the socio-political-relational is unlikely to radically alter them. Formulating an operational set of implications feels like an overwhelming task, but in the mode of antiperfection (Reynolds, 2020 p.3), I have made the following suggestions. I hope these can serve as lines of flight (Deleuze & Guattari, 1987 p.3) seeking to challenge and reconfigure the underlying logics of care, knowledge, and power.

5.4.1 Futures Literacy

"The map to a new world is in the imagination" (Kelley, 2002 p.3). The capacity to imagine alternative futures is regarded as a challenging but necessary component of change. Creating opportunities for futures literacy (Dillahunt et al., 2023; Jamieson & Discepoli, 2021) and cultivating spaces to slow down, reflect, and imagine are essential. Speculative methodologies offer an invitation to do so. For clinicians, this might involve speculative prompts and questions in reflective practice, or the formation of informal peer networks or networks of solidarity dedicated to imagining and reconceptualising care. Inspired by Arpad's thoughts around education, there is potential within professional training programmes, not only to think more philosophically about madness, but also to prompt training staff to reflect on the type of care they would like to provide, and the futures they envision for healthcare etc. However, Kelley (2002 p.xviii) reminds us "it is not enough to imagine a world without oppression…We must also understand the mechanisms or processes that not only reproduce subjugation and exploitation but make them common sense and render them natural or inevitable." Therefore, imagining different futures must also go together with interrogating the current structures and assumptions that constrain them.

5.4.2 Learning From Mad Wisdoms

The research highlighted the importance of broadening our collective understanding of what it means to be human and how we think about care. SU involvement within the NHS runs the risk of being tokenistic, or coopted (Madden & Speed, 2017; Noorani et al., 2019). For meaningful change to take place, SU need to have far greater role than consultation. Services must commit to meaningful co-production, approaching SU not as one monolithic block, but creating space for the diversity of SU knowledges, experiences and imagination (Wallcraft et al., 2003). For this involvement to be meaningful, suggestions made need to be operationalised, or trust in the process will be lost.

However, I am also drawn, like my participants, to the role of arts in sharing the mad wisdoms and non-normative perspectives. Although not psychiatric-specific, groups such as *Sins Invalid*, a disability justice performance collective (USA), and the *Freestylers* (UK) whose website describes them as a "disability led group of neurodivergent artists" (Freestylers, N.D) use performance, dance and film that challenge the notions of 'normal' and 'disabled,' speak to common humanity, and highlight structural issues. These groups focus on the art and messages their members wish to tell, creative expression and catharsis, focusing upon themes of resistance and joy. hooks, (2014 p.149-50) described the margins as a "site of radical possibility, a space of resistance….a central location for the production of counter hegemonic discourse" offering "the possibility of radical perspectives from which to see and create, to imagine alternatives, new worlds." Society at large needs to learn from the margins, and therefore we need more opportunities that allow people to create and be listened to. Arts-based and narrative practices should be recognised not just as therapeutic tools, but as politically and socially generative methods that can help bridge the divide between SU and society more broadly.

5.4.3 Coalition

The research spoke to the value of solidarity and creating community. Moten and Harney, (2013 p.140-141), like Fanon (1967) before them, speak to the need for those in relative positions of privilege or power to recognise that the system also harms them when they say "I don't need your help. I need you to recognize that this shit is killing you, too, however much more softly." Implicit in this is the concept of "interdependence" (Berne et al., 2018 p.228), that is at the core of the Disability Justice movement, the idea that everyone's wellbeing is intertwined.

Basglia's model was powerful in part because it created the conditions for people to build community through ongoing trust and connection. While community cannot be artificially constructed or imposed, there is a pressing need to explore how we dismantle the divide between 'them' and 'us' to acknowledge the humanity of the 'other.' As Thornicroft et al., (2007 p.1124) suggest, stigma is best combatted by "social contact" or community. Staff needed SU perspectives and hope within the research, which pointed to regular joint imagining spaces, consultancy or opportunities to provide training for staff.

5.4.5 Work to Provide Alternatives

Accessing timely and comassionate care within the current system remains deeply challenging (Crawford et al., 2013; Rethink Mental Illness, 2025). In the absence of assessible and responsive alternatives, people are often left with no choice but to wait until they reach crisis point, or to amplify aspects of their experiences (such as risk) in order to be heard. This highlights the urgency of cultivating and resourcing the grassroots, peer networks and organisations that already exist, offering relational, non-pathologising forms of support, alongside enabling new initiatives to develop. Strengthening and legitimising the role of alternative care models helps counterbalance the dominant bio-medically informed crisis care, supporting a more pluralistic mental health system, facilitating SU choice and agency. Ideally future policy and funding decisions should recognise these alternatives not adjunct and ‘nice-to-have’ but essential componants of care, but we cannot risk waiting. In the mean time, strengthening current alternatives can look like volunteering, fundraising and grant writing for alternatives, being part of mutual aid collectives, lobbying and campaigning for change.

5.5 Critical Appraisal

5.5.1 Quality Appraisal

As this is a qualitive study, using a quality appraisal tool which focuses upon reliability, validity, and objectivity, all of which fit more with a positivist epistemology (Winter, 2000), felt less relevant. However, Tracy's, (2010) ‘Big-Tent’ appraisal categories balance rigour with my understanding of research values and integrity. The results of this are presented below:

Table 16 *QA of this Research Using Tracy's (2010) Big Tent*

Criteria	Evaluation	Rating
Worthy Topic	Tracy (2010 p.240) states good qualitive research is "relevant, timely, significant, interesting, or evocative." Although there is much research focused on inpatient care, very little thinks about what alternatives there can be to it, especially from a service user perspective. In using speculative methods, I drew on methodologies from disciplines outside of psychology, leading to a novel approach to a familiar topic.	✓✓
Rich Rigor	I conducted an extensive literature review and detailed methodology, indicating rich rigor. I was able to draw on well-established pre-existing frameworks relating to power, control and bureaucratisation, all of which were situated within the context of inpatient care. I used an interdisciplinary approach, drawing on research and theory from a range of disciplines, as this broadens the perspective of the research. It was challenging to find studies illustrating how speculative methodologies could work in these settings, so in some ways the approach was exploratory. In terms of data sample, it was notable that the SU	✓

	group was majority white, despite research indicating BPOC are disproportionately affected by the MHA (NHS England, 2024). For a richer data set, a broader perspective from a diversity of voices and positionalities would have been preferable.	
Sincerity	I began the study with an exploration into my own position in relation to the research, the reasons for my interest in the topic and the contradictions within my own insider-outsider position as research. Within the research, where appropriate, I have spoken in the first person to highlight my subjective role in some of the decision making, along with my perspective and reflections. I have also included a reflective account. While my own biases will have shaped and impacted my data collection, data analysis and reporting, I have engaged with reflective conversations with the research team, the body of literature and others throughout to expand my perspectives.	✓✓
Credibility	I increased the credibility of my research in a number of ways. I used a wide range of texts, from a range of disciplines, to support and add to my arguments. I used a reflexive analysis (Braun & Clark, 2006) and participant quotes extensively when discussing my themes. I spoke with EbE who supported me with theme checking to ensure the theme names and content were congruent with the quotes provided. However, to improve the credibility I could have included further detail in explanations and examples of the analysis process.	✓
Resonance	I am unsure if I can objectively comment on this. However feedback from supervisors, consultants and people I have spoken with regarding the research has been positive. As mentioned before, I included extensive quotations to ensure the participant voice is heard through the research. While the topic relates to	✓✓

	inpatient care, the themes brought up relate to broader themes relating to inequality, capitalism, what it means to be human and hope which should resonate with those outside of this field.	
Significant Contribution	To my knowledge, there is no research so far within the discipline of psychology that asks both SU and staff how they would try to reimagine crisis care. However, the barriers encountered in doing so led the research to speak more to known conflicts within crisis care than novel reimaginings of crisis care. Regardless, the method allowed for a novel approach to the topic.	✓
Ethical	Ensuring that the project was ethical was central to my process. Ethical approval was obtained from NHS ethics board. I outlined my ethical considerations in my methods chapter. My own values in undertaking this research were paramount, and I sought to go beyond formal ethical requirements; paying my participants, check in calls before and after each focus group, as well as longer debrief spaces as required. I will continue to uphold my obligations to those who took part in the research by ensuring that I disseminate the findings of the research, including participants in the process as and where I can (if they wish to be involved).	✓✓
Meaningful Coherence	I have tried to provide meaningful coherence in my study - the epistemology and methodology I used were compatible with my research aims. I was able to explore the questions I set out to answer, although it was possible to explore some answers more fully that others. I sought to contextualise my research findings within existing literature, making recommendations that could be useful for ongoing practice.	✓

5.5.2 Strengths

A key strength of this research lies in its methodological novelty. Although speculative methodologies have been widely used in design (Dunne & Raby, 2013; Galloway & Caudwell, 2018), they are rarely used within the world of psychology. While inpatient care is an area that has been researched extensively, asking those who have the most knowledge about inpatient crisis services, notably staff and SU, to imagine an alternatives to the current system is something without precedent. Dunne and Raby (2013 p.2) describe how speculative methodologies are a helpful tool to "open up new perspectives on what are sometimes called *wicked problems,"* where there is no easy solution. Haraway, (2016 p.3) described this as "staying with the trouble" and refusing to concede to cynicism. I believe there is great benefit in using methods, explanatory theories and research that spans across academic borders, as transcontextual approaches (Bateson, 2016 p.84), acknowledge the overlapping contexts in which these 'wicked problems' occur and allow us to respond accordingly. Although the study was not without challenges, it identified and explored the implications of the degree to which bureaucracy and prominent discourses curtail imagination, and identified the need for a collective response to this.

Reflexivity was a crucial part of this research process. I used RTA (Braun & Clarke, 2019), which encourages greater researcher reflexivity, identifying my own epistemology, relationship to the research and reflections on my insider outsider researcher positions. Writing a reflexive diary and speaking with both supervisors and EbE allowed me to reflect and explore how my own perspective and desires for the research might be impacting my approach.

5.5.3 Study limitations and reflections on future directions

While this was a novel study, making a unique and original contribution to the field of clinical psychology, there are also important limitations to highlight. Given this research is part of the assessed requirements for obtaining the doctorate in clinical psychology, there are certain elements to the process that potentially inhibited the project. While time and funding are obvious examples, it is unrealistic to expect that any research can be freed from these constraints. However, methodologically speaking, there was a requirement to conduct a review of literature, often a positivist leaning process which in its essence is at odds with a more speculative approach. Given these constraints, a scoping review was designed which felt both worthwhile (not a tick box) and in keeping with the aims of the study; however, it undeniably took time and wordcount that may have been better used to more fully embrace the speculative elements of the research. Similarly, whilst speculative approaches allow for more methodologically amorphous approaches, including less data driven processes such as more creative workshops, the integration of theatre, social dreaming or even an autoethnographic approach in which my own lived experience became part of the data, none of these would have been possible (or at best severely hindered) by the scope and timeframes of DClinPsy research.

While the scoping review was both novel and followed a transparent and replicable design and methodology, the review also had several limitations that need to be considered by the reader. Key terms in a review determine the boundaries of what is included and excluded. Due to my own experience of religion and a desire to personally distance myself from it, I failed to acknowledge how religion or spirituality can be a site of social injustice and therefore did not include it within my key terms. However, as raised by many of my participants, spirituality and faith had vast significance when it came to understanding and making sense of their experiences (of life and madness), therefore neglecting this as an area of potential injustice was an oversite and it is recommended that this is included in future reviews of this area. Similarly, due to the form of the scoping review, I was not able to include practical examples of where people are using speculative methods to combat social justice issues because they were not written up in the literature - for example, *the vacuum cleaner's* MadLove project is a good example of where speculative methodologies have been used to tackle social justice issues, however there was no available literature to include it. This highlights some of the constraints of traditional Western research that foregrounds and validates some forms of knowledge production and sharing (such as academic journal publication) while marginalising others (such as storytelling, more informal community resource creation or art).

Due to concerns around accessibility and equity (e.g. transport, time, and participant comfort) I opted to hold the focus groups online. While this fostered greater inclusion (by e.g., reducing time and financial burden), allowing some to participate that might otherwise not have been able to, on reflection, I believe that conducting these groups in person might have better facilitated the generation and sustainment of imaginative thinking. An in-person setting may have fostered a greater sense of community among staff, helping them feel safer and more supported in exploring imaginative possibilities. Many staff participants were joining from their workplaces, which likely limited their engagement due to competing demands and distractions during the working day and possibly impacting their ability to 'step outside' of their contexts. A new space may have created opportunities for greater imaginative scope. An in-person format would also have allowed for the use of more physical, creative tools, such as drawing materials, Lego, or photographs, which may have further enriched the discussions by opening up alternative modes of expression and exploration (Hitchings & Latham, 2020).

Speculative methodologies speak to the use of ‘probes’ (Bosley et al., 2022; Bray et al., 2022; Dillahunt et al., 2023) in generating and cultivating speculative thought. While the initial session used numerous creative activities to support speculative thought, session two and three focused upon the questions participants raised. I had decided on this approach to give participants more agency, allowing for the sessions to be shaped by the questions they had sought to ask. However, it might have supported further speculative thought, and approaches to their questions, if these activities had continued throughout, as suggested by other speculative methodologies researchers (e.g. Dillahunt et al., 2023; Harrington & Dillahunt, 2021). As a result, the speculative element of the research felt largely limited to the first focus group, with the second two being less distinguishable from a ‘traditional focus group.’ On reflection, along with additional probes, or the use of more immersive techniques to enhance people’s resource to imagination (such as immersive theatre approaches e.g. creating a ‘spaceship’ to travel to a future where mental health care needs are met before exploring speculative prompts), with more time I could also have explored people’s artwork. Within the current project, not everyone took up the creative prompt; however, more space to create art works within the session might have changed this, and a chance for participants to use their creative output as a prompt to explore their speculations might have enhanced things further. Similarly, within the current project, a follow up interview with those who had completed creative pieces to unpick the meaning of them might have added further richness and data for analysis. These additional steps are recommended for future psychology researchers who apply speculative design in their studies.

Given that the MHA is disproportionately used against people of the Global Majority, with Black people most disproportionally effected (NHS England, 2024), it was noticeable that although the staff group was racially diverse, the SU group was majority white. I am mindful there are very good reasons that people from communities that have been systematically discriminated against might not want to engage in research relating to that discrimination, especially with a white middle class trainee clinical psychologist researcher. However, that does not absolve me of the responsibility of reflecting on how I could have better approached my recruitment, and if there were things I could have done differently that might have led to a more diverse SU group.

5.6 Invitations for Future Study

The current study has invited SU and staff to reimagine crisis care services. Reflecting on the findings and the process of the research, there are several suggestions for further research:

Table 17 *Suggestions for Future Studies*

Theme	Reflection
Repeat in Person	I would be interested to explore how this research would have differed if it took place in person, with speculative probes interspersed across sessions, with easier access to additional means of expression (art materials). It would be especially interesting to see if being removed from a clinical context created a significant difference for staff imaginings.
Repeat with Different Groups	The decision to recruit staff and SU was due to their proximity to (and therefore expertise of) the ward in mind. However, I did receive a suggestion I should have included families and those who support those experiencing madness. Additionally, although logistically challenging, I wondered if it might also be possible to conduct a version of the group with people currently within services. Finally, I thought about how different it might have been if there had been a number of staff groups, differentiated by profession.
Use Speculative Methods in Psychology	Although there were significant barriers to imagination, this (to me at least) is an indication that we need to encourage and cultivate imagination more. As a methodology it supports the “embrace [of]…complexity” (Gerber, 2018 p.2) and broadening of perspectives, rather than the narrowing of focus. While these methods may especially lend themselves to service (re)design projects, I think it could equally be well suited to think about broader topics such as stigma, or around so-called wicked problems such as child protection processes.
Current Alternatives to Inpatient Care	Although current alternatives to inpatient care were briefly explored within this study, it would be beneficial for further comparative investigations between different alternatives.

5.7 Dissemination

My proposed strategy for dissemination can be seen below:

Table 18 *Dissemination Strategy*

Activity	Description	Audience	Goals
Publish in Open Access Journal	Submit an article based on key findings	Academics, clinicians, policy-makers	Share findings widely, contribute to scholarship, ensure accessibility
Co-Produced Workshop Series	Develop and run participatory workshops with study participants, sharing findings and asking workshop participants speculative prompts from the research. Tailored for NHS teams, peer support groups, and DClinPsy programmes	NHS staff, SU networks, DClinPsy trainees and academic staff	Spark dialogue, influence practice, extend speculative methods, create feedback loop
Podcast / Article/Zine Featuring Participants	Collaboratively produce a podcast, zine or creative article exploring the findings and the process of doing speculative work	General public, clinical communities	Share voices, democratise research impact, reflect on method and power, foster creative engagement

5.8 Conclusion

This study spoke to two sets of participants, SU and staff, both of whom had experience of inpatient care, to invite them to reimagine crisis care. As part of this process, I was also interested in understanding how people defined crisis care, what would need to change in the world for crisis care to change, and how people responded to the prompt around imagination. To conduct the research, I was inspired by speculative design approaches in which group-members are encouraged to think about and critically engage with the future. To my knowledge speculative methodologies have not been used within psychological research, therefore it makes an important methodological contribution.

Findings emphasised how an understanding of crisis and the role of stigma mediate current approaches to crisis care. On the whole, participants described the role of imagination as something that fostered hope, and acted as an anchor during tough times. However several people challenged the assumption that imagination was always a positive force. Participants imagined a range of alternatives to crisis care; SU focusing specifically on a crisis retreat, where autonomy and connection were paramount and SU had access to a range of support options, notably body-based therapies such as yoga, massage and aromatherapy. Staff also spoke to a more relational configuration of crisis care, in which genuine care was prioritised for both staff and SU. Participants explained that there were numerous challenges to their process of imagining, describing how institutional constraints, current models of care, financial discourses around cost and efficiency, power hierarchies and the subsequent state of stuckness they experienced impacted how possible it felt to imagine. Finally, they explored how changes to societal understandings of madness, alongside connection and collective effort might enable imagination and foster a new approach to crisis care. The discussion explored the impact of bureaucratic systems on the ability to provide care, the machinations of disciplinary power and the challenges with recreating pre-existing systems. It then looked at the challenges experienced by the current alternatives to inpatient care, from co-option to insufficient funding before exploring the role of working utopias in enabling a change to harmful systems.

5.9 Final Reflections

Writing these reflections as part of the final push of the write up, in the context of news updates that make me want to cry daily, I am aware of the fragility of hope. The process has been a discipline that has allowed me the opportunity to think deeper, read more and engage in many conversations about what it means to be human and to dream of a better world. I am conscious of my confidence at the start of the project that led me to dismiss queries about how challenging it might be for people to imagine. I would have benefitted from reflecting about this when planning sessions, and thinking about more ways to facilitate imagination and encourage people to stay with the glimpses of imagination they had.

I am hugely indebted to the people who gave up their time to speak to me, strove to imagine different worlds and were honest about how and where their imagination faltered. The research highlighted to me, for the times when I forgot, the transformatory power of community and connection, and brought me back to my starting point - one in which care for self involves care for others as part of a “global vision wherein we see our lives and our fate as intimately connected to those of everyone else on the planet” (hooks, 2000, pp.87-88).

Now more than ever, we need to practice hope, practice imagination, and build community that will enable us to endure and transform.

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Appendix

Appendix A - Search Terms for Scoping Review

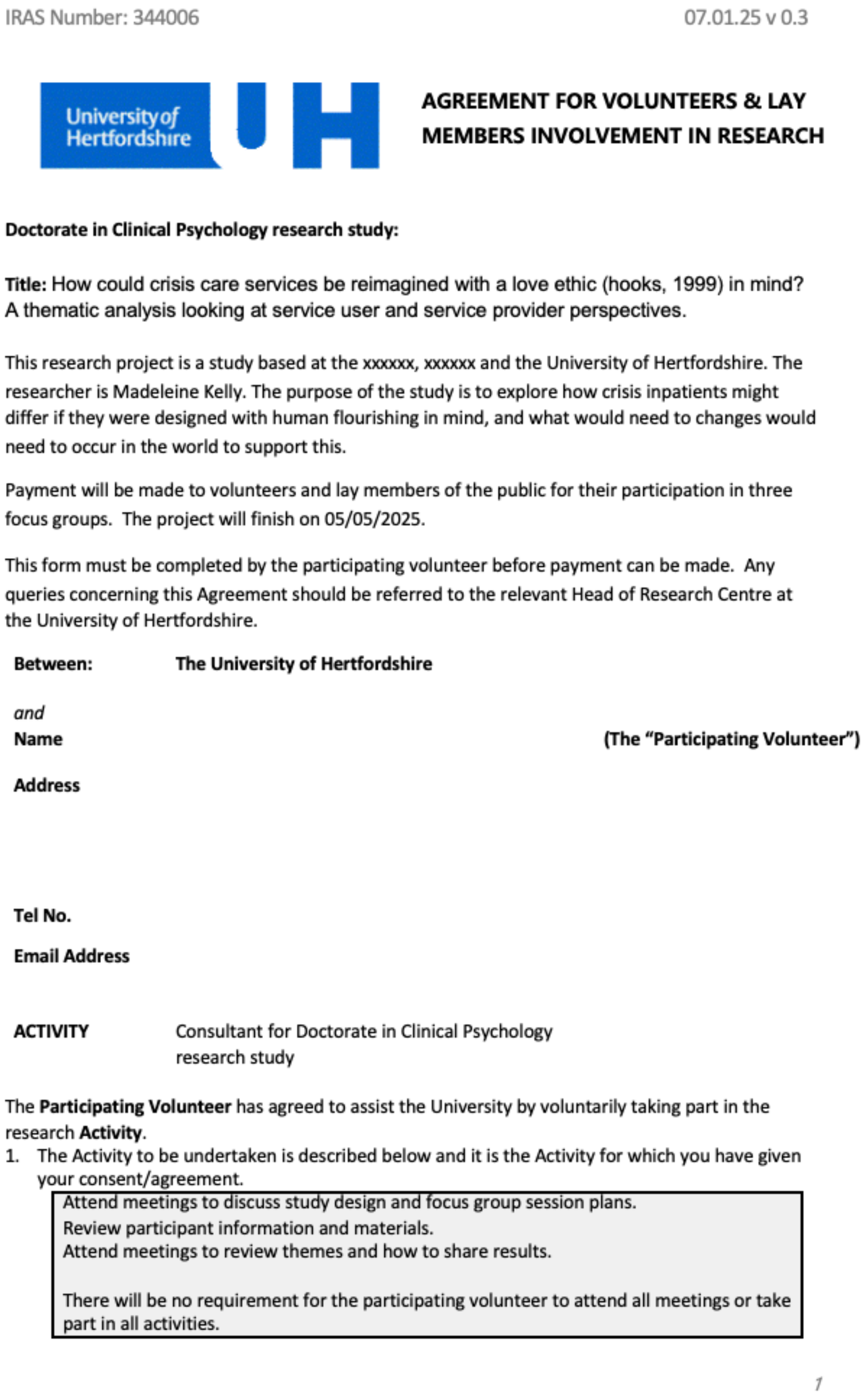
Due to differences in databases, it was not possible to input the same search terms for all databases. The search terms for Scopus, Medline and Google Scholar were illustrated in Table 2.

The search terms for J-Store can be seen in the table below:

Table 19 *J-Store Search Strategy*

J-Store Search Terms Example	
1	“speculative design”
2	“social justice”
3	“racial justice”
4	“disability justice”
5	“restorative justice”
6	“transformative justice”
7	"design justice"
8	Or/2-7
13	AND/1,8

Appendix B- Consultant Payment Form



IRAS Number: 344006 07.01.25 v 0.3

University of Hertfordshire UH

AGREEMENT FOR VOLUNTEERS & LAY MEMBERS INVOLVEMENT IN RESEARCH

Doctorate in Clinical Psychology research study:

Title: How could crisis care services be reimagined with a love ethic (hooks, 1999) in mind? A thematic analysis looking at service user and service provider perspectives.

This research project is a study based at the xxxxxx, xxxxxx and the University of Hertfordshire. The researcher is Madeleine Kelly. The purpose of the study is to explore how crisis inpatients might differ if they were designed with human flourishing in mind, and what would need to changes would need to occur in the world to support this.

Payment will be made to volunteers and lay members of the public for their participation in three focus groups. The project will finish on 05/05/2025.

This form must be completed by the participating volunteer before payment can be made. Any queries concerning this Agreement should be referred to the relevant Head of Research Centre at the University of Hertfordshire.

Between: **The University of Hertfordshire**

and

Name **(The "Participating Volunteer")**

Address

Tel No.

Email Address

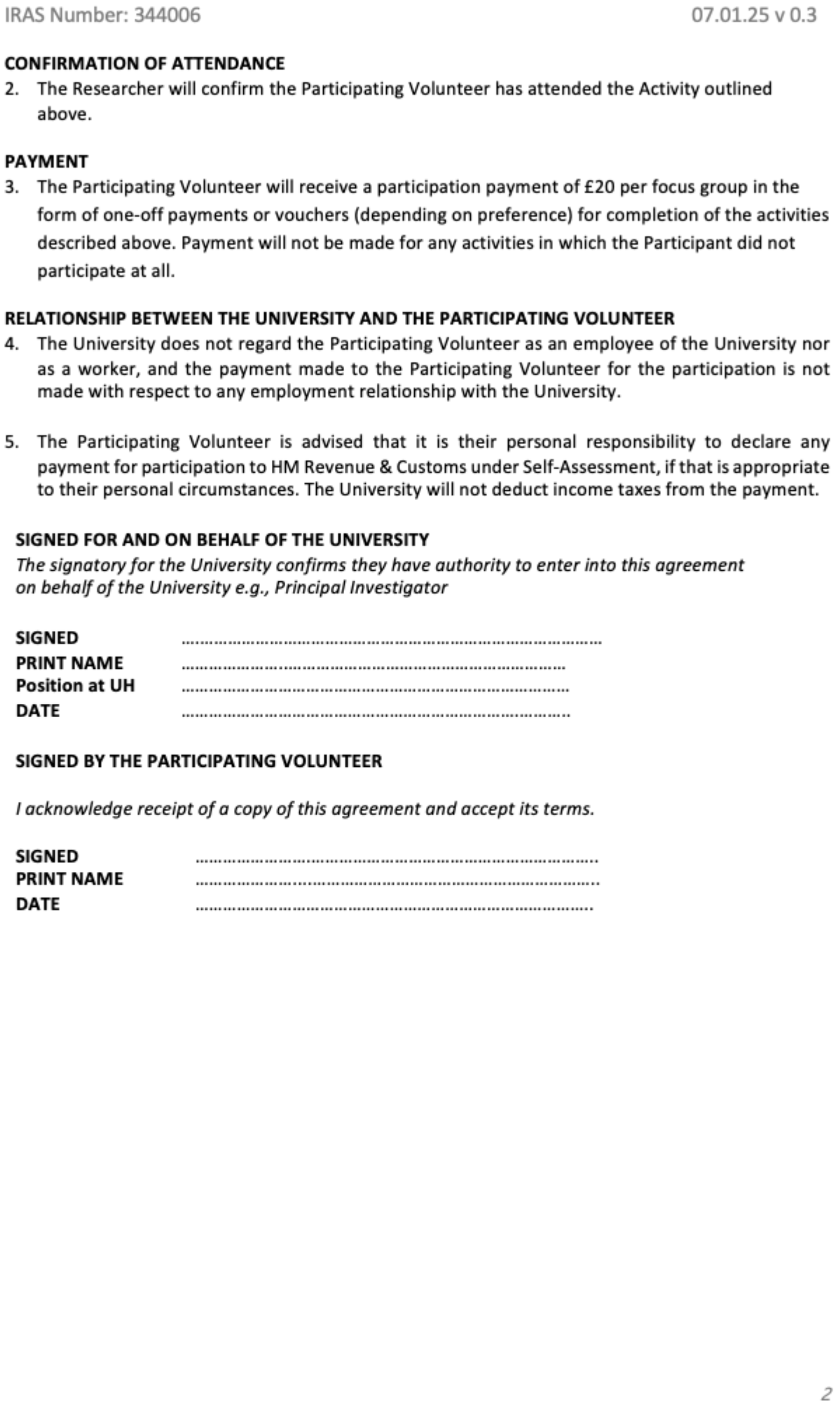
ACTIVITY Consultant for Doctorate in Clinical Psychology research study

The **Participating Volunteer** has agreed to assist the University by voluntarily taking part in the research **Activity**.

1. The Activity to be undertaken is described below and it is the Activity for which you have given your consent/agreement.

Attend meetings to discuss study design and focus group session plans. Review participant information and materials. Attend meetings to review themes and how to share results. There will be no requirement for the participating volunteer to attend all meetings or take part in all activities.

1



CONFIRMATION OF ATTENDANCE

2. The Researcher will confirm the Participating Volunteer has attended the Activity outlined above.

PAYMENT

3. The Participating Volunteer will receive a participation payment of £20 per focus group in the form of one-off payments or vouchers (depending on preference) for completion of the activities described above. Payment will not be made for any activities in which the Participant did not participate at all.

RELATIONSHIP BETWEEN THE UNIVERSITY AND THE PARTICIPATING VOLUNTEER

4. The University does not regard the Participating Volunteer as an employee of the University nor as a worker, and the payment made to the Participating Volunteer for the participation is not made with respect to any employment relationship with the University.

5. The Participating Volunteer is advised that it is their personal responsibility to declare any payment for participation to HM Revenue & Customs under Self-Assessment, if that is appropriate to their personal circumstances. The University will not deduct income taxes from the payment.

SIGNED FOR AND ON BEHALF OF THE UNIVERSITY

The signatory for the University confirms they have authority to enter into this agreement on behalf of the University e.g., Principal Investigator

SIGNED ……………………………………………………………………………………
PRINT NAME ………………………………………………………………………………
Position at UH ……………………………………………………………………………
DATE ………………………………………………………………………………..

SIGNED BY THE PARTICIPATING VOLUNTEER

I acknowledge receipt of a copy of this agreement and accept its terms.

SIGNED ……………………………………………………………………………..
PRINT NAME ………………………………………………………………………..
DATE ……………………………………………………………………………..

Appendix C- Quotes Given to Participants to Read Prior to Focus Groups

“Without an image of tomorrow, one is trapped by blind history, economics, and politics beyond our control. One is tied up in a web, in a net, with no way to struggle free. Only by having clear and vital images of the many alternatives, good and bad, of where one can go, will we have any control over the way we may actually get there in a reality tomorrow will bring too quickly.” (p.35 Delany, 1984)

“To be truly visionary we have to root our imagination in our concrete reality whilst simultaneously imagining possibilities beyond that reality,” (p.110 hooks, 2014)

“Whenever we try to envision a world without war, without violence… without capitalism, we are engaging in speculative fiction. All organising is science fiction.” (Walidah Imarisha quoted p. 3 in Imarisha, brown & Thomas, 2015)

“All that you touch you change. All that you change changes you. The only lasting truth is change.” (p.3 Butler, 1993)

“the future must be internationally built, and it must be built today” (p.102, Sebatindira 2023)

“everyone has the right to be free, to live fully and well” (p.87 hooks, 2000)

The need for a “global vision wherein we see our lives and our fate as intimately connected to those of everyone else on the planet.” (p. 88 hooks, 2000)

“Freedom is largely a matter of seeing that there are alternatives.” (p.25 Le Guin, 2007)

“We must love each other, and support each other.” (p.52 Shakur 1987)

“A lot of things people say ‘cannot be done’ have not been meaningfully attempted in our context or our lifetimes. It’s easy to maintain myths of impossibility if you crush all experiments” (Kelly Hayes, quoted p. 141 Benjamin, 2024)

“an abolitionist vision is about more than dismantling… it is about building a world where we work together to meet each other’s needs, a world in which every living being has access to safety, self-determination, freedom, and dignity" (Hill et al, 2020)

“There is value in clarifying the outcomes of social justice work. Futures do not just happen; they are created by our actions.” (Carey, 2023, p. 2)

“what we don’t see, we assume can’t be” (Butler, n.d. quoted in Russel, 2017).

“You have to act as if it were possible to radically transform the world. And you have to do it all the time.” (Davis, 2014)

“Sometimes we have to do the work even though we don't yet see a glimmer on the horizon that it's actually going to be possible.” (p. 31 Davis, 2016)

“I don't think we have any alternative other than remaining optimistic. Optimism is an absolute necessity, even if it's only optimism of the will, as Gramsci said, and pessimism of the intellect.” (p.49 Davis, 2016)

“Where life is precious, life is precious.” (Gilmore, quoted in Kushner, 2019)

Our practice “centres creation, not ruin: it visualises the world we want to live in, not just the one we want to leave behind” (p.9 Aviah Day and McBean, 2022)

“We’ll figure it out by working to get there. You don’t have to know all the answers in order to be able to press for a vision” (p. 167 Kaba, 2021)

“There is no one alternative. There are a million alternatives. And the issue is to figure out which alternative works for what situation… It’s like what works for this particular situation that we’re in? What works for these people? How are we going to address this based on human needs.” (p. 167 Kaba, 2021)

“I am dreaming like my life depends on it. Because it does” (p. 135 Piepzna-Samarasinha, 2018)

“So much of the work of oppression is about policing the imagination” (Hartman, 2020)

“Why not wish for more than is possible?” (p. 118, Olufemi, 2021)

“Hope is the refusal of inevitability” (p. 163 Bradley & De Noronha, 2022)

“We are consistently exhorted to work through procedural means towards ‘realistic’ or ‘achievable’ reforms; to follow interminable focus groups and opinion polls at the expense of imagination, hope and collective power” (p. 161 Bradley & De Noronha, 2022)

“you have a responsibility to live in this world. Your responsibility is not just to yourself. You are connected to everyone” (Moussa Kaba quoted pp. 177- 178 Kaba, 2021)

“The future, like the present, will not be easy; but we can act now to open greater possibilities for ourselves and those who come next. This requires dreaming and imagining and using these visions to orient us in the present” (p.169 Bradley & De Noronha, 2022)

“Disability Justice is a vision and practice of a yet-to-be, a map that we create with our ancestors and our great grandchildren onward, in the width and depth of our multiplicities and histories, a movement towards a world in which every body and mind is known as beautiful.” (p.9 Berne, 2015)

“by tapping into the potential goodness in each of us we can generate justice and liberation, growing a healing abundance where we have been socialised to believe only scarcity exists” (p. 13 brown, 2019)

“Justice can also look like fulfilment, joy and thus, abundance” (p. 8, Hylton, 2020)

“When I am happy, it is good for the world” (p.14, brown, 2019)

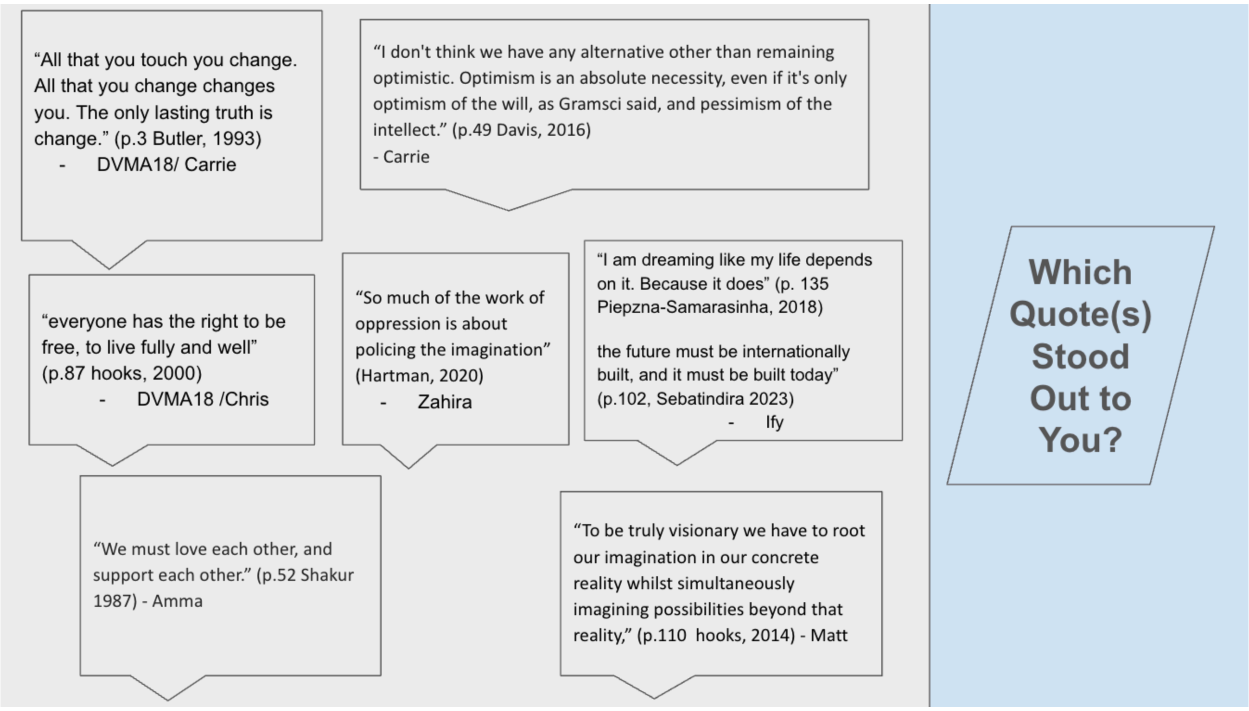
“care is the antidote to violence—we do not yet know a world where people learn first and foremost that others are to be loved and cared for. That world is a world without cages.” (Saidiya Hartman, quoted in Sharpe et al, 2017)

“Dream a little before you think” (Morrison, 2019)

“The map to a new world is in the imagination” (p.3 Kelley, 2002)

Appendix D – Quotes Participants Chose

Image 1: SU quotes



"All that you touch you change. All that you change changes you. The only lasting truth is change." (p.3 Butler, 1993)
- DVMA18/ Carrie

"I don't think we have any alternative other than remaining optimistic. Optimism is an absolute necessity, even if it's only optimism of the will, as Gramsci said, and pessimism of the intellect." (p.49 Davis, 2016)
- Carrie

"everyone has the right to be free, to live fully and well" (p.87 hooks, 2000)
- DVMA18 /Chris

"So much of the work of oppression is about policing the imagination" (Hartman, 2020)
- Zahira

"I am dreaming like my life depends on it. Because it does" (p. 135 Piepzna-Samarasinha, 2018)

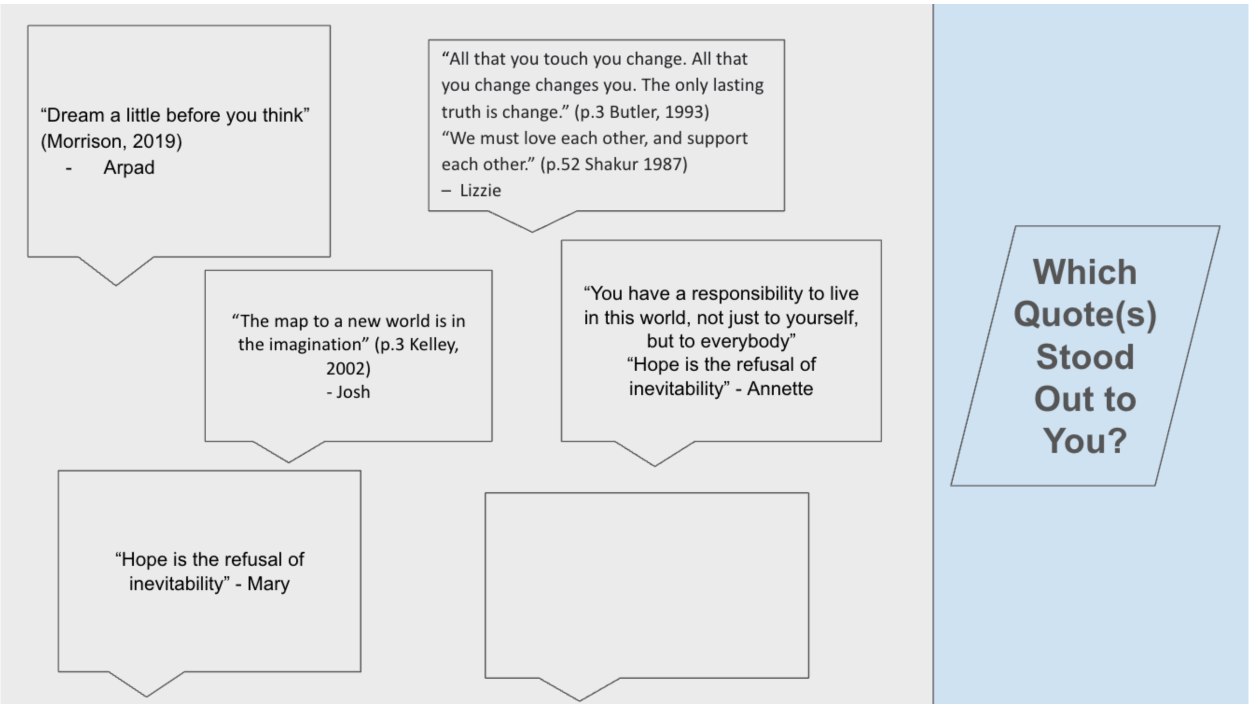
the future must be internationally built, and it must be built today" (p.102, Sebatindira 2023)
- Ify

"We must love each other, and support each other." (p.52 Shakur 1987) - Amma

"To be truly visionary we have to root our imagination in our concrete reality whilst simultaneously imagining possibilities beyond that reality," (p.110 hooks, 2014) - Matt

Which Quote(s) Stood Out to You?

Image 2: Staff Quotes



"Dream a little before you think" (Morrison, 2019)
- Arpad

"All that you touch you change. All that you change changes you. The only lasting truth is change." (p.3 Butler, 1993)
"We must love each other, and support each other." (p.52 Shakur 1987)
– Lizzie

"The map to a new world is in the imagination" (p.3 Kelley, 2002)
- Josh

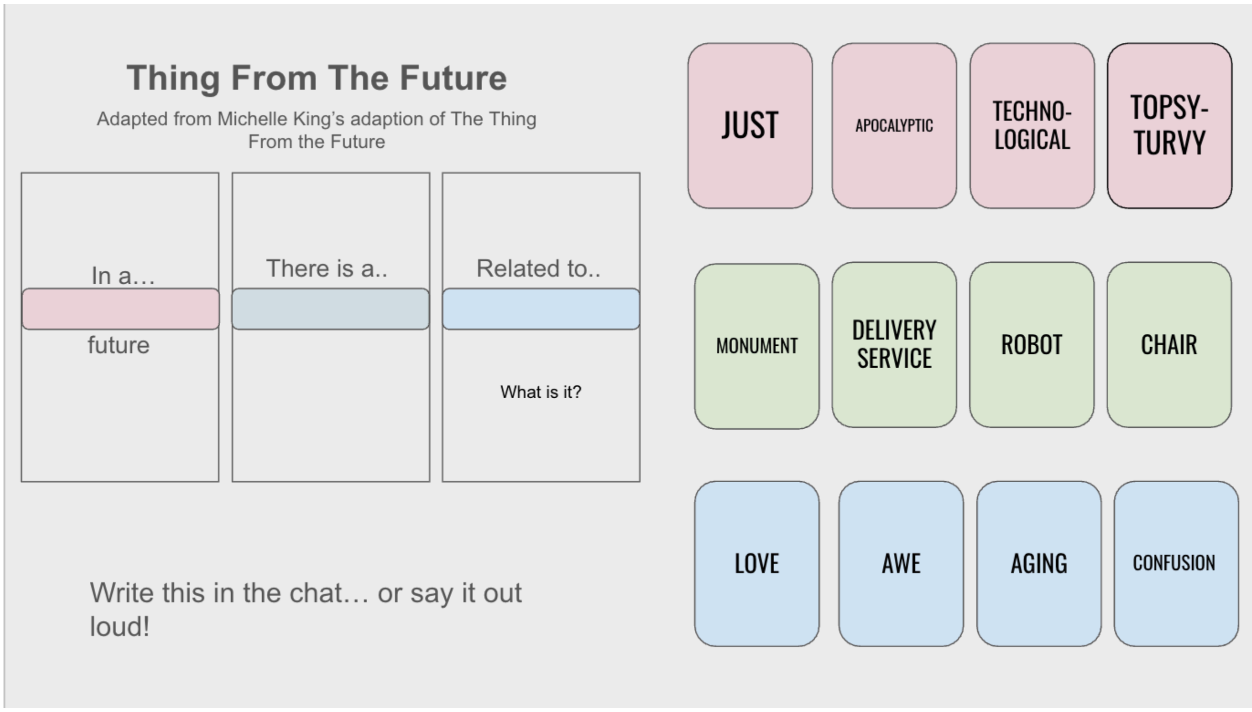
"You have a responsibility to live in this world, not just to yourself, but to everybody"
"Hope is the refusal of inevitability" - Annette

"Hope is the refusal of inevitability" - Mary

Which Quote(s) Stood Out to You?

Appendix E - "Thing From the Future" Candy & Watson (2015) Slides From Focus Groups

Image 3: Screen Grab of Initial "Thing From the Future" Exercise



Thing From The Future

Adapted from Michelle King's adaption of The Thing From the Future

In a…

future

There is a..

Related to..

What is it?

Write this in the chat… or say it out loud!

JUST

APOCALYPTIC

TECHNO-LOGICAL

TOPSY-TURVY

MONUMENT

DELIVERY SERVICE

ROBOT

CHAIR

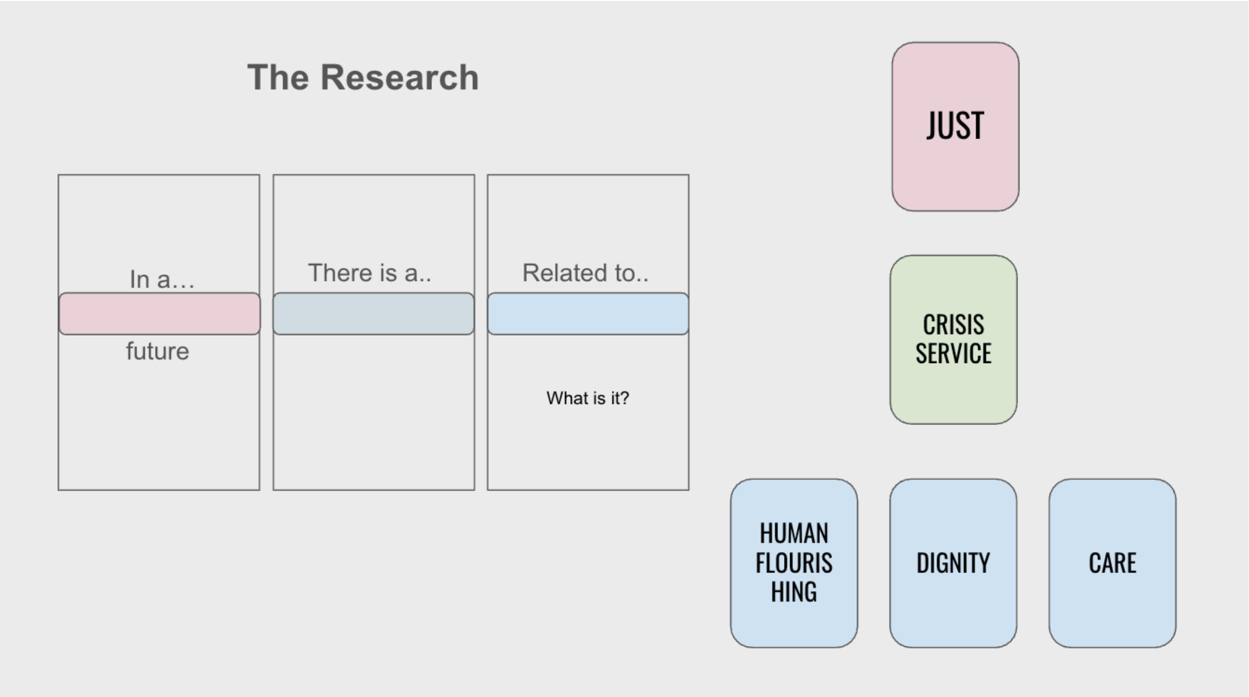
LOVE

AWE

AGING

CONFUSION

Image 3: Screen Grab of How "Thing From the Future" Applies to the Research



The Research

In a…

future

There is a..

Related to..

What is it?

JUST

CRISIS SERVICE

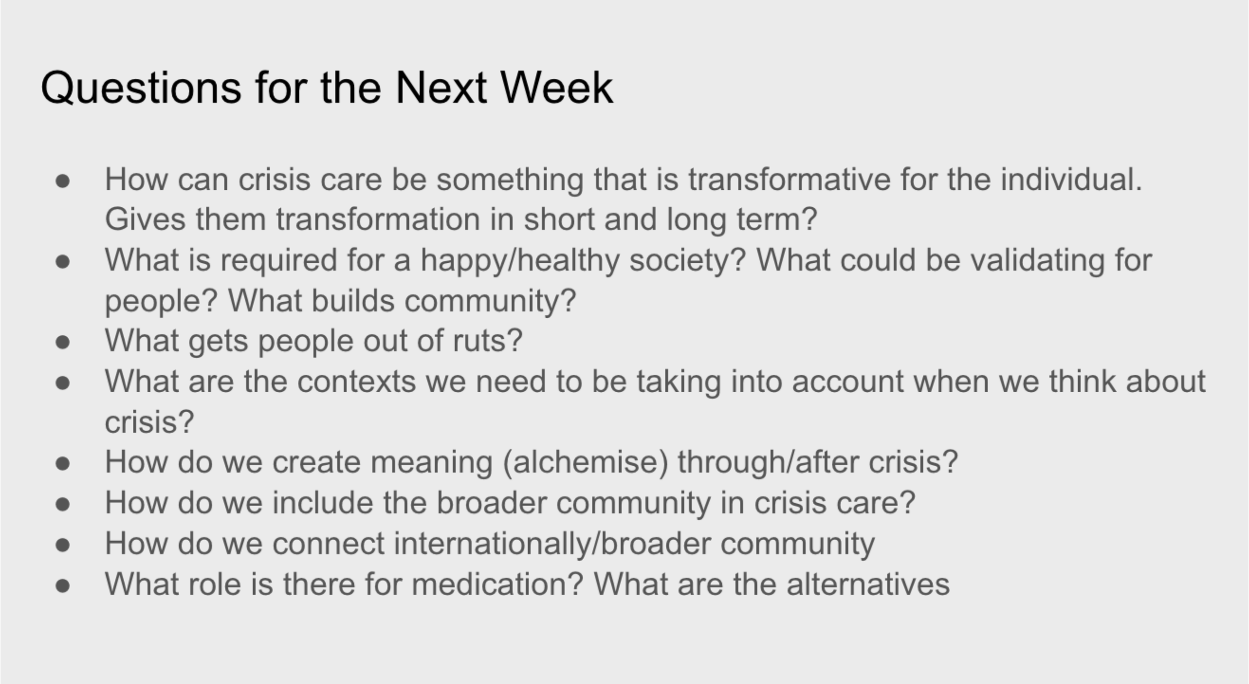
HUMAN FLOURIS HING

DIGNITY

CARE

Appendix F- Questions Participants Chose to Answer

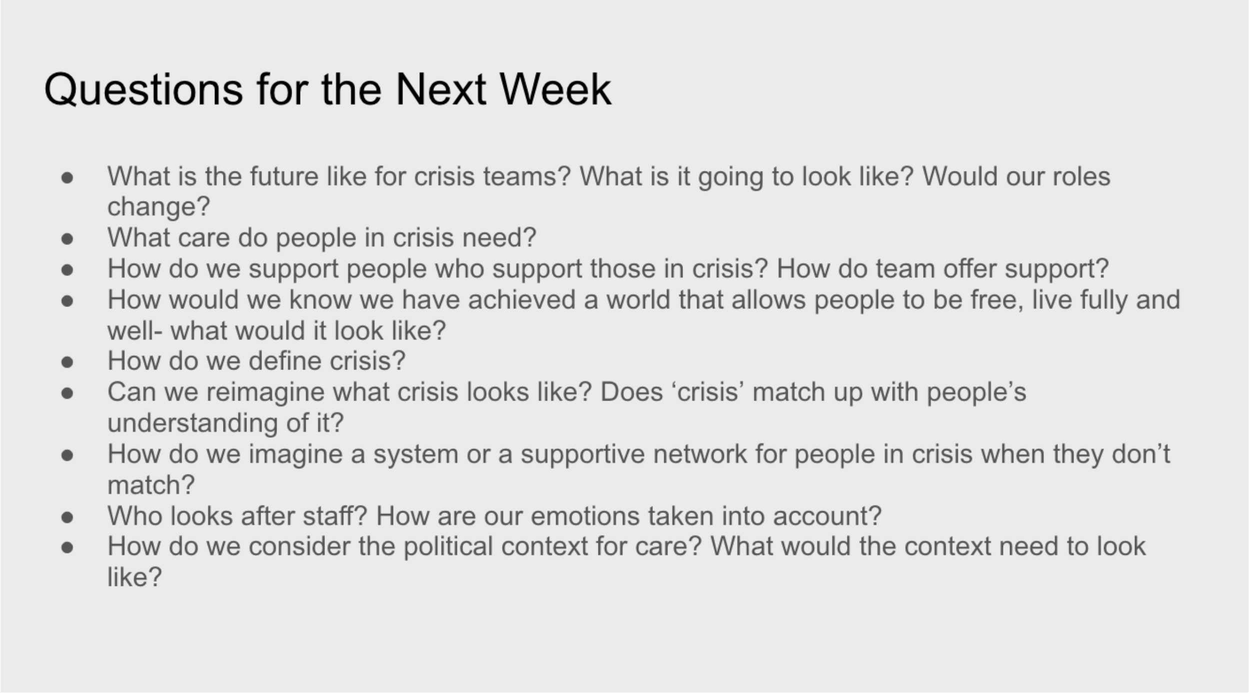
Image 4: SU Questions



Questions for the Next Week

- How can crisis care be something that is transformative for the individual. Gives them transformation in short and long term?
- What is required for a happy/healthy society? What could be validating for people? What builds community?
- What gets people out of ruts?
- What are the contexts we need to be taking into account when we think about crisis?
- How do we create meaning (alchemise) through/after crisis?
- How do we include the broader community in crisis care?
- How do we connect internationally/broader community
- What role is there for medication? What are the alternatives

Image 5: Staff Questions

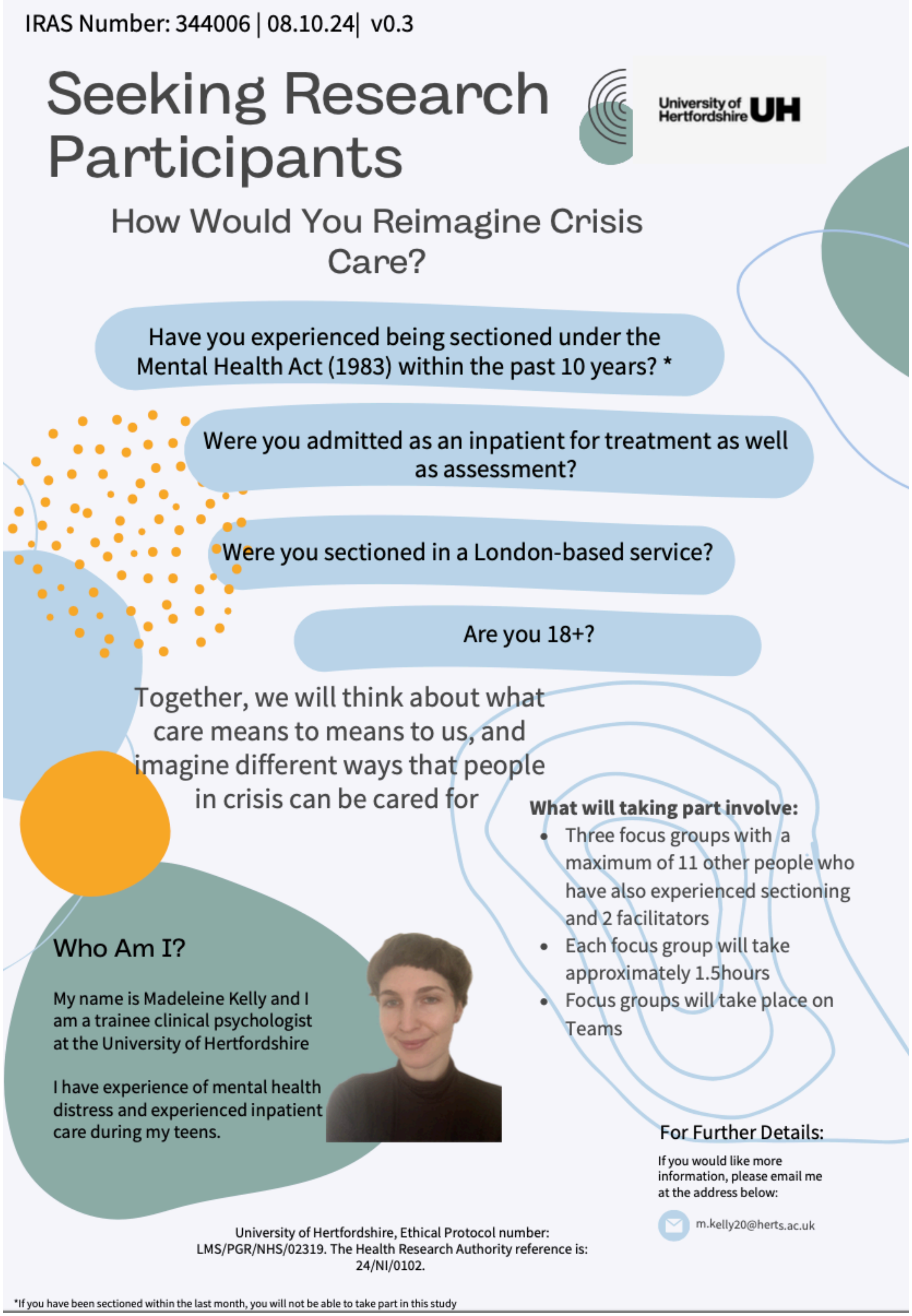


Questions for the Next Week

- What is the future like for crisis teams? What is it going to look like? Would our roles change?
- What care do people in crisis need?
- How do we support people who support those in crisis? How do team offer support?
- How would we know we have achieved a world that allows people to be free, live fully and well- what would it look like?
- How do we define crisis?
- Can we reimagine what crisis looks like? Does ‘crisis’ match up with people’s understanding of it?
- How do we imagine a system or a supportive network for people in crisis when they don’t match?
- Who looks after staff? How are our emotions taken into account?
- How do we consider the political context for care? What would the context need to look like?

Appendix G- Posters

Image 6: SU Recruitment Poster



IRAS Number: 344006 | 08.10.24| v0.3

Seeking Research Participants

University of Hertfordshire UH

How Would You Reimagine Crisis Care?

Have you experienced being sectioned under the Mental Health Act (1983) within the past 10 years? *

Were you admitted as an inpatient for treatment as well as assessment?

Were you sectioned in a London-based service?

Are you 18+?

Together, we will think about what care means to means to us, and imagine different ways that people in crisis can be cared for

What will taking part involve:

- Three focus groups with a maximum of 11 other people who have also experienced sectioning and 2 facilitators
- Each focus group will take approximately 1.5hours
- Focus groups will take place on Teams

Who Am I?

My name is Madeleine Kelly and I am a trainee clinical psychologist at the University of Hertfordshire

I have experience of mental health distress and experienced inpatient care during my teens.

For Further Details:

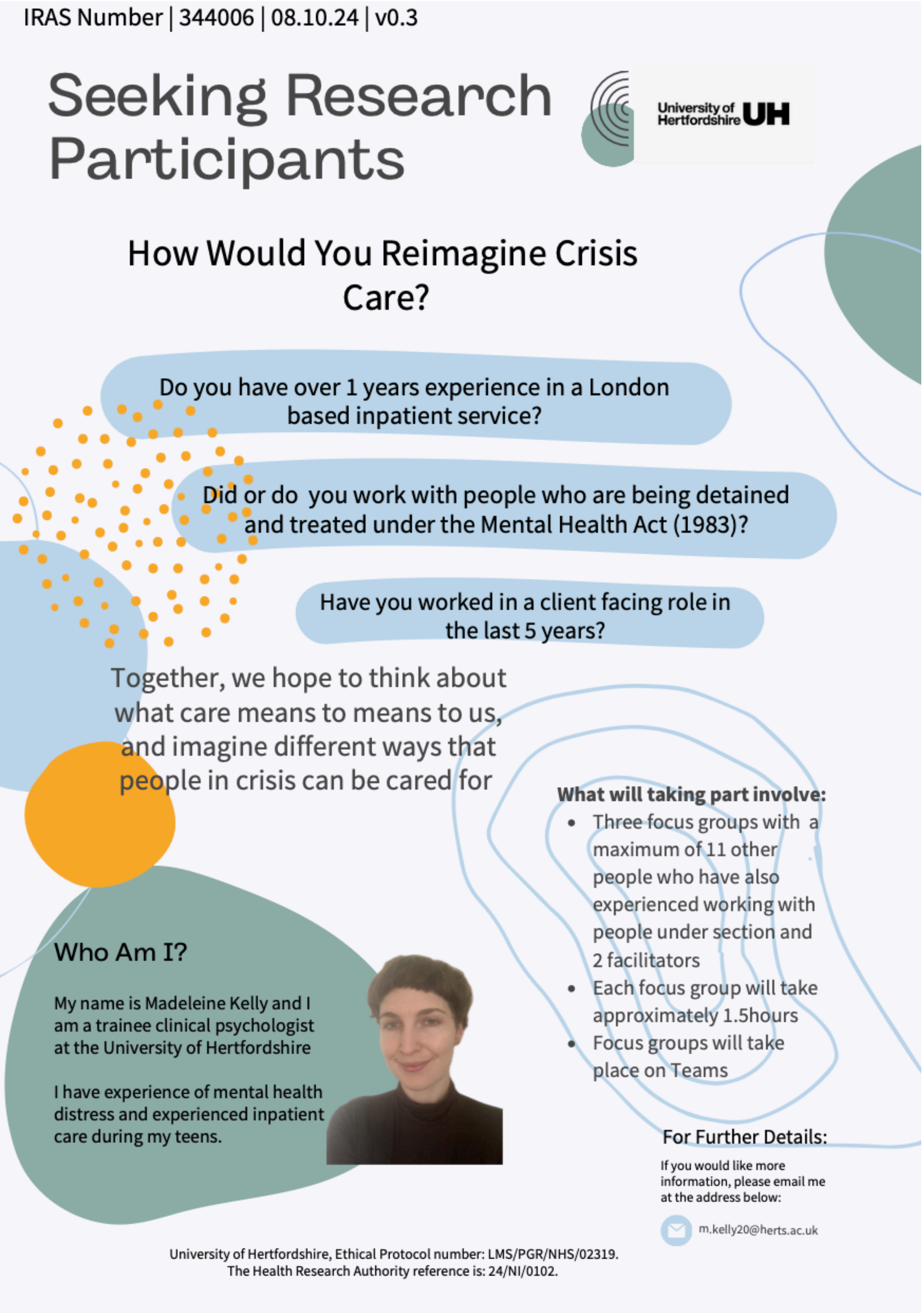
If you would like more information, please email me at the address below:

✉ m.kelly20@herts.ac.uk

University of Hertfordshire, Ethical Protocol number: LMS/PGR/NHS/02319. The Health Research Authority reference is: 24/NI/0102.

*If you have been sectioned within the last month, you will not be able to take part in this study

Image 7: Staff Recruitment Poster (standard)



IRAS Number | 344006 | 08.10.24 | v0.3

Seeking Research Participants

University of Hertfordshire UH

How Would You Reimagine Crisis Care?

Do you have over 1 years experience in a London based inpatient service?

Did or do you work with people who are being detained and treated under the Mental Health Act (1983)?

Have you worked in a client facing role in the last 5 years?

Together, we hope to think about what care means to means to us, and imagine different ways that people in crisis can be cared for

What will taking part involve:

- Three focus groups with a maximum of 11 other people who have also experienced working with people under section and 2 facilitators
- Each focus group will take approximately 1.5hours
- Focus groups will take place on Teams

Who Am I?

My name is Madeleine Kelly and I am a trainee clinical psychologist at the University of Hertfordshire

I have experience of mental health distress and experienced inpatient care during my teens.

For Further Details:

If you would like more information, please email me at the address below:

m.kelly20@herts.ac.uk

University of Hertfordshire, Ethical Protocol number: LMS/PGR/NHS/02319.
The Health Research Authority reference is: 24/NI/0102.

Appendix H- PIF (easy read)

Images 8 and 9: Summary Of Participant Information Form

What Will Happen To My Data?

- Your consent form and demographic data will be stored on a secure University of Hertfordshire OneDrive (digital storage) and deleted by December 2025
- Your anonymised anonymised data will be stored on the secure OneDrive for 5 years, then it will be deleted.
- We will make a report with the data from the focus groups and optional creative piece. This will be submitted to the University of Hertfordshire as part of Madeleine Kelly's Doctorate in Clinical Psychology.
- The results may be published in an academic journal or media outlet.
- Anonymised transcripts may be reused in other studies.
- Your confidentiality will be protected so no one will be able to work out who you are in any report or publication.
- The Participant Information form has more details

Payment

- If you take part you will receive £13.85/hour for your participation in the focus groups as an acknowledgement of your time and expertise.

What Should I Do Now?

- If you want to take part you can email Madeleine at m.kelly20@herts.ac.uk.
- If you are not interested then you don't need to do anything

Meet The Research Team

.Madeleine is the lead researcher and will be with you in the focus group
m.kelly20@herts.ac.uk

Lizette is Madeleine's first supervisor. She is a Clinical Psychologist and researcher and works [redacted]rdshire.
l.nolte@herts.ac.uk

Tehseen Noorani is Madeleine's second supervisor. He is a Senior Research Fellow at the University of Auckland.

If you have any questions, feel free to get in touch with either myself or Lizette

If you have any complaints or concerns about how you have been treated, please write to Secretary and Registrar University of Hertfordshire, College Lane Hatfield Herts AL10 9AB

University of Hertfordshire UH

University of Hertfordshire UH

Alternatives to Crisis Care

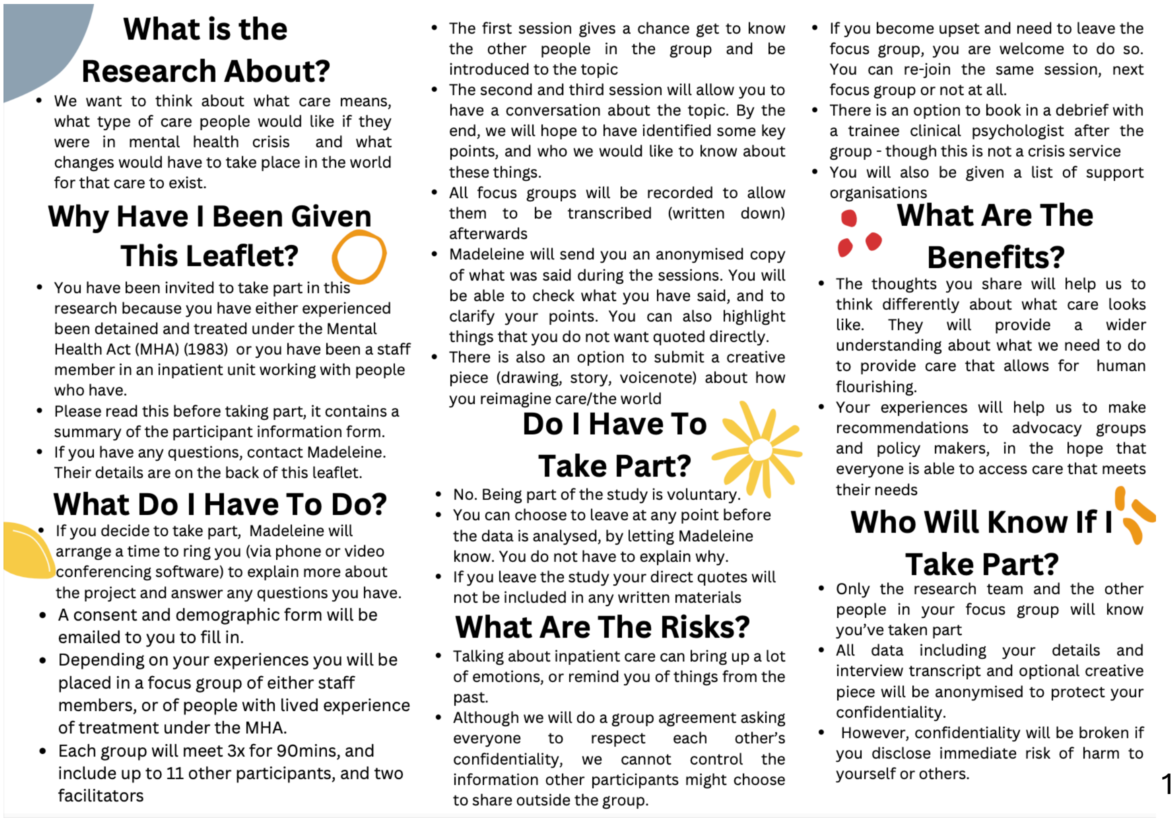
Full Title: How could crisis care services be reimagined with a love ethic (hooks, 1999) in mind? A thematic analysis looking at service user and service provider perspectives.

Summary of Participant Information Form

An invitation to take part in a research project from the University of Herefordshire

The UH protocol number is LMS/PGR/NHS/02319
The Health Research Authority reference is: 24/NI/0102

IRAS Number: 344006 | v0.3| 08.10.24



What is the Research About?

- We want to think about what care means, what type of care people would like if they were in mental health crisis and what changes would have to take place in the world for that care to exist.

Why Have I Been Given This Leaflet?

- You have been invited to take part in this research because you have either experienced been detained and treated under the Mental Health Act (MHA) (1983) or you have been a staff member in an inpatient unit working with people who have.
- Please read this before taking part, it contains a summary of the participant information form.
- If you have any questions, contact Madeleine. Their details are on the back of this leaflet.

What Do I Have To Do?

- If you decide to take part, Madeleine will arrange a time to ring you (via phone or video conferencing software) to explain more about the project and answer any questions you have.
- A consent and demographic form will be emailed to you to fill in.
- Depending on your experiences you will be placed in a focus group of either staff members, or of people with lived experience of treatment under the MHA.
- Each group will meet 3x for 90mins, and include up to 11 other participants, and two facilitators
- The first session gives a chance get to know the other people in the group and be introduced to the topic
- The second and third session will allow you to have a conversation about the topic. By the end, we will hope to have identified some key points, and who we would like to know about these things.
- All focus groups will be recorded to allow them to be transcribed (written down) afterwards
- Madeleine will send you an anonymised copy of what was said during the sessions. You will be able to check what you have said, and to clarify your points. You can also highlight things that you do not want quoted directly.
- There is also an option to submit a creative piece (drawing, story, voicenote) about how you reimagine care/the world

Do I Have To Take Part?

- No. Being part of the study is voluntary.
- You can choose to leave at any point before the data is analysed, by letting Madeleine know. You do not have to explain why.
- If you leave the study your direct quotes will not be included in any written materials

What Are The Risks?

- Talking about inpatient care can bring up a lot of emotions, or remind you of things from the past.
- Although we will do a group agreement asking everyone to respect each other's confidentiality, we cannot control the information other participants might choose to share outside the group.
- If you become upset and need to leave the focus group, you are welcome to do so. You can re-join the same session, next focus group or not at all.
- There is an option to book in a debrief with a trainee clinical psychologist after the group - though this is not a crisis service
- You will also be given a list of support organisations

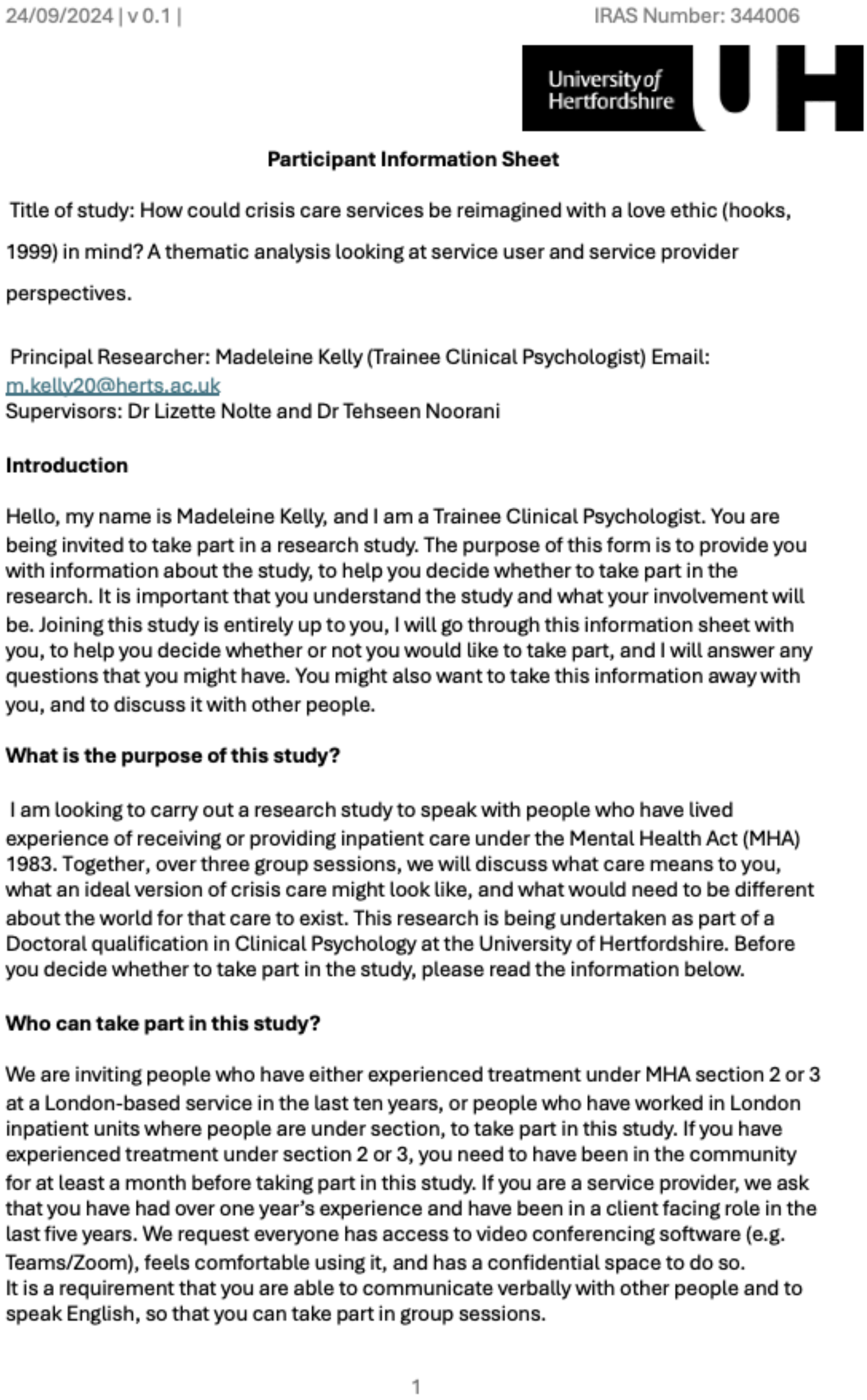
What Are The Benefits?

- The thoughts you share will help us to think differently about what care looks like. They will provide a wider understanding about what we need to do to provide care that allows for human flourishing.
- Your experiences will help us to make recommendations to advocacy groups and policy makers, in the hope that everyone is able to access care that meets their needs

Who Will Know If I Take Part?

- Only the research team and the other people in your focus group will know you've taken part
- All data including your details and interview transcript and optional creative piece will be anonymised to protect your confidentiality.
- However, confidentiality will be broken if you disclose immediate risk of harm to yourself or others.

Appendix I: Long Form Participant Information Sheet



University of Hertfordshire

Participant Information Sheet

Title of study: How could crisis care services be reimagined with a love ethic (hooks, 1999) in mind? A thematic analysis looking at service user and service provider perspectives.

Principal Researcher: Madeleine Kelly (Trainee Clinical Psychologist) Email: m.kelly20@herts.ac.uk
Supervisors: Dr Lizette Nolte and Dr Tehseen Noorani

Introduction

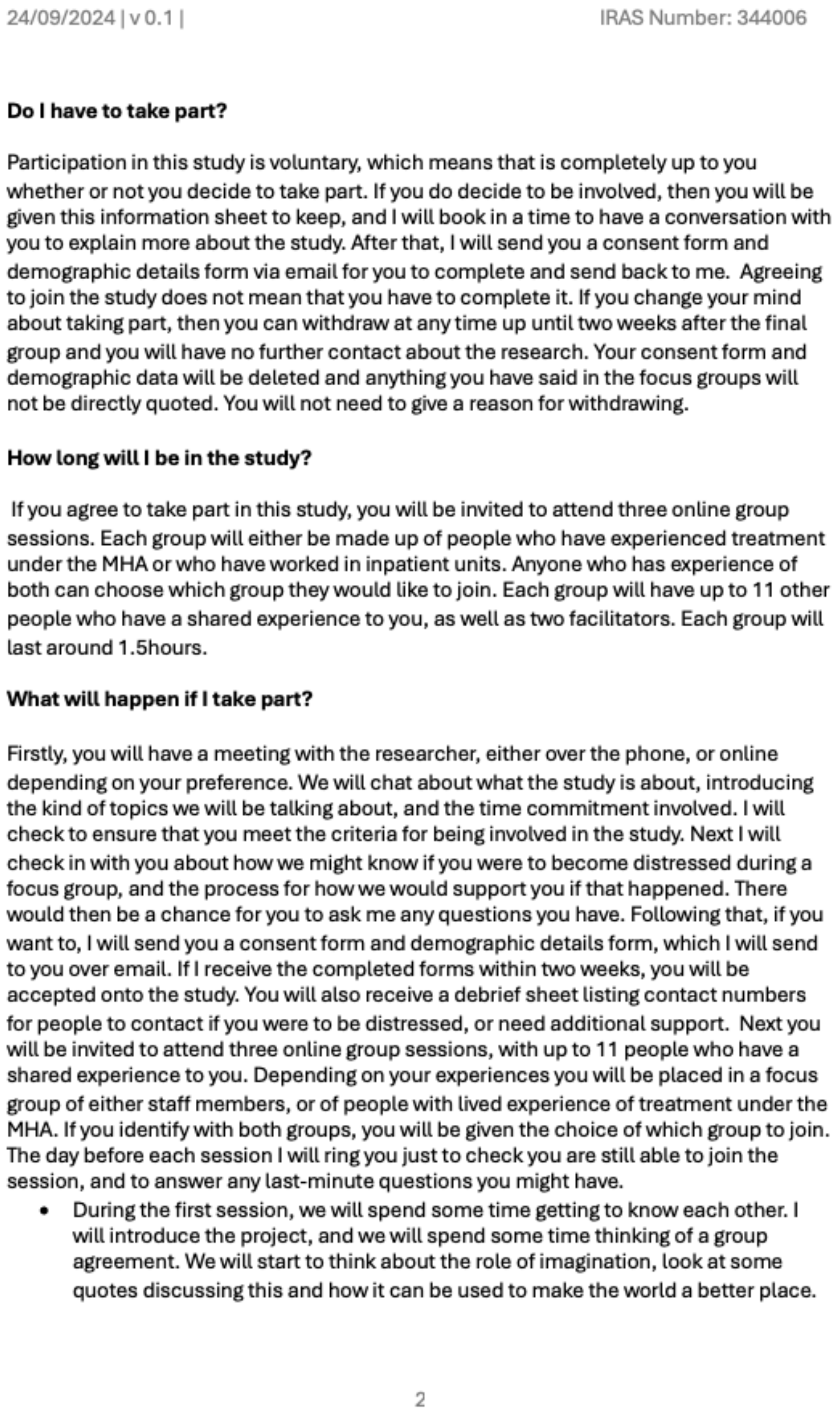
Hello, my name is Madeleine Kelly, and I am a Trainee Clinical Psychologist. You are being invited to take part in a research study. The purpose of this form is to provide you with information about the study, to help you decide whether to take part in the research. It is important that you understand the study and what your involvement will be. Joining this study is entirely up to you, I will go through this information sheet with you, to help you decide whether or not you would like to take part, and I will answer any questions that you might have. You might also want to take this information away with you, and to discuss it with other people.

What is the purpose of this study?

I am looking to carry out a research study to speak with people who have lived experience of receiving or providing inpatient care under the Mental Health Act (MHA) 1983. Together, over three group sessions, we will discuss what care means to you, what an ideal version of crisis care might look like, and what would need to be different about the world for that care to exist. This research is being undertaken as part of a Doctoral qualification in Clinical Psychology at the University of Hertfordshire. Before you decide whether to take part in the study, please read the information below.

Who can take part in this study?

We are inviting people who have either experienced treatment under MHA section 2 or 3 at a London-based service in the last ten years, or people who have worked in London inpatient units where people are under section, to take part in this study. If you have experienced treatment under section 2 or 3, you need to have been in the community for at least a month before taking part in this study. If you are a service provider, we ask that you have had over one year's experience and have been in a client facing role in the last five years. We request everyone has access to video conferencing software (e.g. Teams/Zoom), feels comfortable using it, and has a confidential space to do so.
It is a requirement that you are able to communicate verbally with other people and to speak English, so that you can take part in group sessions.



Do I have to take part?

Participation in this study is voluntary, which means that is completely up to you whether or not you decide to take part. If you do decide to be involved, then you will be given this information sheet to keep, and I will book in a time to have a conversation with you to explain more about the study. After that, I will send you a consent form and demographic details form via email for you to complete and send back to me. Agreeing to join the study does not mean that you have to complete it. If you change your mind about taking part, then you can withdraw at any time up until two weeks after the final group and you will have no further contact about the research. Your consent form and demographic data will be deleted and anything you have said in the focus groups will not be directly quoted. You will not need to give a reason for withdrawing.

How long will I be in the study?

If you agree to take part in this study, you will be invited to attend three online group sessions. Each group will either be made up of people who have experienced treatment under the MHA or who have worked in inpatient units. Anyone who has experience of both can choose which group they would like to join. Each group will have up to 11 other people who have a shared experience to you, as well as two facilitators. Each group will last around 1.5hours.

What will happen if I take part?

Firstly, you will have a meeting with the researcher, either over the phone, or online depending on your preference. We will chat about what the study is about, introducing the kind of topics we will be talking about, and the time commitment involved. I will check to ensure that you meet the criteria for being involved in the study. Next I will check in with you about how we might know if you were to become distressed during a focus group, and the process for how we would support you if that happened. There would then be a chance for you to ask me any questions you have. Following that, if you want to, I will send you a consent form and demographic details form, which I will send to you over email. If I receive the completed forms within two weeks, you will be accepted onto the study. You will also receive a debrief sheet listing contact numbers for people to contact if you were to be distressed, or need additional support. Next you will be invited to attend three online group sessions, with up to 11 people who have a shared experience to you. Depending on your experiences you will be placed in a focus group of either staff members, or of people with lived experience of treatment under the MHA. If you identify with both groups, you will be given the choice of which group to join. The day before each session I will ring you just to check you are still able to join the session, and to answer any last-minute questions you might have.

- During the first session, we will spend some time getting to know each other. I will introduce the project, and we will spend some time thinking of a group agreement. We will start to think about the role of imagination, look at some quotes discussing this and how it can be used to make the world a better place.

Finally we will think up some questions relating to care and the speculative that we can answer in subsequent sessions.

- During the next session, I will present some themes that I drew from the previous session and ask people if they agree or have other themes that stood out to them. We will then begin to discuss the questions from the previous week.
- In the final session, I will again present some themes from the previous session and ask people to chip in with their thoughts. We will answer any unanswered questions from the previous session, before reflecting on key points, and who you think it would be helpful to be informed of these.

I will also ask you to take part in an additional and optional project of writing, drawing, collaging, voice-noting (however you want really!) about the world you imagine in which people in crisis are able to receive the care they need, or what that care might look like. If you take part in this, I would request that you submit this to me via email within two weeks of the last focus group. These will be stored securely in their own file on the UH One Drive and kept for the same length as anonymised transcripts. Extracts, images, etc. from this could be used in the write up and dissemination of the research.

Following each session, I will make a quick check in call to see how you are doing, if you have any questions, and to see if you would like to book in for an optional debrief call in the upcoming week. Debrief calls are to support you to think about the session, or to talk through any questions. They are not a crisis service or counselling.

What are the possible disadvantages or risks of taking part?

Although the aim is less to focus on personal experience of the past, but on future imaginings of crisis care, understandably talking about inpatient care can bring up a lot of emotions, or remind you of things from the past. I will do my best to support you with this. Each focus group session will be attended by a co-facilitator who is there should you want to dip into a breakout room to chat with them. Should you wish to stop then you can decide to have a break or leave the group. Committing to three group sessions may be difficult and take up your time. We hope that the group will be a supportive place to meet other people who may have had similar experiences. At the end of our group meetings, I will check in to see how everyone is doing, as well as following up with an individual check in call and offering an optional debrief session.

What are the possible benefits of taking part?

Whilst there is no direct benefit for taking part, I hope that thinking about alternatives to crisis care might be an interesting and hopeful thing to do amongst a group of people with similar experiences. At the end of the project, as a group we can think about how we can share the findings; this could include making a booklet for professionals, or sharing information with MPs and policy makers. The thoughts you share will help us to think differently about what care looks like and will provide a wider understanding about what we need to do to provide care that allows for human flourishing. Your experiences will help us to make recommendations to advocacy groups and policy makers, in the hope that everyone is able to access care that meets their needs

Payment

If you take part, you will receive £13.85/hour for your participation in the focus groups as an acknowledgement of your time and expertise. This will be provided at the end of the research study.

What details do you collect and why?

You will complete a consent form. On your consent form, I will ask for your name, preferred pseudonym, phone number, email and address. These will be so I can contact you, to send you links for sessions or for check in calls. These will be shared under no circumstances, with the exception of an emergency in which you are at risk, in which case they will be shared with support services.

Some demographic details will be collected about you. For example, age, ethnicity, gender, sexuality, disability. This demographic data together with recordings of the conversations you have during the focus group (anonymised) will form the data that is used in my study.

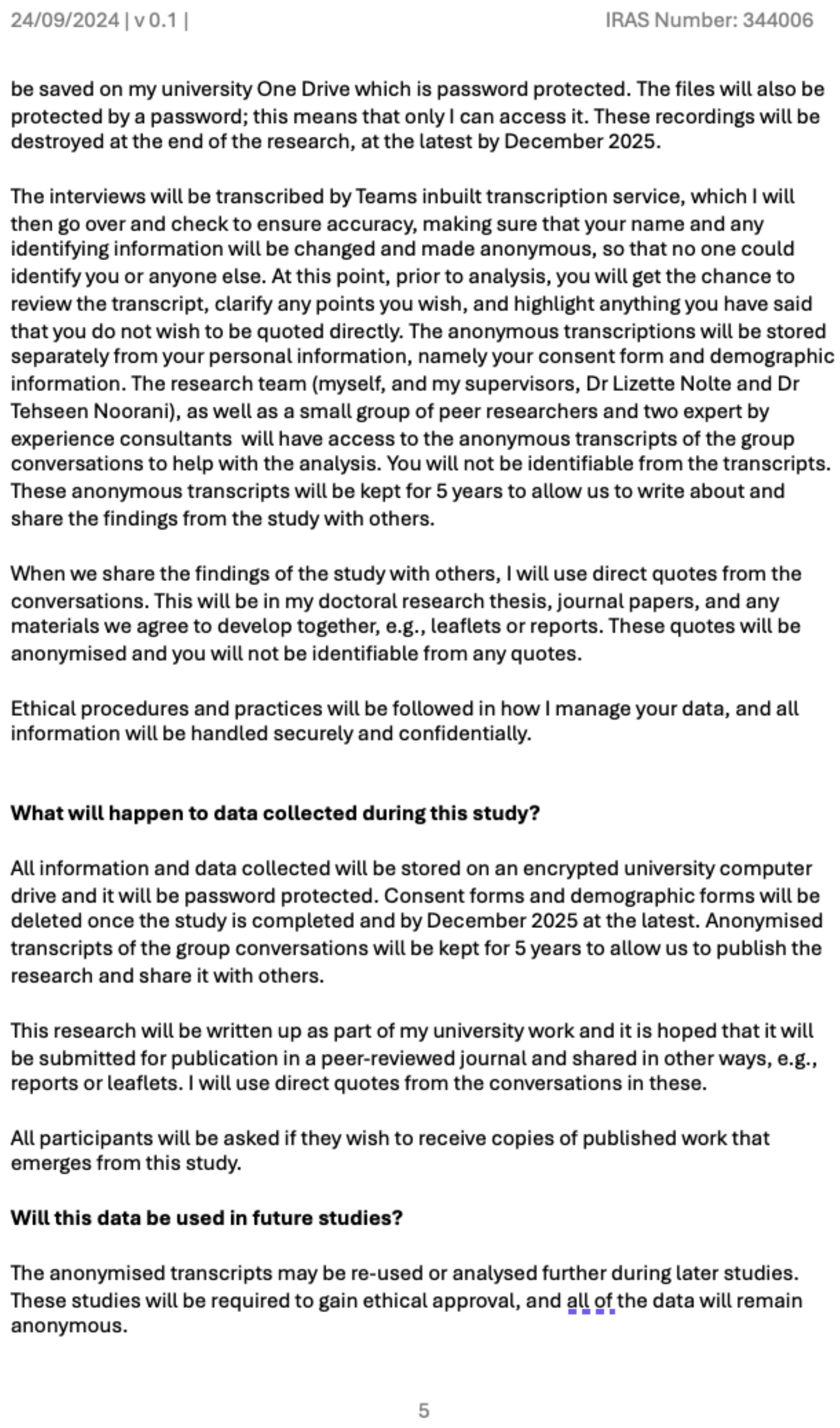
Audio-visual material

The group discussions will be recorded visually online via the inbuilt video conferencing software and also audibly using an encrypted dictaphone. This is to make sure that I record the conversations correctly and that the information would be available in the event of any technical issues. I will check that the recording is of a good quality and stored safely after the end of the group, before deleting the audio recording. If you decided to additionally take part in creating a piece of writing, drawing, collage, voice-note (which I will transcribe) these will be anonymised (unless you specifically state otherwise) and stored securely.

How will my information be kept confidential?

I will hold some personal information about you on a signed consent form and on the demographic form. These forms will be securely stored on my university One Drive that is password protected and to which only I have access. I will also password protect the files where I store your information. I will store these forms separately from any recordings of the group conversations and from the transcripts. I will destroy these forms when I have completed the research, at the latest by December 2025.

You will assign yourself a pseudonym, instead of your real name. There will be no way of linking your participant ID back to you from any future publications or material that emerge from the study. All of your information, and the audio and visual recordings will



be saved on my university One Drive which is password protected. The files will also be protected by a password; this means that only I can access it. These recordings will be destroyed at the end of the research, at the latest by December 2025.

The interviews will be transcribed by Teams inbuilt transcription service, which I will then go over and check to ensure accuracy, making sure that your name and any identifying information will be changed and made anonymous, so that no one could identify you or anyone else. At this point, prior to analysis, you will get the chance to review the transcript, clarify any points you wish, and highlight anything you have said that you do not wish to be quoted directly. The anonymous transcriptions will be stored separately from your personal information, namely your consent form and demographic information. The research team (myself, and my supervisors, Dr Lizette Nolte and Dr Tehseen Noorani), as well as a small group of peer researchers and two expert by experience consultants will have access to the anonymous transcripts of the group conversations to help with the analysis. You will not be identifiable from the transcripts. These anonymous transcripts will be kept for 5 years to allow us to write about and share the findings from the study with others.

When we share the findings of the study with others, I will use direct quotes from the conversations. This will be in my doctoral research thesis, journal papers, and any materials we agree to develop together, e.g., leaflets or reports. These quotes will be anonymised and you will not be identifiable from any quotes.

Ethical procedures and practices will be followed in how I manage your data, and all information will be handled securely and confidentially.

What will happen to data collected during this study?

All information and data collected will be stored on an encrypted university computer drive and it will be password protected. Consent forms and demographic forms will be deleted once the study is completed and by December 2025 at the latest. Anonymised transcripts of the group conversations will be kept for 5 years to allow us to publish the research and share it with others.

This research will be written up as part of my university work and it is hoped that it will be submitted for publication in a peer-reviewed journal and shared in other ways, e.g., reports or leaflets. I will use direct quotes from the conversations in these.

All participants will be asked if they wish to receive copies of published work that emerges from this study.

Will this data be used in future studies?

The anonymised transcripts may be re-used or analysed further during later studies. These studies will be required to gain ethical approval, and all of the data will remain anonymous.

Are there any exceptions to confidentiality

All of the information that you give will be kept confidential to the best of our ability. However, there is an occasion in which I would need to pass information about you to other people - if you told me something that I thought was a risk to either yourself or someone else. If I needed to pass on information to other people, such as a crisis service (e.g.999), I would do my best to let you know before I do this.

Also, although we will do a group agreement asking everyone to respect each other's confidentiality, we cannot control the information other participants might choose to share outside the group.

Who can I contact if I have any questions?

If you would like further information about anything above, how your information is used or would like to discuss any other aspect of the study, please get in contact, with the research team:

Research lead: Madeleine Kelly. I can be reached at m.kelly20@herts.ac.uk
Research supervisor: Dr Lizette Nolte. Lizette can be reached at xxxxx

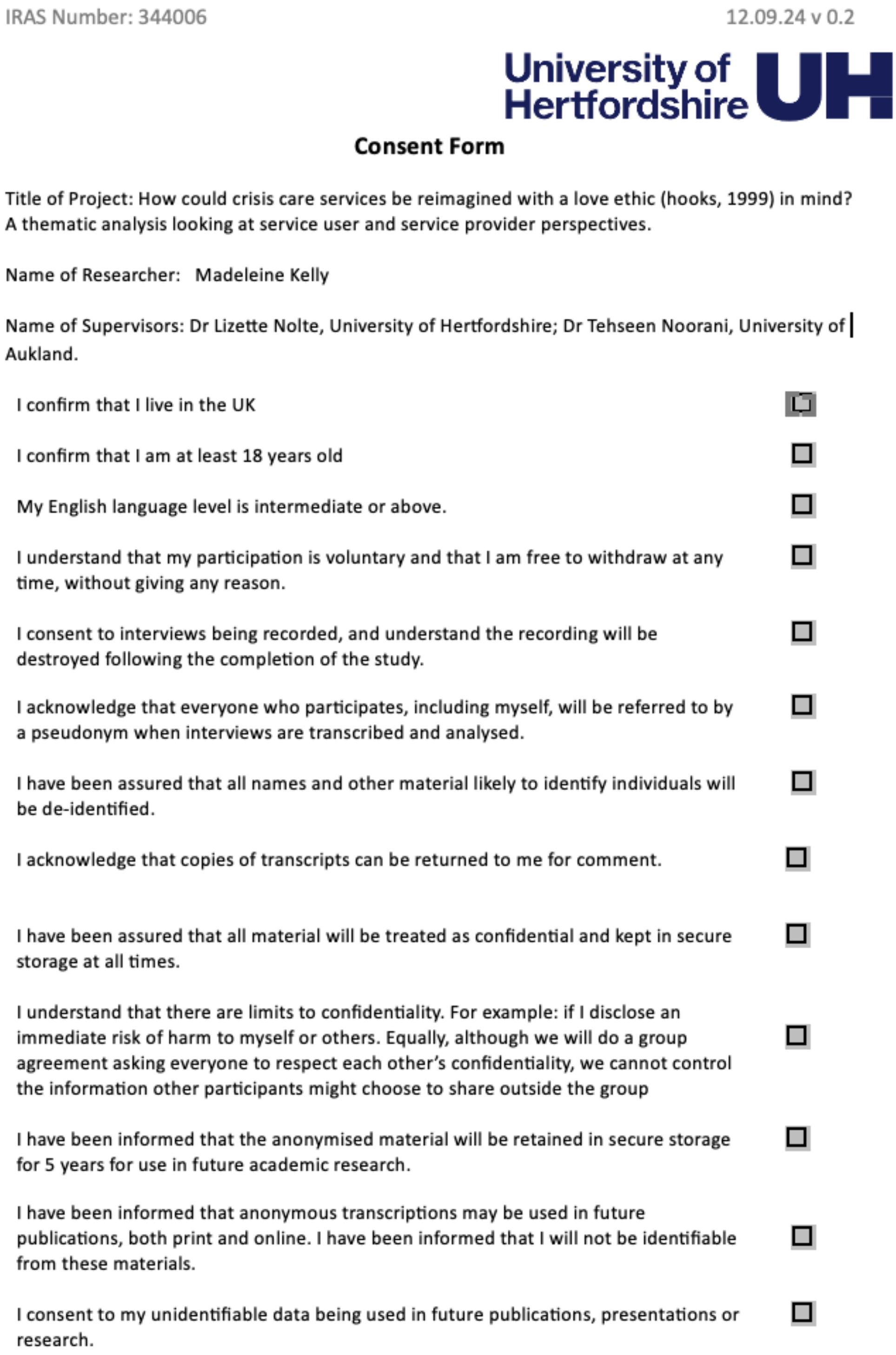
Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar at the following address:
Secretary and Registrar University of Hertfordshire
College Lane
Hatfield
Herts
AL10 9AB

Who has reviewed this study?

Before a study like this can go ahead it is checked by a NHS Research Ethics Committee, to ensure the study has been thought through carefully and is appropriate. University of Hertfordshire, Ethical Protocol number: LMS/PGR/NHS/02319. The Health Research Authority reference is: 24/NI/0102.

Thank you very much for reading this information and considering taking part in this study

Appendix J- Consent Form



IRAS Number: 344006 12.09.24 v 0.2

University of Hertfordshire UH

Consent Form

Title of Project: How could crisis care services be reimagined with a love ethic (hooks, 1999) in mind? A thematic analysis looking at service user and service provider perspectives.

Name of Researcher: Madeleine Kelly

Name of Supervisors: Dr Lizette Nolte, University of Hertfordshire; Dr Tehseen Noorani, University of Aukland.

I confirm that I live in the UK ☐

I confirm that I am at least 18 years old ☐

My English language level is intermediate or above. ☐

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. ☐

I consent to interviews being recorded, and understand the recording will be destroyed following the completion of the study. ☐

I acknowledge that everyone who participates, including myself, will be referred to by a pseudonym when interviews are transcribed and analysed. ☐

I have been assured that all names and other material likely to identify individuals will be de-identified. ☐

I acknowledge that copies of transcripts can be returned to me for comment. ☐

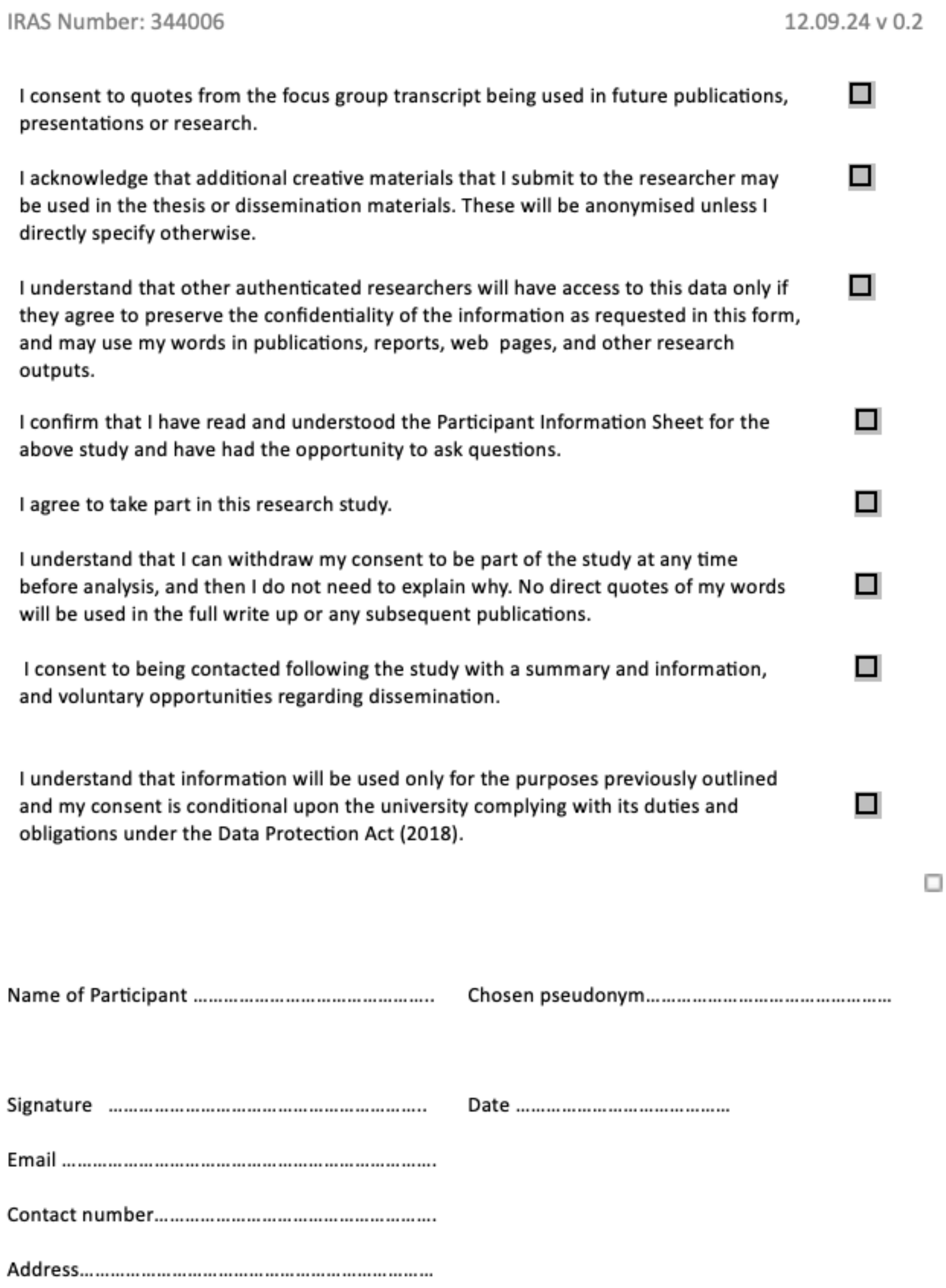
I have been assured that all material will be treated as confidential and kept in secure storage at all times. ☐

I understand that there are limits to confidentiality. For example: if I disclose an immediate risk of harm to myself or others. Equally, although we will do a group agreement asking everyone to respect each other's confidentiality, we cannot control the information other participants might choose to share outside the group ☐

I have been informed that the anonymised material will be retained in secure storage for 5 years for use in future academic research. ☐

I have been informed that anonymous transcriptions may be used in future publications, both print and online. I have been informed that I will not be identifiable from these materials. ☐

I consent to my unidentifiable data being used in future publications, presentations or research. ☐



IRAS Number: 344006 12.09.24 v 0.2

I consent to quotes from the focus group transcript being used in future publications, presentations or research. ☐

I acknowledge that additional creative materials that I submit to the researcher may be used in the thesis or dissemination materials. These will be anonymised unless I directly specify otherwise. ☐

I understand that other authenticated researchers will have access to this data only if they agree to preserve the confidentiality of the information as requested in this form, and may use my words in publications, reports, web pages, and other research outputs. ☐

I confirm that I have read and understood the Participant Information Sheet for the above study and have had the opportunity to ask questions. ☐

I agree to take part in this research study. ☐

I understand that I can withdraw my consent to be part of the study at any time before analysis, and then I do not need to explain why. No direct quotes of my words will be used in the full write up or any subsequent publications. ☐

I consent to being contacted following the study with a summary and information, and voluntary opportunities regarding dissemination. ☐

I understand that information will be used only for the purposes previously outlined and my consent is conditional upon the university complying with its duties and obligations under the Data Protection Act (2018). ☐

☐

Name of Participant ……………………………………….. Chosen pseudonym………………………………………..

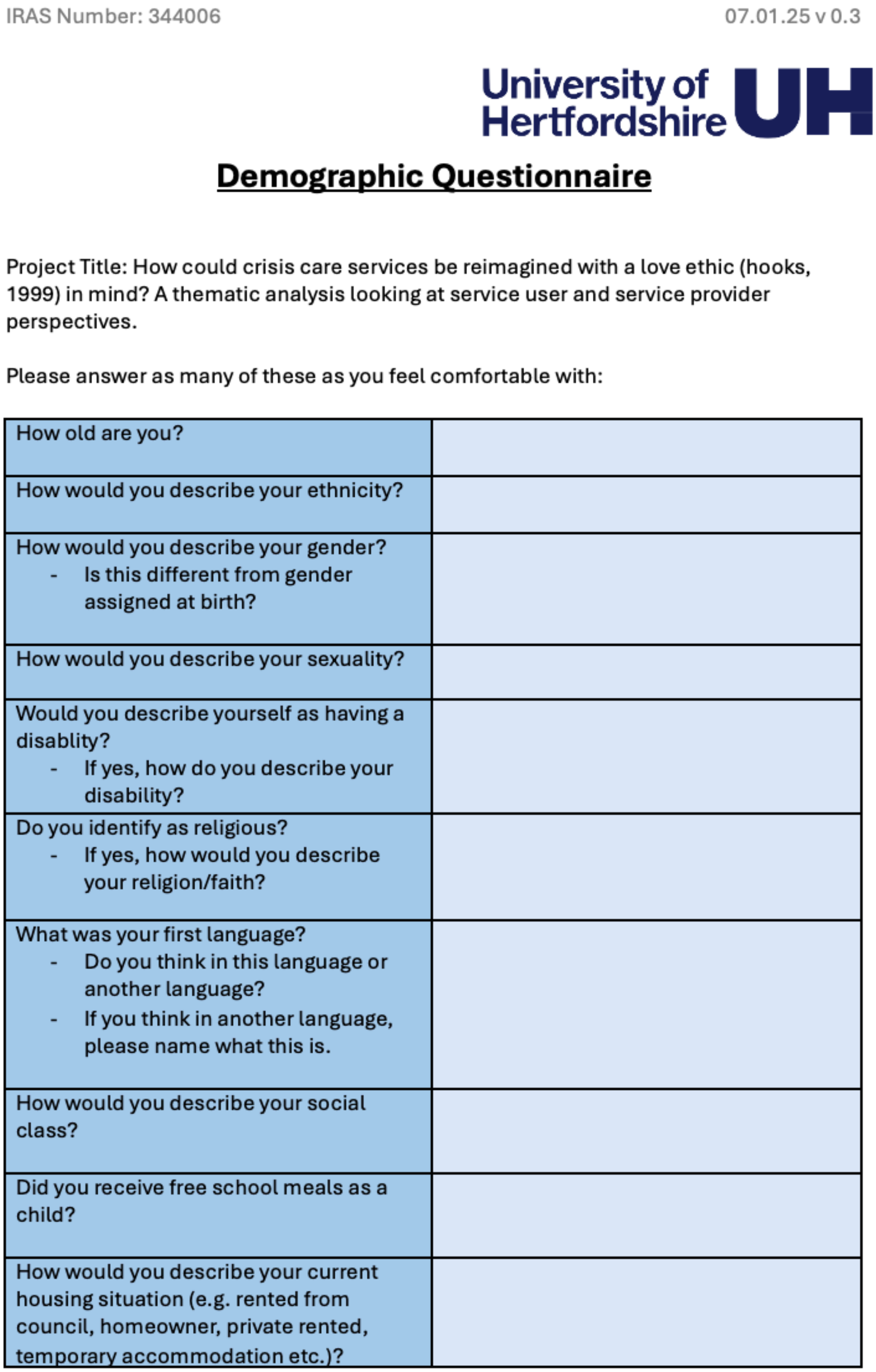
Signature ……………………………………………………. Date …………………………………..

Email ………………………………………………………………..

Contact number………………………………………………..

Address……………………………………………………………

Appendix K - Demographic Questionnaire



IRAS Number: 344006 07.01.25 v 0.3

University of Hertfordshire UH

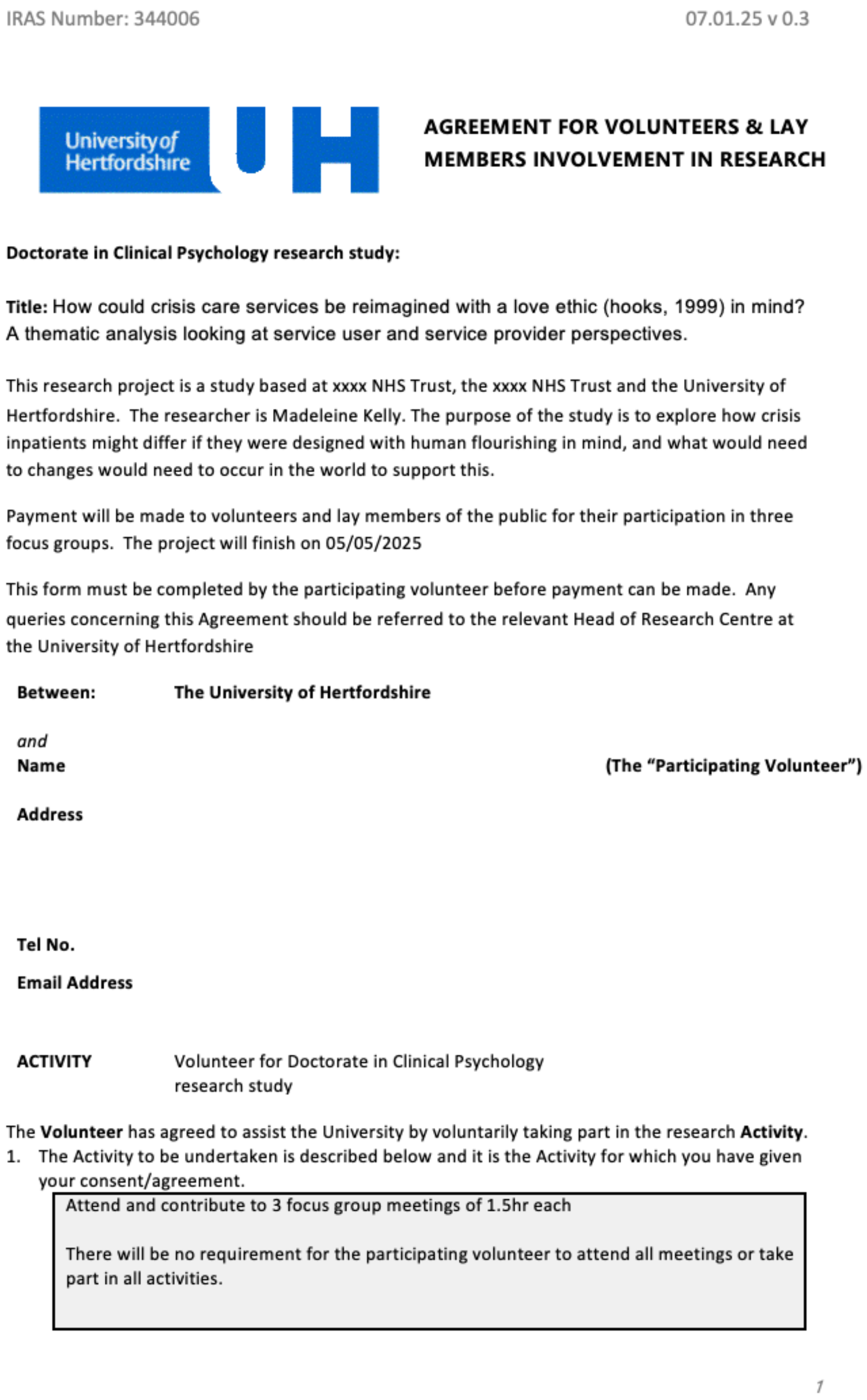
Demographic Questionnaire

Project Title: How could crisis care services be reimagined with a love ethic (hooks, 1999) in mind? A thematic analysis looking at service user and service provider perspectives.

Please answer as many of these as you feel comfortable with:

How old are you?	
How would you describe your ethnicity?	
How would you describe your gender? - Is this different from gender assigned at birth?	
How would you describe your sexuality?	
Would you describe yourself as having a disablity? - If yes, how do you describe your disability?	
Do you identify as religious? - If yes, how would you describe your religion/faith?	
What was your first language? - Do you think in this language or another language? - If you think in another language, please name what this is.	
How would you describe your social class?	
Did you receive free school meals as a child?	
How would you describe your current housing situation (e.g. rented from council, homeowner, private rented, temporary accommodation etc.)?	

Appendix L – Participant Payment Form



IRAS Number: 344006 07.01.25 v 0.3

AGREEMENT FOR VOLUNTEERS & LAY MEMBERS INVOLVEMENT IN RESEARCH

Doctorate in Clinical Psychology research study:

Title: How could crisis care services be reimagined with a love ethic (hooks, 1999) in mind? A thematic analysis looking at service user and service provider perspectives.

This research project is a study based at xxxx NHS Trust, the xxxx NHS Trust and the University of Hertfordshire. The researcher is Madeleine Kelly. The purpose of the study is to explore how crisis inpatients might differ if they were designed with human flourishing in mind, and what would need to changes would need to occur in the world to support this.

Payment will be made to volunteers and lay members of the public for their participation in three focus groups. The project will finish on 05/05/2025

This form must be completed by the participating volunteer before payment can be made. Any queries concerning this Agreement should be referred to the relevant Head of Research Centre at the University of Hertfordshire

Between: **The University of Hertfordshire**

and

Name **(The "Participating Volunteer")**

Address

Tel No.

Email Address

ACTIVITY Volunteer for Doctorate in Clinical Psychology research study

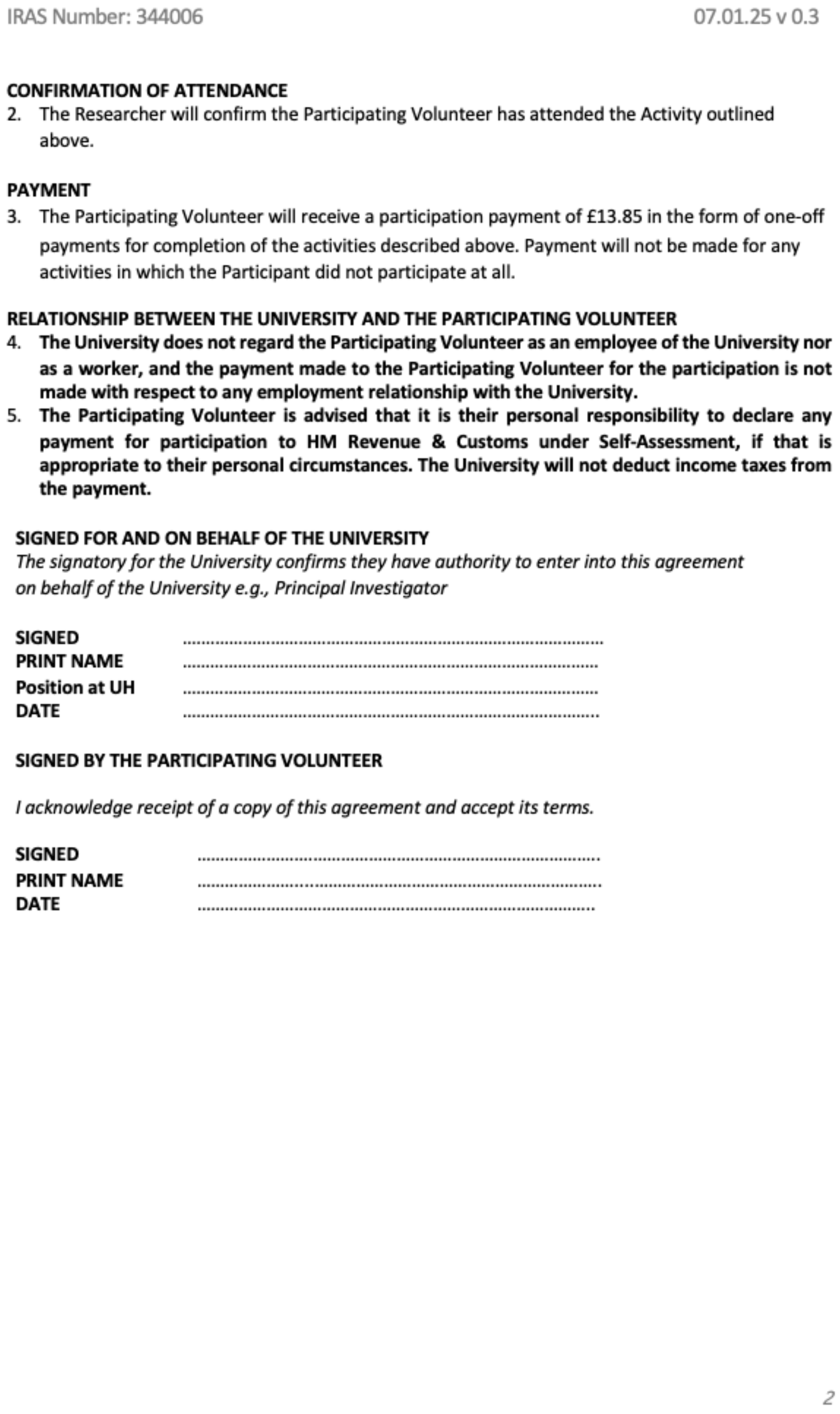
The **Volunteer** has agreed to assist the University by voluntarily taking part in the research **Activity**.

1. The Activity to be undertaken is described below and it is the Activity for which you have given your consent/agreement.

Attend and contribute to 3 focus group meetings of 1.5hr each

There will be no requirement for the participating volunteer to attend all meetings or take part in all activities.

1



CONFIRMATION OF ATTENDANCE

2. The Researcher will confirm the Participating Volunteer has attended the Activity outlined above.

PAYMENT

3. The Participating Volunteer will receive a participation payment of £13.85 in the form of one-off payments for completion of the activities described above. Payment will not be made for any activities in which the Participant did not participate at all.

RELATIONSHIP BETWEEN THE UNIVERSITY AND THE PARTICIPATING VOLUNTEER

4. **The University does not regard the Participating Volunteer as an employee of the University nor as a worker, and the payment made to the Participating Volunteer for the participation is not made with respect to any employment relationship with the University.**
5. **The Participating Volunteer is advised that it is their personal responsibility to declare any payment for participation to HM Revenue & Customs under Self-Assessment, if that is appropriate to their personal circumstances. The University will not deduct income taxes from the payment.**

SIGNED FOR AND ON BEHALF OF THE UNIVERSITY

The signatory for the University confirms they have authority to enter into this agreement on behalf of the University e.g., Principal Investigator

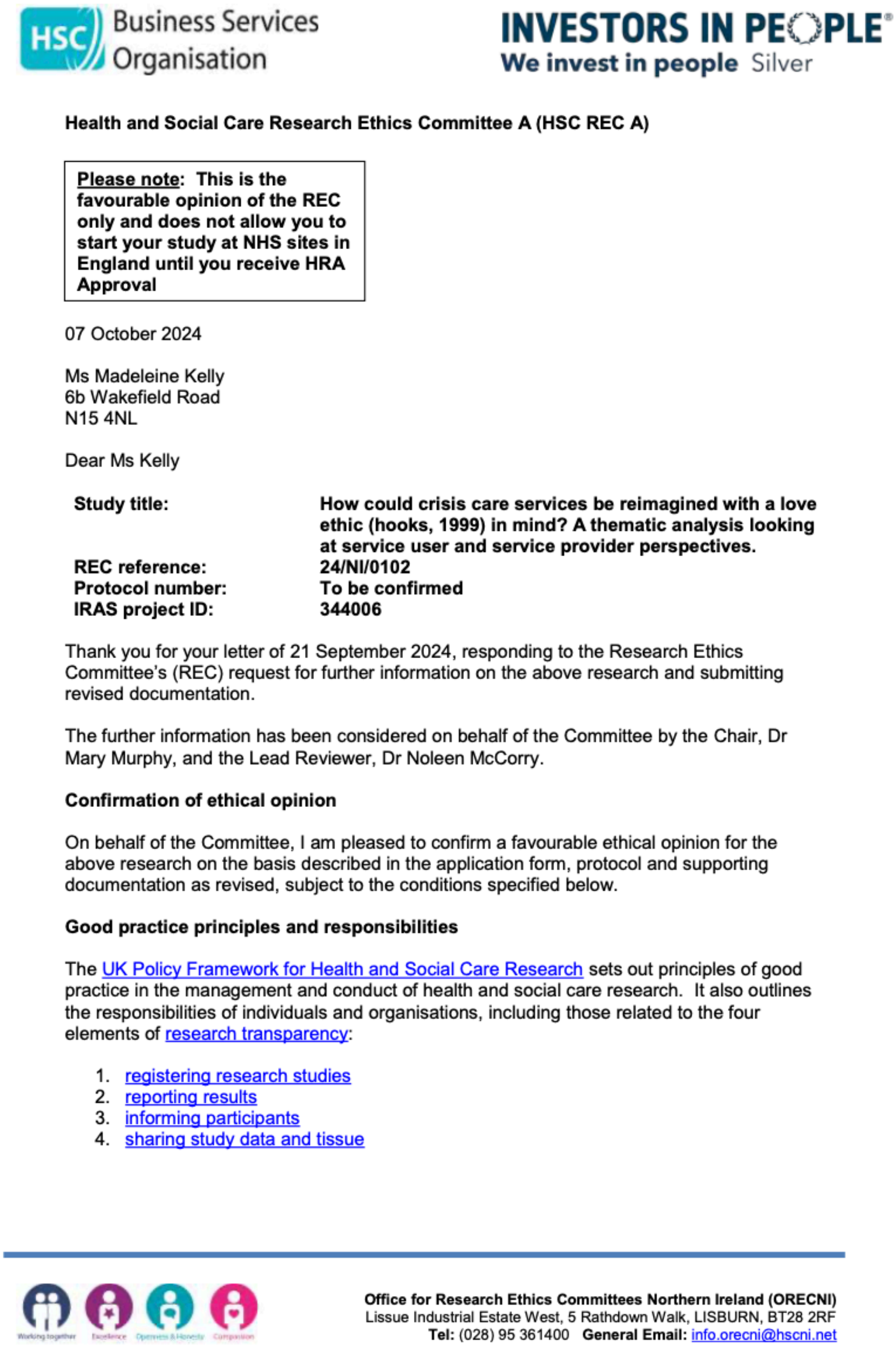
SIGNED ....
PRINT NAME ....
Position at UH ....
DATE ....

SIGNED BY THE PARTICIPATING VOLUNTEER

I acknowledge receipt of a copy of this agreement and accept its terms.

SIGNED ....
PRINT NAME ....
DATE ....

Appendix M- REC Favourable Approval



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Health and Social Care Research Ethics Committee A (HSC REC A)

<u>Please note</u>: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

07 October 2024

Ms Madeleine Kelly
6b Wakefield Road
N15 4NL

Dear Ms Kelly

Study title:	**How could crisis care services be reimagined with a love ethic (hooks, 1999) in mind? A thematic analysis looking at service user and service provider perspectives.**
REC reference:	**24/NI/0102**
Protocol number:	**To be confirmed**
IRAS project ID:	**344006**

Thank you for your letter of 21 September 2024, responding to the Research Ethics Committee's (REC) request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair, Dr Mary Murphy, and the Lead Reviewer, Dr Noleen McCorry.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Good practice principles and responsibilities

The UK Policy Framework for Health and Social Care Research sets out principles of good practice in the management and conduct of health and social care research. It also outlines the responsibilities of individuals and organisations, including those related to the four elements of research transparency:

1. registering research studies
2. reporting results
3. informing participants
4. sharing study data and tissue

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

1. In the recruitment poster for healthcare professionals, please replace '<u>im</u>patient service' with 'inpatient service'.
2. In the Participant Information Sheet v0.2, please replace '…what <u>time</u> of care…' with 'type', under the section 'What is the Research About?'.
3. In the Participant Information Sheet v0.2, please complete the sentence 'We will make a report with the data from the focus groups, and optional.' under the section 'What Will Happen To My Data?'.
4. The posters refer to 'focus groups with a maximum of 12 other people…and 2 facilitators', whilst the long Participant Information Sheet refers to 'Each group will have up to 11 other people who have a shared experience to you, as well as two facilitators.' Please make these consistent.

<u>Recommendation Only</u>

5. The Committee recommended that you review the wording under 'What will taking part involve?' of the poster for healthcare professionals as it refers to "Three focus groups with a maximum of 12 other people who have also experienced sectioning and 2 facilitators". The Committee recommended that you revise this to '…have experienced working with/caring for people who have been sectioned…'.

You should notify the REC once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. Revised documents should be submitted to the REC electronically from IRAS. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which you can make available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

<u>Confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or NHS management permission (in Scotland) should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.</u> Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

<u>Registration of Clinical Trials</u>

All research should be registered in a publicly accessible database and we expect all researchers, research sponsors and others to meet this fundamental best practice standard.

It is a condition of the REC favourable opinion that **all clinical trials are registered** on a public registry before the first participant is recruited and no later than six weeks after. For this purpose, 'clinical trials' are defined as:

- clinical trial of an investigational medicinal product
- clinical investigation or other study of a medical device
- combined trial of an investigational medicinal product and an investigational medical device
- other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice.

A 'public registry' means any registry on the WHO list of primary registries or the ICMJE list of registries provided the registry facilitates public access to information about the UK trial.

Failure to register a clinical trial is a breach of these approval conditions, unless a deferral has been agreed by the HRA (for more information on registration and requesting a deferral see: Research registration and research project identifiers).

Where a deferral is agreed we expect the sponsor to publish a minimal record on a publicly accessible registry. When the deferral period ends, the sponsor should publish the full record on the same registry, to fulfil the condition of the REC favourable opinion.

If you have not already included registration details in your IRAS application form you should notify the REC of the registration details as soon as possible.

Where the study is registered on ClinicalTrials.gov, please inform deferrals@hra.nhs.uk and the Research Ethics Committee (REC) which issued the final ethical opinion so that our records can be updated.

Publication of Your Research Summary

We will publish your research summary for the above study on the research summaries section of our website, together with your contact details, no earlier than three months from the date of this favourable opinion letter. Where a deferral is agreed, a minimum research summary will still be published in the research summaries database. At the end of the deferral period, we will publish the full research summary.

Should you wish to provide a substitute contact point, make a request to defer, or require further information, please visit: Research summaries - Health Research Authority (hra.nhs.uk)

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

After ethical review: Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study, including early termination of the study
- Final report

- Reporting results

The latest guidance on these topics can be found at Managing your approval - Health Research Authority (hra.nhs.uk)

Ethical review of research sites

NHS/HSC sites

The favourable opinion applies to all NHS/HSC sites taking part in the study, subject to confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or management permission (in Scotland) being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

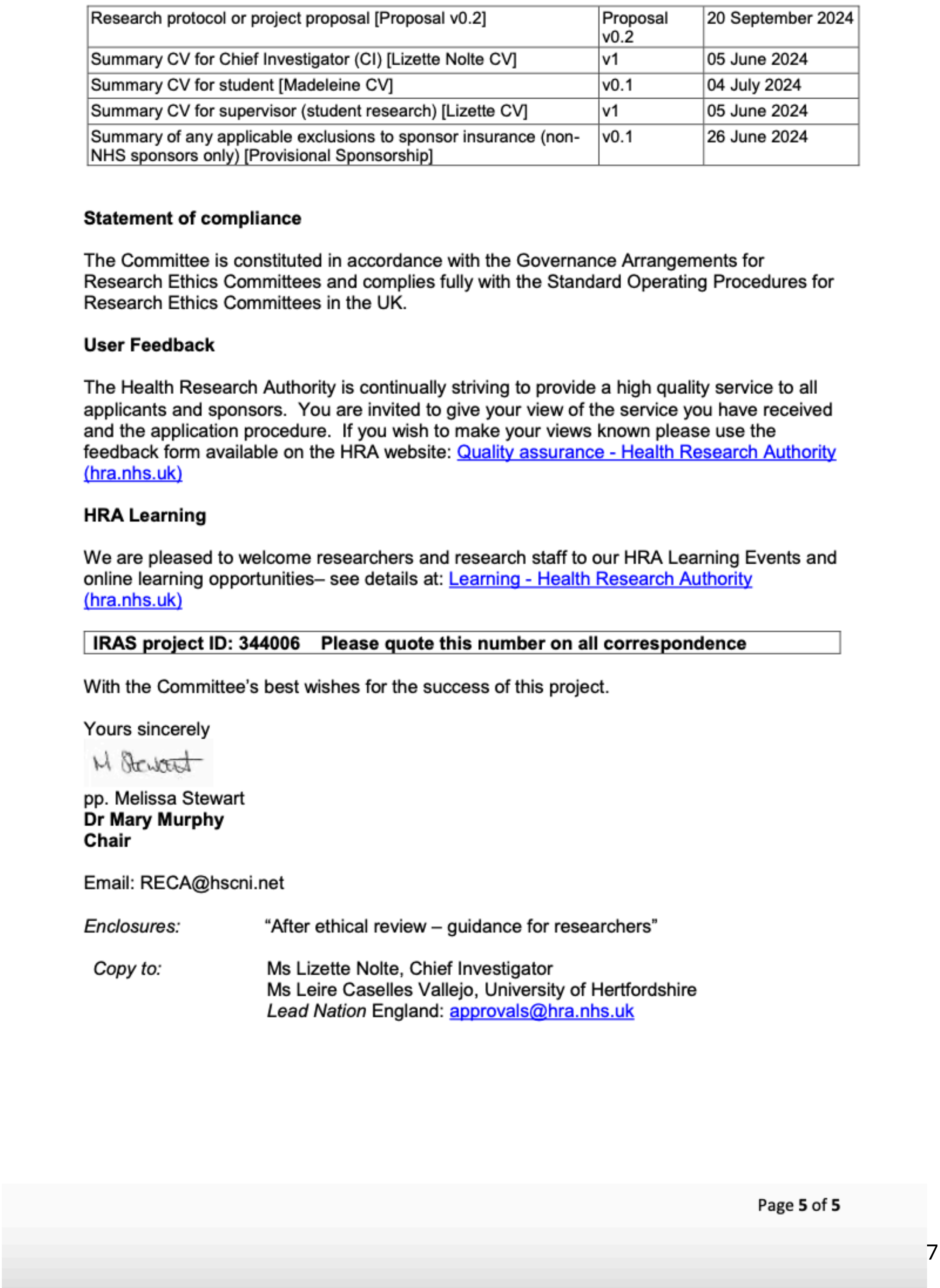
Non-NHS/HSC sites

I am pleased to confirm that the favourable opinion applies to any non-NHS/HSC sites listed in the application, subject to site management permission being obtained prior to the start of the study at the site.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Copies of materials calling attention of potential participants to the research [Poster v0.2]	v0.2	12 September 2024
Copies of materials calling attention of potential participants to the research [Poster WL v0.2]	v0.2	12 September 2024
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Evidence of Sponsor Insurance]	v1	04 July 2024
Interview schedules or topic guides for participants [Session plans v0.1]	v0.1	18 July 2024
IRAS Application Form [IRAS_Form_18072024]		18 July 2024
Letter from sponsor [UH Sponsorship in Principle]	v1	04 July 2024
Other [Payment Agreement- consultants]	v0.2	19 September 2024
Other [Payment agreement- participants]	v0.2	19 September 2024
Other [Demographic questionnaire]	v0.2	20 September 2024
Other [Debrief Participants]	v0.2	19 September 2024
Other [Debrief- Staff]	v0.2	19 September 2024
Other [Distress Protocol]	v0.2	19 September 2024
Other [If client drops off call]	v0.1	19 September 2024
Other [Student Researcher Welfare v0.1]	v0.1	12 September 2024
Other [IRAS Amendments/Cover letter]		21 September 2024
Participant consent form [Consent Form v0.2]	v0.2	12 September 2024
Participant information sheet (PIS) [Participant Information Sheet (Long) v0.1]	v0.1	24 September 2024
Participant information sheet (PIS) [Participant Information Summary v0.2]	v0.2	12 September 2024
Participant information sheet (PIS) [Participant Information Summary- WL v0.2]	v0.2	12 September 2024
Research protocol or project proposal [Proposal v0.1]	v0.1	11 July 2024



Research protocol or project proposal [Proposal v0.2]	Proposal v0.2	20 September 2024
Summary CV for Chief Investigator (CI) [Lizette Nolte CV]	v1	05 June 2024
Summary CV for student [Madeleine CV]	v0.1	04 July 2024
Summary CV for supervisor (student research) [Lizette CV]	v1	05 June 2024
Summary of any applicable exclusions to sponsor insurance (non-NHS sponsors only) [Provisional Sponsorship]	v0.1	26 June 2024

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: Quality assurance - Health Research Authority (hra.nhs.uk)

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: Learning - Health Research Authority (hra.nhs.uk)

IRAS project ID: 344006 Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely

M Stewart

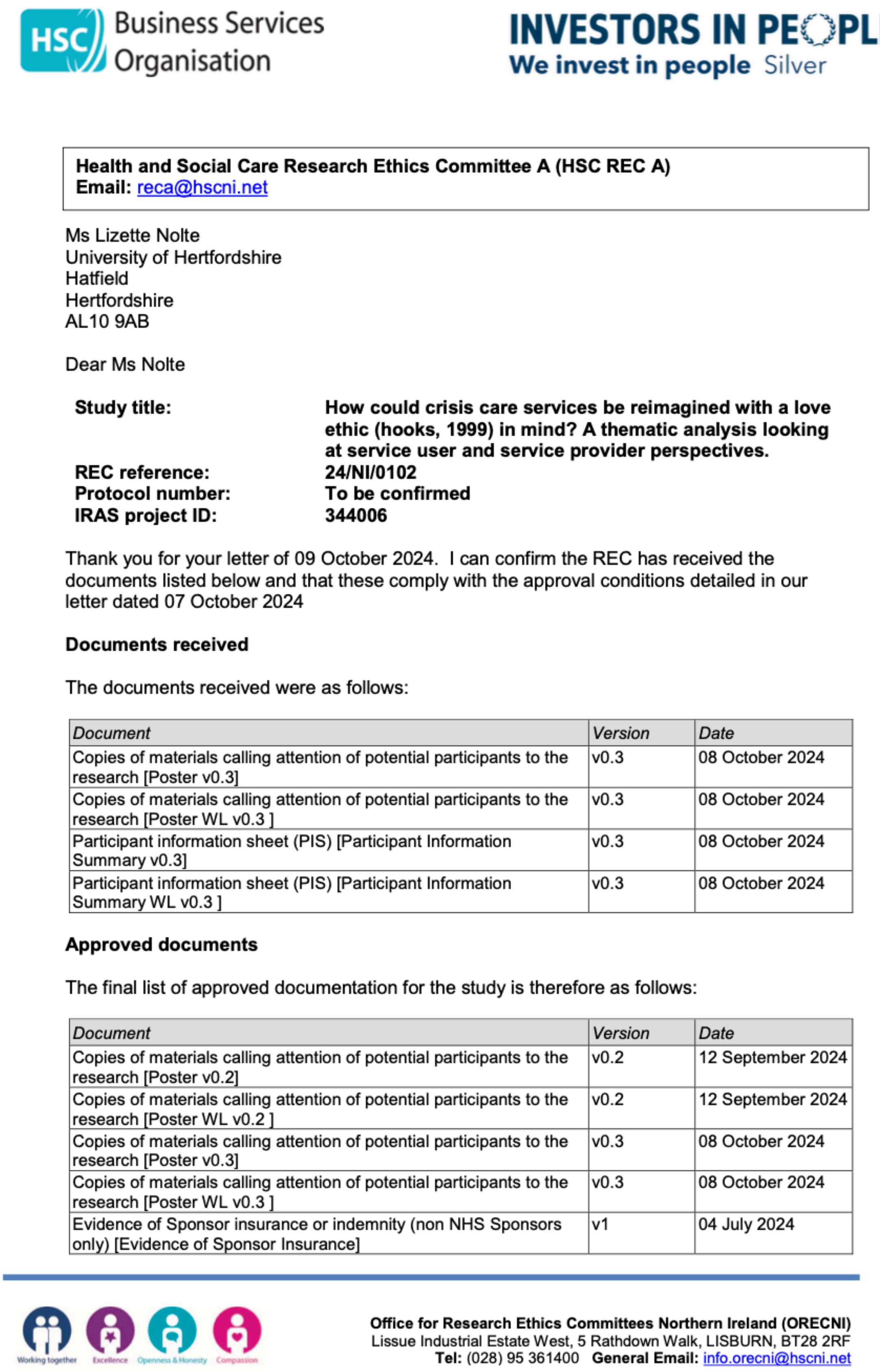
pp. Melissa Stewart
Dr Mary Murphy
Chair

Email: RECA@hscni.net

Enclosures: "After ethical review – guidance for researchers"

Copy to:
Ms Lizette Nolte, Chief Investigator
Ms Leire Caselles Vallejo, University of Hertfordshire
Lead Nation England: approvals@hra.nhs.uk

Appendix N: Confirmation that Favourable Conditions Met



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Health and Social Care Research Ethics Committee A (HSC REC A)
Email: reca@hscni.net

Ms Lizette Nolte
University of Hertfordshire
Hatfield
Hertfordshire
AL10 9AB

Dear Ms Nolte

Study title:	**How could crisis care services be reimagined with a love ethic (hooks, 1999) in mind? A thematic analysis looking at service user and service provider perspectives.**
REC reference:	**24/NI/0102**
Protocol number:	**To be confirmed**
IRAS project ID:	**344006**

Thank you for your letter of 09 October 2024. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 07 October 2024

Documents received

The documents received were as follows:

Document	*Version*	*Date*
Copies of materials calling attention of potential participants to the research [Poster v0.3]	v0.3	08 October 2024
Copies of materials calling attention of potential participants to the research [Poster WL v0.3]	v0.3	08 October 2024
Participant information sheet (PIS) [Participant Information Summary v0.3]	v0.3	08 October 2024
Participant information sheet (PIS) [Participant Information Summary WL v0.3]	v0.3	08 October 2024

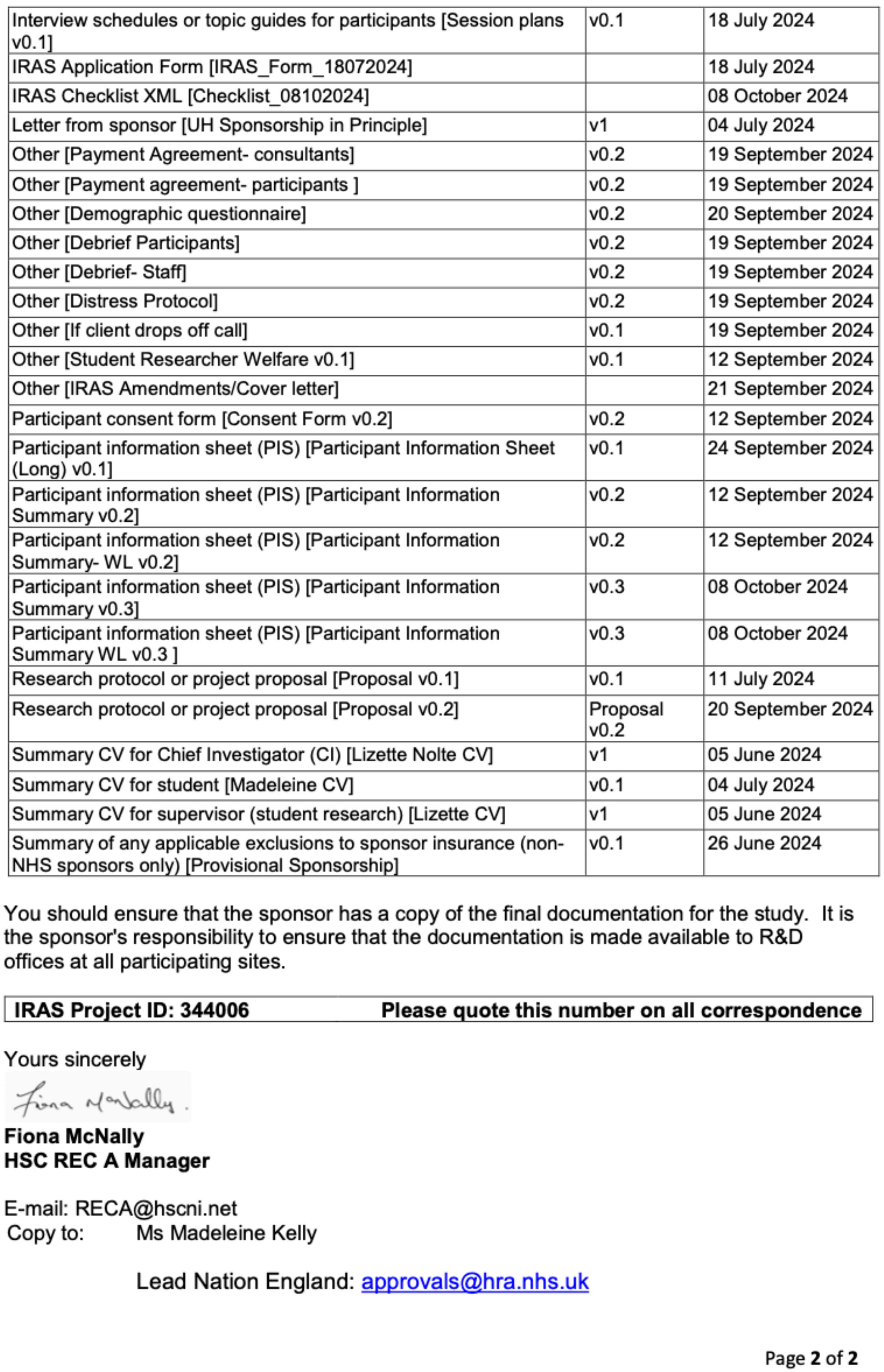
Approved documents

The final list of approved documentation for the study is therefore as follows:

Document	*Version*	*Date*
Copies of materials calling attention of potential participants to the research [Poster v0.2]	v0.2	12 September 2024
Copies of materials calling attention of potential participants to the research [Poster WL v0.2]	v0.2	12 September 2024
Copies of materials calling attention of potential participants to the research [Poster v0.3]	v0.3	08 October 2024
Copies of materials calling attention of potential participants to the research [Poster WL v0.3]	v0.3	08 October 2024
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Evidence of Sponsor Insurance]	v1	04 July 2024

Working together Excellence Openness & Honesty Compassion

Office for Research Ethics Committees Northern Ireland (ORECNI)
Lissue Industrial Estate West, 5 Rathdown Walk, LISBURN, BT28 2RF
Tel: (028) 95 361400 **General Email:** info.orecni@hscni.net



Interview schedules or topic guides for participants [Session plans v0.1]	v0.1	18 July 2024
IRAS Application Form [IRAS_Form_18072024]		18 July 2024
IRAS Checklist XML [Checklist_08102024]		08 October 2024
Letter from sponsor [UH Sponsorship in Principle]	v1	04 July 2024
Other [Payment Agreement- consultants]	v0.2	19 September 2024
Other [Payment agreement- participants]	v0.2	19 September 2024
Other [Demographic questionnaire]	v0.2	20 September 2024
Other [Debrief Participants]	v0.2	19 September 2024
Other [Debrief- Staff]	v0.2	19 September 2024
Other [Distress Protocol]	v0.2	19 September 2024
Other [If client drops off call]	v0.1	19 September 2024
Other [Student Researcher Welfare v0.1]	v0.1	12 September 2024
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Participant information sheet (PIS) [Participant Information Summary v0.2]	v0.2	12 September 2024
Participant information sheet (PIS) [Participant Information Summary- WL v0.2]	v0.2	12 September 2024
Participant information sheet (PIS) [Participant Information Summary v0.3]	v0.3	08 October 2024
Participant information sheet (PIS) [Participant Information Summary WL v0.3]	v0.3	08 October 2024
Research protocol or project proposal [Proposal v0.1]	v0.1	11 July 2024
Research protocol or project proposal [Proposal v0.2]	Proposal v0.2	20 September 2024
Summary CV for Chief Investigator (CI) [Lizette Nolte CV]	v1	05 June 2024
Summary CV for student [Madeleine CV]	v0.1	04 July 2024
Summary CV for supervisor (student research) [Lizette CV]	v1	05 June 2024
Summary of any applicable exclusions to sponsor insurance (non-NHS sponsors only) [Provisional Sponsorship]	v0.1	26 June 2024

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

IRAS Project ID: 344006 **Please quote this number on all correspondence**

Yours sincerely

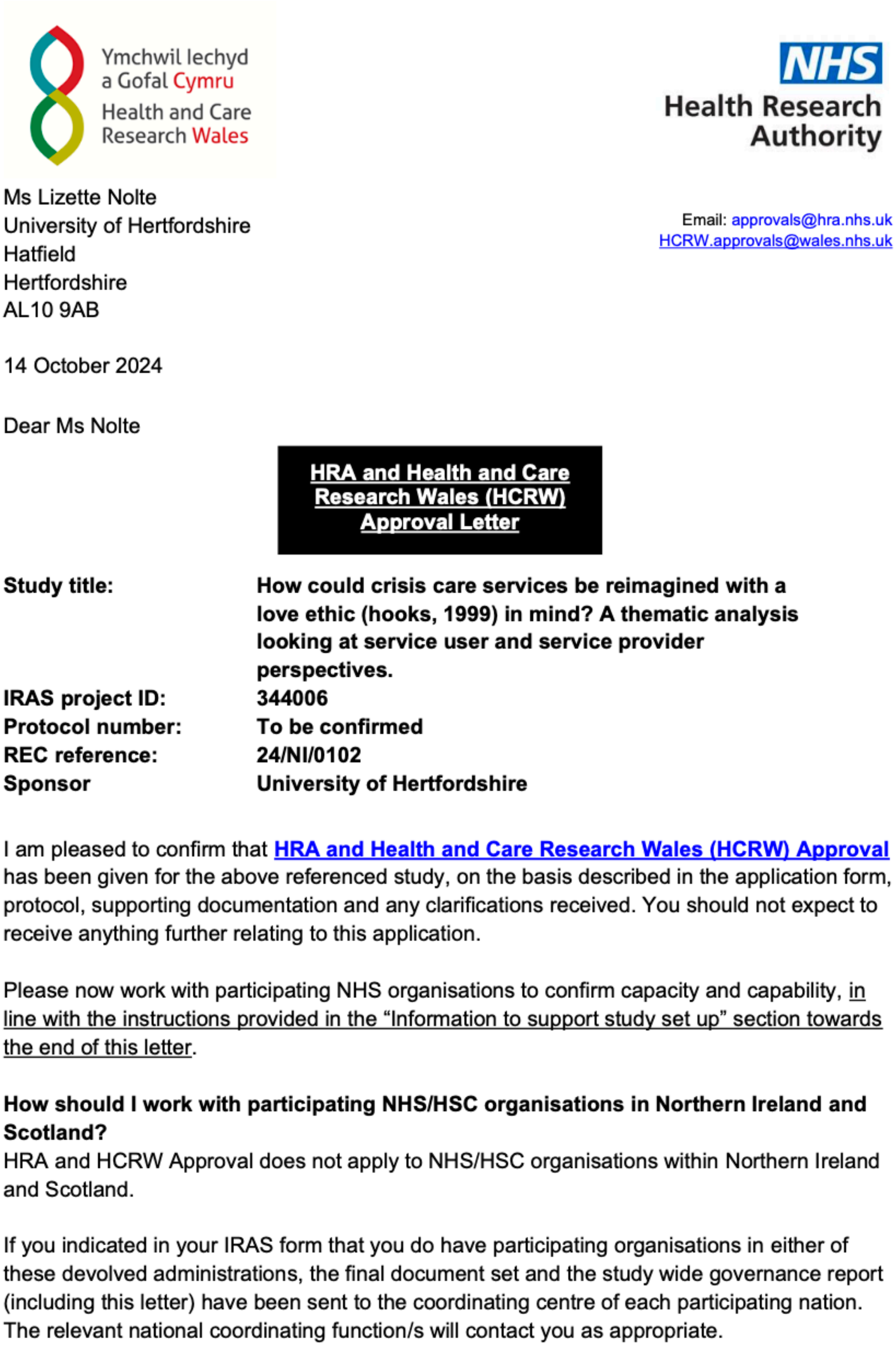
Fiona McNally.

Fiona McNally
HSC REC A Manager

E-mail: RECA@hscni.net
Copy to: Ms Madeleine Kelly

Lead Nation England: approvals@hra.nhs.uk

Appendix O- HRA Approval



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a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research
Authority

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

Ms Lizette Nolte
University of Hertfordshire
Hatfield
Hertfordshire
AL10 9AB

14 October 2024

Dear Ms Nolte

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**How could crisis care services be reimagined with a love ethic (hooks, 1999) in mind? A thematic analysis looking at service user and service provider perspectives.**
IRAS project ID:	**344006**
Protocol number:	**To be confirmed**
REC reference:	**24/NI/0102**
Sponsor	**University of Hertfordshire**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

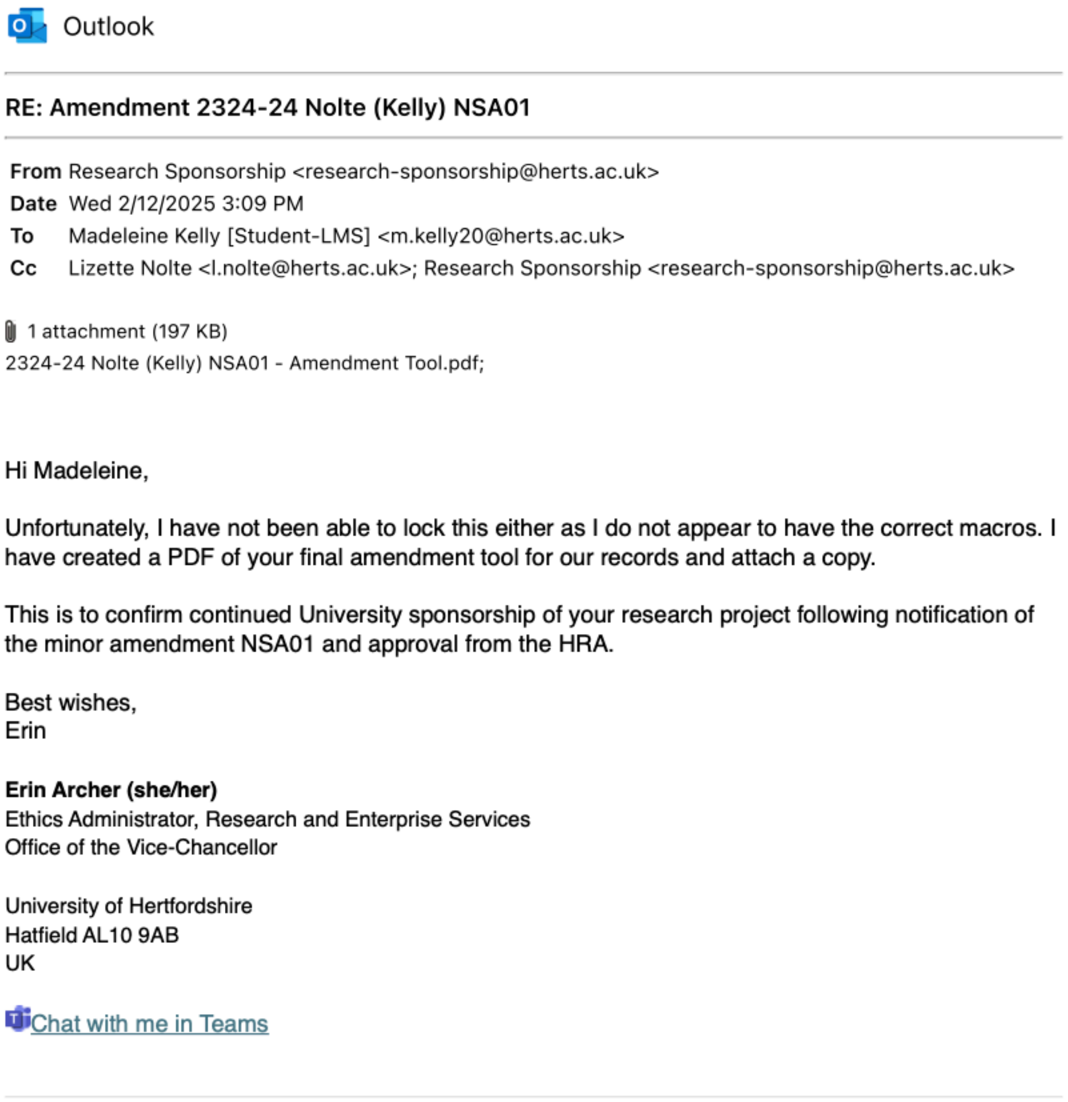
Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Appendix P- Amendments

a) Minor Amendment NSA01 (changes to demographic forms)



RE: Amendment 2324-24 Nolte (Kelly) NSA01

From Research Sponsorship <research-sponsorship@herts.ac.uk>
Date Wed 2/12/2025 3:09 PM
To Madeleine Kelly [Student-LMS] <m.kelly20@herts.ac.uk>
Cc Lizette Nolte <l.nolte@herts.ac.uk>; Research Sponsorship <research-sponsorship@herts.ac.uk>

1 attachment (197 KB)
2324-24 Nolte (Kelly) NSA01 - Amendment Tool.pdf;

Hi Madeleine,

Unfortunately, I have not been able to lock this either as I do not appear to have the correct macros. I have created a PDF of your final amendment tool for our records and attach a copy.

This is to confirm continued University sponsorship of your research project following notification of the minor amendment NSA01 and approval from the HRA.

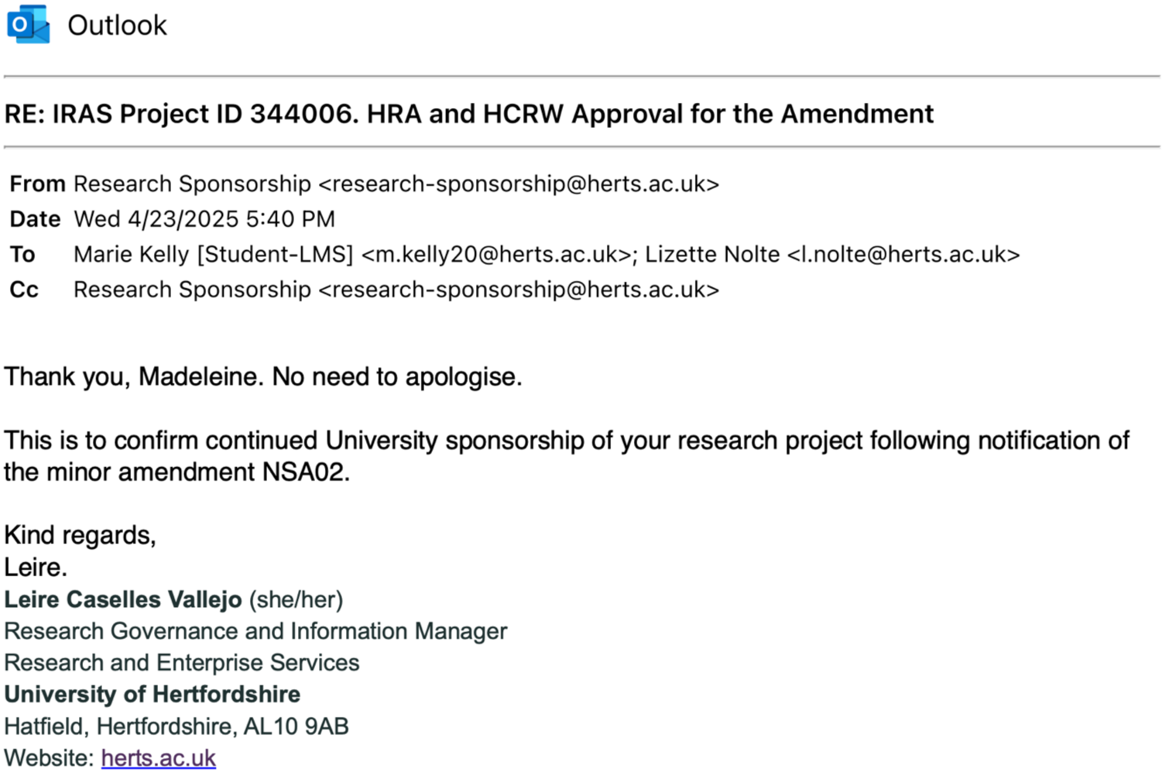
Best wishes,
Erin

Erin Archer (she/her)
Ethics Administrator, Research and Enterprise Services
Office of the Vice-Chancellor

University of Hertfordshire
Hatfield AL10 9AB
UK

Chat with me in Teams

b) Minor Amendment NSA01 (change from Teams to Zoom)



RE: IRAS Project ID 344006. HRA and HCRW Approval for the Amendment

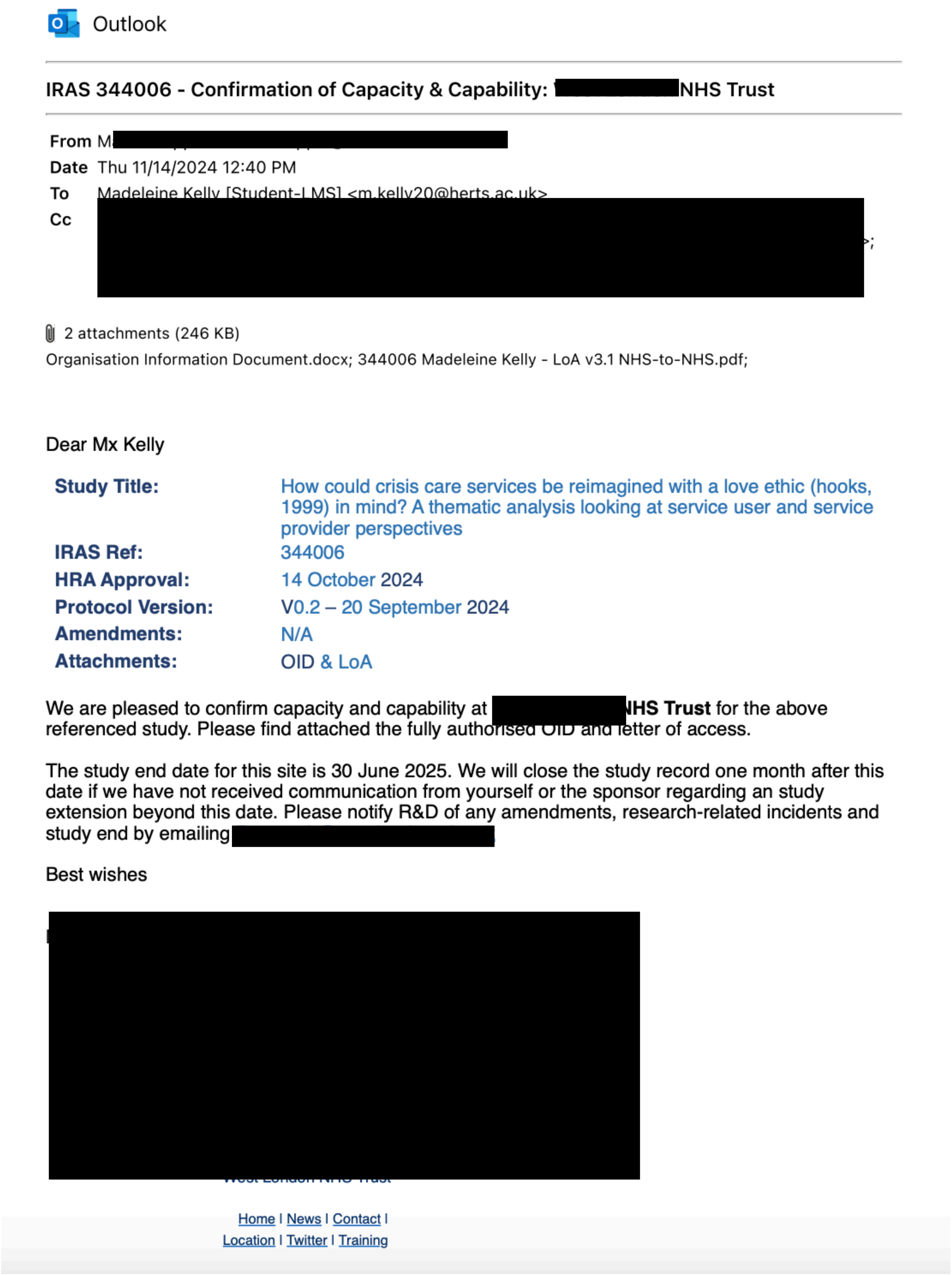
From Research Sponsorship <research-sponsorship@herts.ac.uk>
Date Wed 4/23/2025 5:40 PM
To Marie Kelly [Student-LMS] <m.kelly20@herts.ac.uk>; Lizette Nolte <l.nolte@herts.ac.uk>
Cc Research Sponsorship <research-sponsorship@herts.ac.uk>

Thank you, Madeleine. No need to apologise.

This is to confirm continued University sponsorship of your research project following notification of the minor amendment NSA02.

Kind regards,
Leire.
Leire Caselles Vallejo (she/her)
Research Governance and Information Manager
Research and Enterprise Services
University of Hertfordshire
Hatfield, Hertfordshire, AL10 9AB
Website: herts.ac.uk

Appendix Q- Approval from NHS site



Outlook

IRAS 344006 - Confirmation of Capacity & Capability: [redacted]NHS Trust

From [redacted]
Date Thu 11/14/2024 12:40 PM
To Madeleine Kelly [Student-LMS] <m.kelly20@herts.ac.uk>
Cc [redacted]

2 attachments (246 KB)
Organisation Information Document.docx; 344006 Madeleine Kelly - LoA v3.1 NHS-to-NHS.pdf;

Dear Mx Kelly

Study Title:	How could crisis care services be reimagined with a love ethic (hooks, 1999) in mind? A thematic analysis looking at service user and service provider perspectives
IRAS Ref:	344006
HRA Approval:	14 October 2024
Protocol Version:	V0.2 – 20 September 2024
Amendments:	N/A
Attachments:	OID & LoA

We are pleased to confirm capacity and capability at [redacted]**NHS Trust** for the above referenced study. Please find attached the fully authorised OID and letter of access.

The study end date for this site is 30 June 2025. We will close the study record one month after this date if we have not received communication from yourself or the sponsor regarding an study extension beyond this date. Please notify R&D of any amendments, research-related incidents and study end by emailing [redacted]

Best wishes

[redacted]

Home | News | Contact |
Location | Twitter | Training

Appendix R- Site Withdrawal

IRAS 34400[redacted] Site Withdrawal - How can crisis care be reimagined with a "love ethic" in mind

From [redacted]

Date Wed 1/22/2025 2:47 PM

To [redacted]

Cc [redacted]

Dear Madeleine and Lizette,

I hope you are both well.

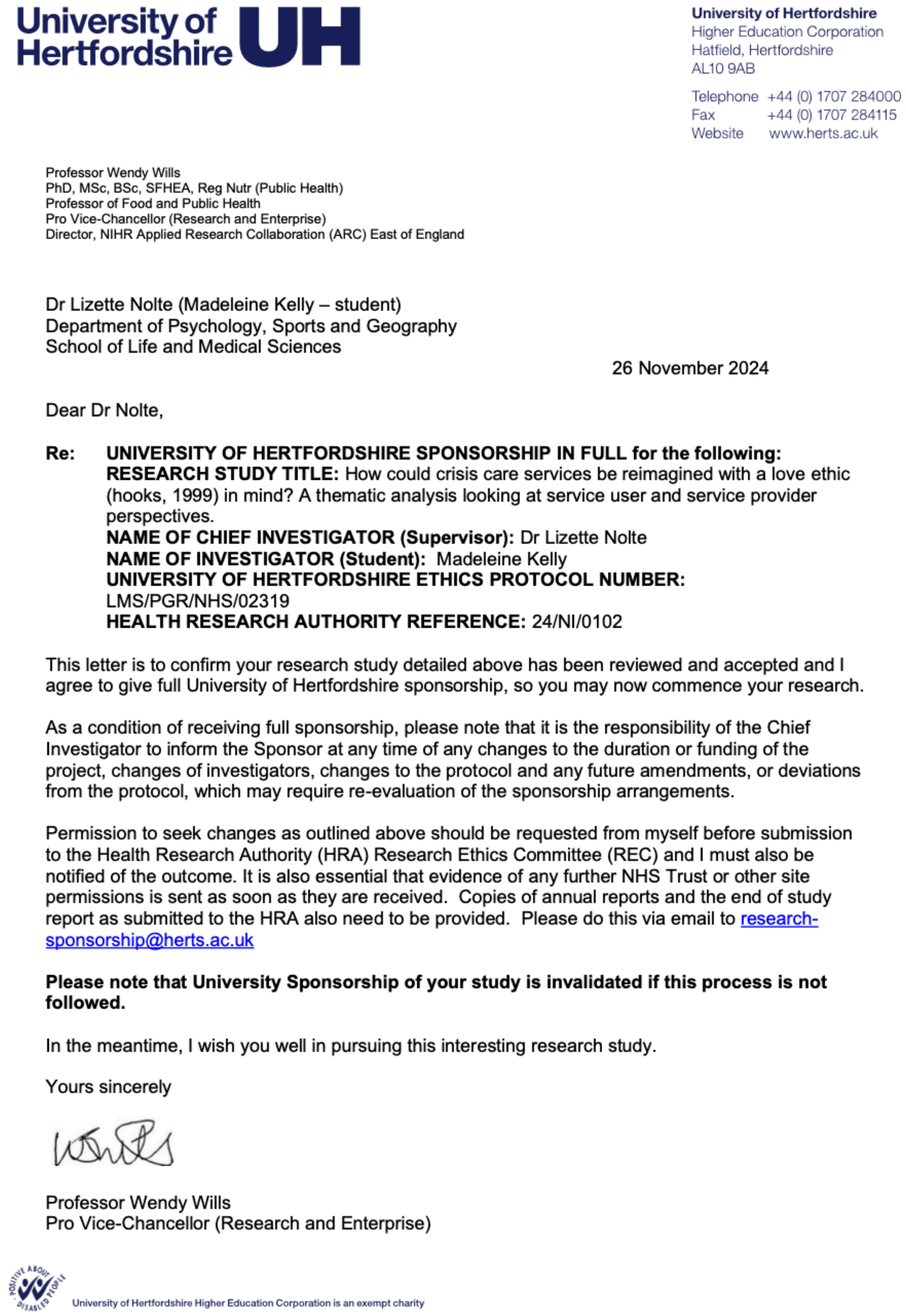
Unfortunately the clinical leads within services at [redacted] have not provided authorisation locally for your study, and have said that owning to local pressures on these services they will not have capacity to take part.

We are sorry that the Trust are not able to participate in the study and will need to withdraw. We will mark the site as withdrawn and close the record from our side.

Kind regards,

[redacted]

Appendix S- University of Hertfordshire Ethics Sponsorship



University of Hertfordshire UH

University of Hertfordshire
Higher Education Corporation
Hatfield, Hertfordshire
AL10 9AB

Telephone +44 (0) 1707 284000
Fax +44 (0) 1707 284115
Website www.herts.ac.uk

Professor Wendy Wills
PhD, MSc, BSc, SFHEA, Reg Nutr (Public Health)
Professor of Food and Public Health
Pro Vice-Chancellor (Research and Enterprise)
Director, NIHR Applied Research Collaboration (ARC) East of England

Dr Lizette Nolte (Madeleine Kelly – student)
Department of Psychology, Sports and Geography
School of Life and Medical Sciences

26 November 2024

Dear Dr Nolte,

Re: UNIVERSITY OF HERTFORDSHIRE SPONSORSHIP IN FULL for the following:
RESEARCH STUDY TITLE: How could crisis care services be reimagined with a love ethic (hooks, 1999) in mind? A thematic analysis looking at service user and service provider perspectives.
NAME OF CHIEF INVESTIGATOR (Supervisor): Dr Lizette Nolte
NAME OF INVESTIGATOR (Student): Madeleine Kelly
UNIVERSITY OF HERTFORDSHIRE ETHICS PROTOCOL NUMBER:
LMS/PGR/NHS/02319
HEALTH RESEARCH AUTHORITY REFERENCE: 24/NI/0102

This letter is to confirm your research study detailed above has been reviewed and accepted and I agree to give full University of Hertfordshire sponsorship, so you may now commence your research.

As a condition of receiving full sponsorship, please note that it is the responsibility of the Chief Investigator to inform the Sponsor at any time of any changes to the duration or funding of the project, changes of investigators, changes to the protocol and any future amendments, or deviations from the protocol, which may require re-evaluation of the sponsorship arrangements.

Permission to seek changes as outlined above should be requested from myself before submission to the Health Research Authority (HRA) Research Ethics Committee (REC) and I must also be notified of the outcome. It is also essential that evidence of any further NHS Trust or other site permissions is sent as soon as they are received. Copies of annual reports and the end of study report as submitted to the HRA also need to be provided. Please do this via email to research-sponsorship@herts.ac.uk

Please note that University Sponsorship of your study is invalidated if this process is not followed.

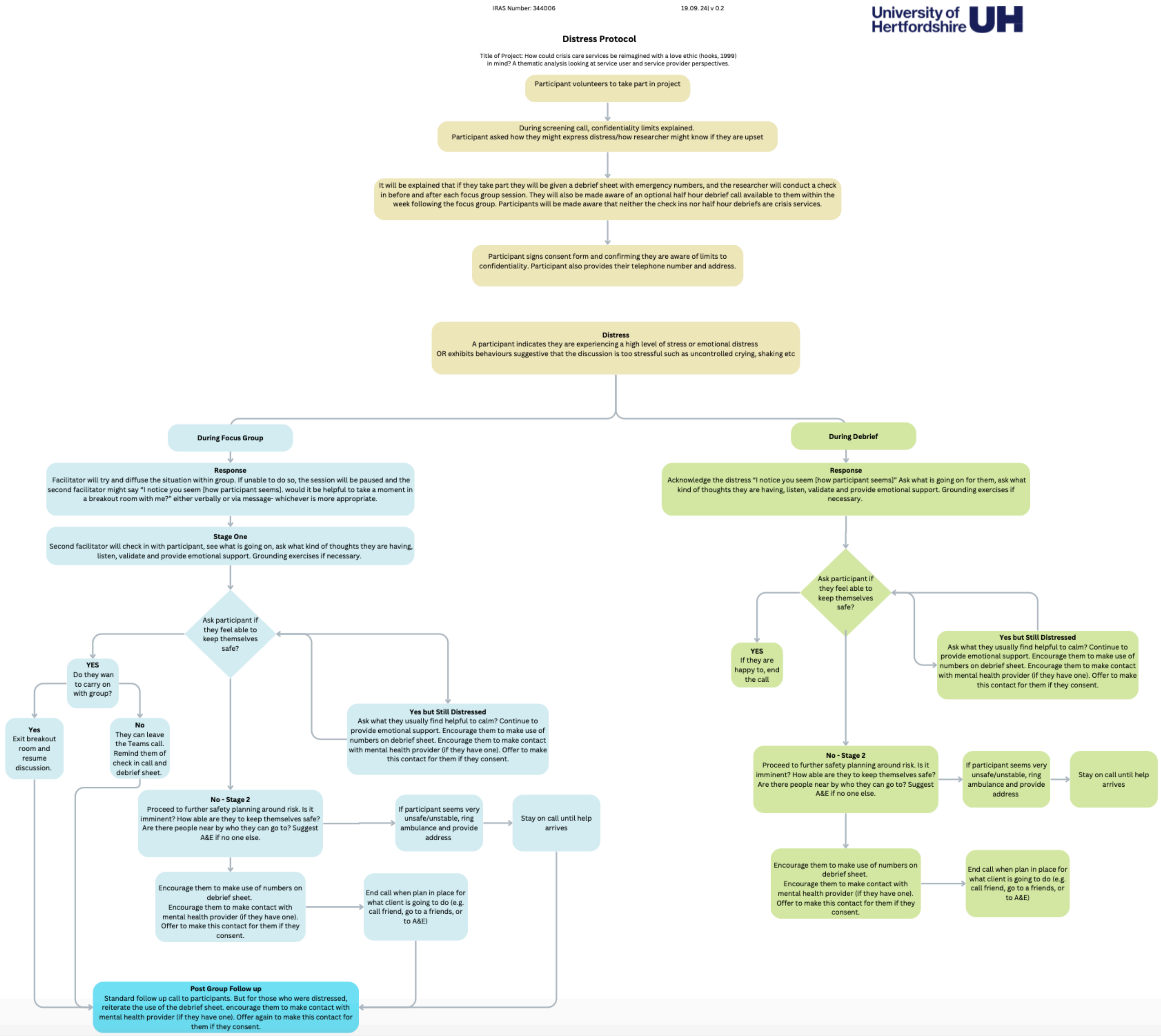
In the meantime, I wish you well in pursuing this interesting research study.

Yours sincerely

Professor Wendy Wills
Pro Vice-Chancellor (Research and Enterprise)

University of Hertfordshire Higher Education Corporation is an exempt charity

Appendix T- Distress Protocol



IRAS Number: 344006 19.09. 24| v 0.2

Distress Protocol

Title of Project: How could crisis care services be reimagined with a love ethic (hooks, 1999) in mind? A thematic analysis looking at service user and service provider perspectives.

Participant volunteers to take part in project

During screening call, confidentiality limits explained.
Participant asked how they might express distress/how researcher might know if they are upset

It will be explained that if they take part they will be given a debrief sheet with emergency numbers, and the researcher will conduct a check in before and after each focus group session. They will also be made aware of an optional half hour debrief call available to them within the week following the focus group. Participants will be made aware that neither the check ins nor half hour debriefs are crisis services.

Participant signs consent form and confirming they are aware of limits to confidentiality. Participant also provides their telephone number and address.

Distress
A participant indicates they are experiencing a high level of stress or emotional distress
OR exhibits behaviours suggestive that the discussion is too stressful such as uncontrolled crying, shaking etc

During Focus Group

Response
Facilitator will try and diffuse the situation within group. If unable to do so, the session will be paused and the second facilitator might say "I notice you seem [how participant seems]. would it be helpful to take a moment in a breakout room with me?" either verbally or via message- whichever is more appropriate.

Stage One
Second facilitator will check in with participant, see what is going on, ask what kind of thoughts they are having, listen, validate and provide emotional support. Grounding exercises if necessary.

Ask participant if they feel able to keep themselves safe?

YES
Do they wan to carry on with group?

Yes
Exit breakout room and resume discussion.

No
They can leave the Teams call. Remind them of check in call and debrief sheet.

Yes but Still Distressed
Ask what they usually find helpful to calm? Continue to provide emotional support. Encourage them to make use of numbers on debrief sheet. Encourage them to make contact with mental health provider (if they have one). Offer to make this contact for them if they consent.

No - Stage 2
Proceed to further safety planning around risk. Is it imminent? How able are they to keep themselves safe? Are there people near by who they can go to? Suggest A&E if no one else.

If participant seems very unsafe/unstable, ring ambulance and provide address

Stay on call until help arrives

Encourage them to make use of numbers on debrief sheet.
Encourage them to make contact with mental health provider (if they have one).
Offer to make this contact for them if they consent.

End call when plan in place for what client is going to do (e.g. call friend, go to a friends, or to A&E)

Post Group Follow up
Standard follow up call to participants. But for those who were distressed, reiterate the use of the debrief sheet. encourage them to make contact with mental health provider (if they have one). Offer again to make this contact for them if they consent.

During Debrief

Response
Acknowledge the distress "I notice you seem [how participant seems]" Ask what is going on for them, ask what kind of thoughts they are having, listen, validate and provide emotional support. Grounding exercises if necessary.

Ask participant if they feel able to keep themselves safe?

YES
If they are happy to, end the call

Yes but Still Distressed
Ask what they usually find helpful to calm? Continue to provide emotional support. Encourage them to make use of numbers on debrief sheet. Encourage them to make contact with mental health provider (if they have one). Offer to make this contact for them if they consent.

No - Stage 2
Proceed to further safety planning around risk. Is it imminent? How able are they to keep themselves safe? Are there people near by who they can go to? Suggest A&E if no one else.

If participant seems very unsafe/unstable, ring ambulance and provide address

Stay on call until help arrives

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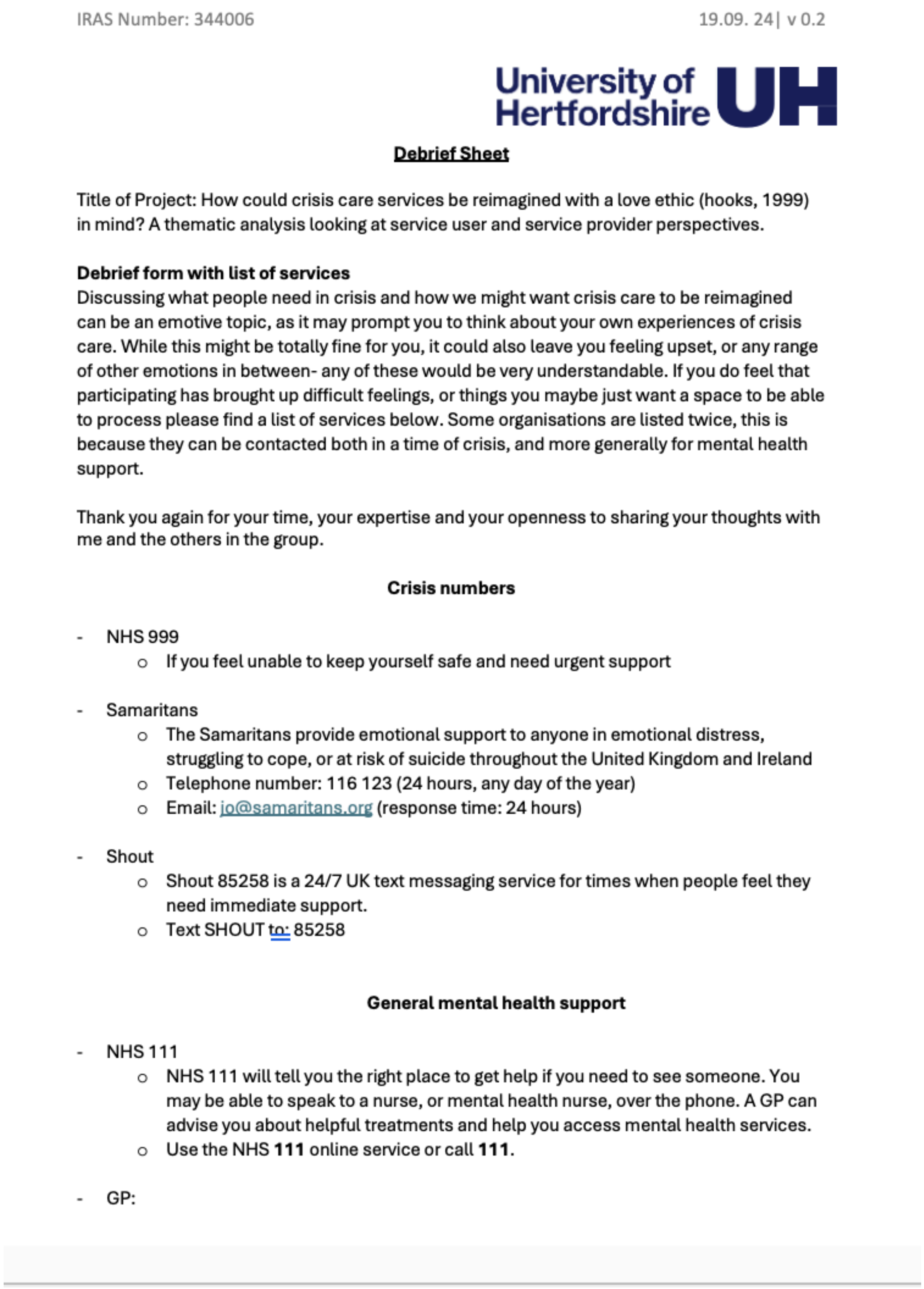
Encourage them to make contact with mental health provider (if they have one).
Offer to make this contact for them if they consent.

End call when plan in place for what client is going to do (e.g. call friend, go to a friends, or to A&E)

Appendix U: Debrief Sheets

a) SU Debrief Sheet



IRAS Number: 344006 19.09. 24| v 0.2

University of Hertfordshire UH

Debrief Sheet

Title of Project: How could crisis care services be reimagined with a love ethic (hooks, 1999) in mind? A thematic analysis looking at service user and service provider perspectives.

Debrief form with list of services

Discussing what people need in crisis and how we might want crisis care to be reimagined can be an emotive topic, as it may prompt you to think about your own experiences of crisis care. While this might be totally fine for you, it could also leave you feeling upset, or any range of other emotions in between- any of these would be very understandable. If you do feel that participating has brought up difficult feelings, or things you maybe just want a space to be able to process please find a list of services below. Some organisations are listed twice, this is because they can be contacted both in a time of crisis, and more generally for mental health support.

Thank you again for your time, your expertise and your openness to sharing your thoughts with me and the others in the group.

Crisis numbers

- NHS 999
    - If you feel unable to keep yourself safe and need urgent support

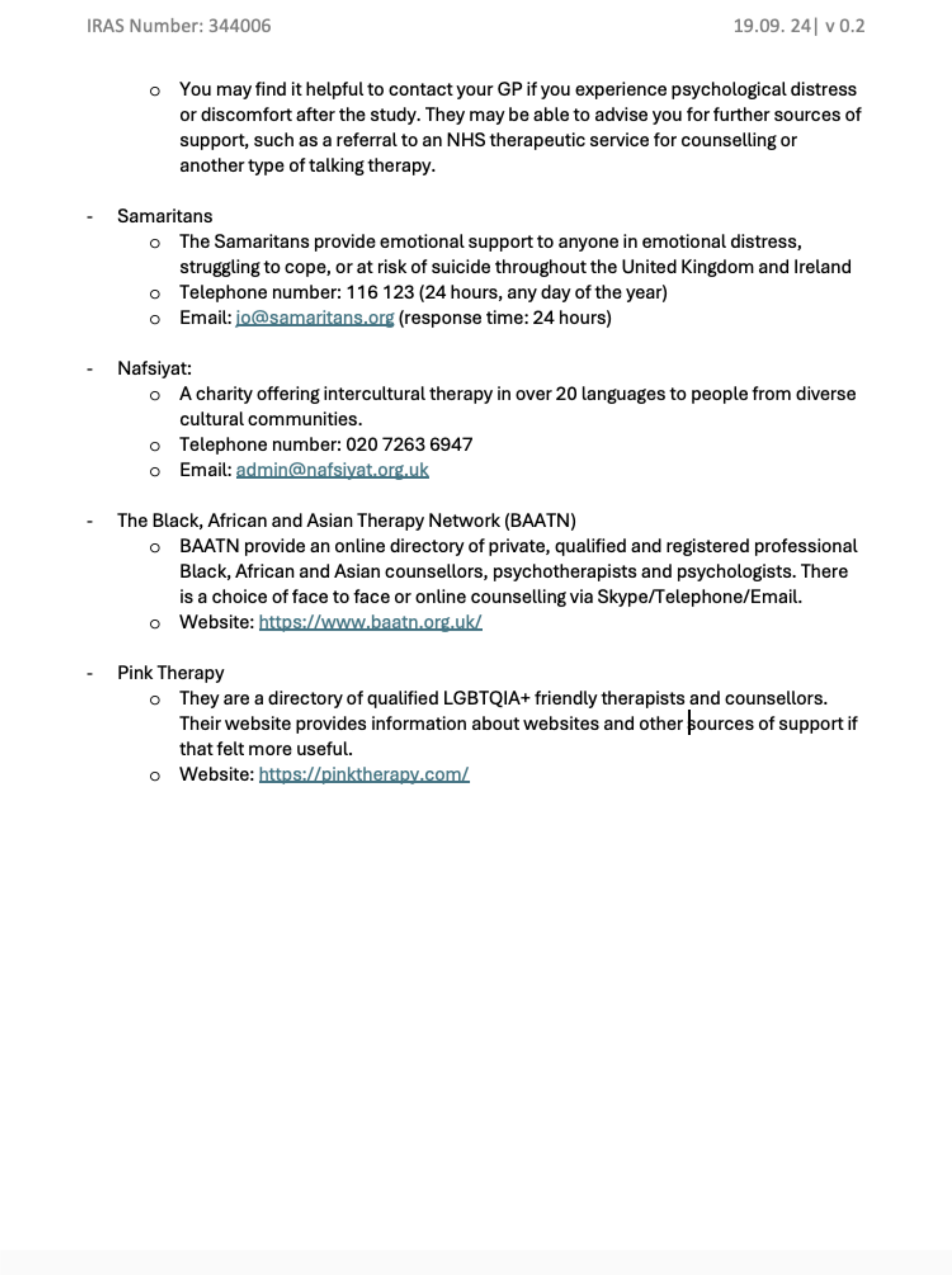
- Samaritans
    - The Samaritans provide emotional support to anyone in emotional distress, struggling to cope, or at risk of suicide throughout the United Kingdom and Ireland
    - Telephone number: 116 123 (24 hours, any day of the year)
    - Email: jo@samaritans.org (response time: 24 hours)

- Shout
    - Shout 85258 is a 24/7 UK text messaging service for times when people feel they need immediate support.
    - Text SHOUT to: 85258

General mental health support

- NHS 111
    - NHS 111 will tell you the right place to get help if you need to see someone. You may be able to speak to a nurse, or mental health nurse, over the phone. A GP can advise you about helpful treatments and help you access mental health services.
    - Use the NHS **111** online service or call **111**.

- GP:



IRAS Number: 344006 19.09. 24| v 0.2

  - You may find it helpful to contact your GP if you experience psychological distress or discomfort after the study. They may be able to advise you for further sources of support, such as a referral to an NHS therapeutic service for counselling or another type of talking therapy.

- Samaritans
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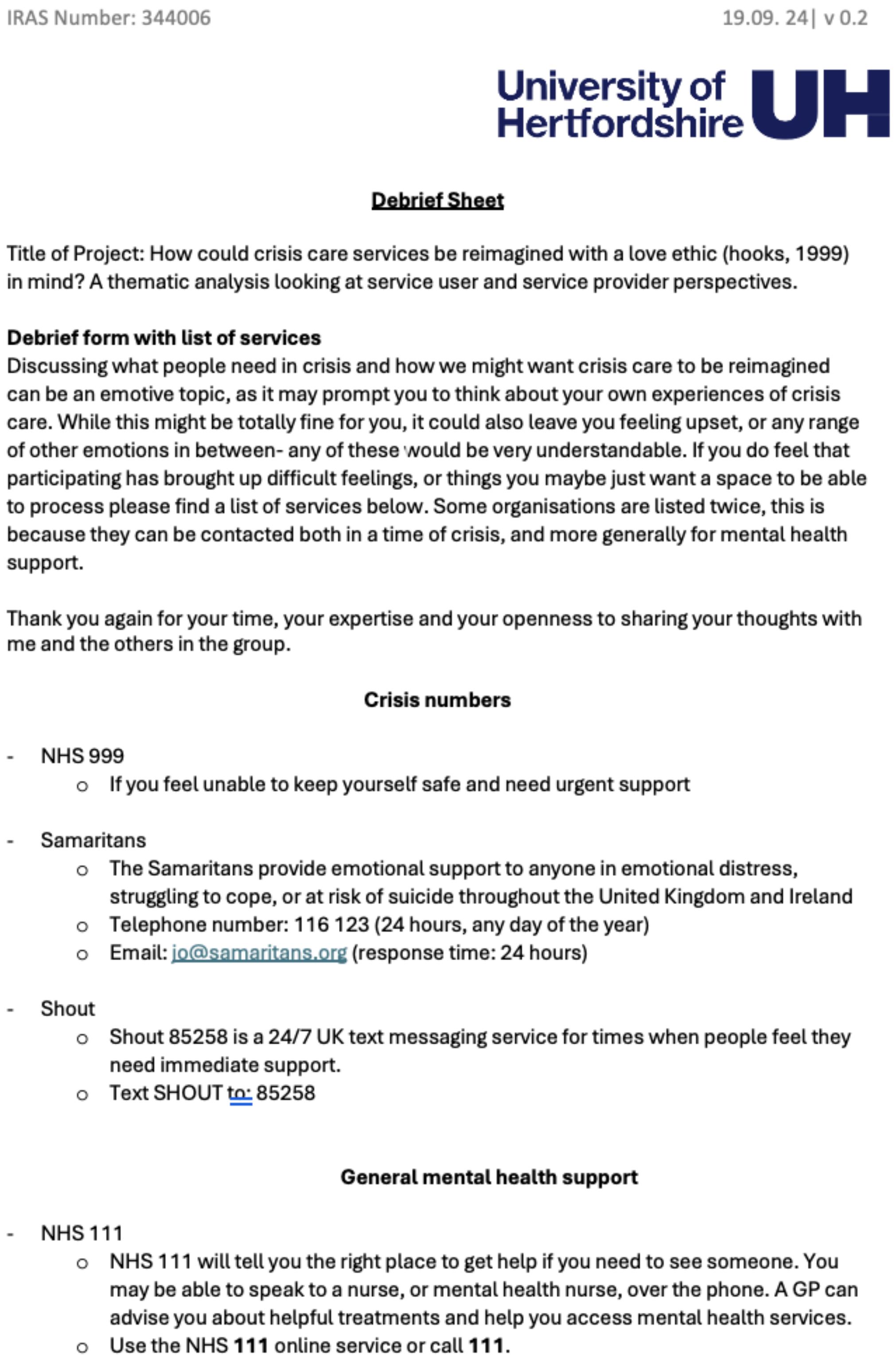
- Nafsiyat:
  - A charity offering intercultural therapy in over 20 languages to people from diverse cultural communities.
  - Telephone number: 020 7263 6947
  - Email: admin@nafsiyat.org.uk

- The Black, African and Asian Therapy Network (BAATN)
  - BAATN provide an online directory of private, qualified and registered professional Black, African and Asian counsellors, psychotherapists and psychologists. There is a choice of face to face or online counselling via Skype/Telephone/Email.
  - Website: https://www.baatn.org.uk/

- Pink Therapy
  - They are a directory of qualified LGBTQIA+ friendly therapists and counsellors. Their website provides information about websites and other sources of support if that felt more useful.
  - Website: https://pinktherapy.com/

b) Staff Debrief Sheet



IRAS Number: 344006 19.09. 24| v 0.2

University of Hertfordshire UH

Debrief Sheet

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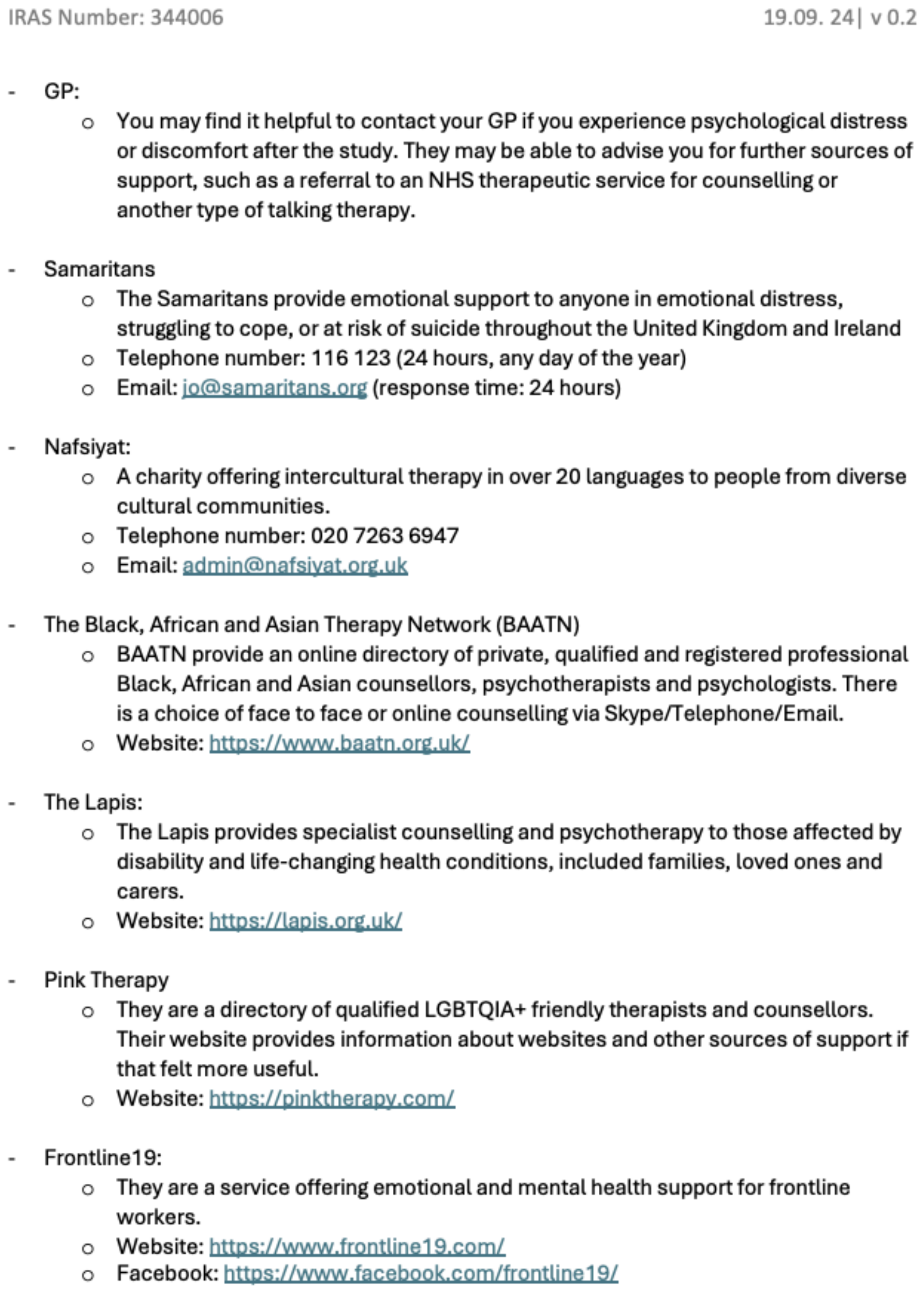

IRAS Number: 344006 19.09. 24| v 0.2

- GP:
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  - Website: https://www.baatn.org.uk/

- The Lapis:
  - The Lapis provides specialist counselling and psychotherapy to those affected by disability and life-changing health conditions, included families, loved ones and carers.
  - Website: https://lapis.org.uk/

- Pink Therapy
  - They are a directory of qualified LGBTQIA+ friendly therapists and counsellors. Their website provides information about websites and other sources of support if that felt more useful.
  - Website: https://pinktherapy.com/

- Frontline19:
  - They are a service offering emotional and mental health support for frontline workers.
  - Website: https://www.frontline19.com/
  - Facebook: https://www.facebook.com/frontline19/

Appendix V: Creative Pieces from Participants

a) Poem written by a SU

I go in dead; spiritually and physically torn, worn out and grey.
Alive, but not living and all but willing myself not to exist.
How can life be so vacuous and yet so very painful
The first thing I hear is laughter; a warm cacophony of voices igniting in laughter.
There is humour here and real human warmth,
People are valued here, and not seen as merely walking talking risk entities.
There is a multiverse of pathways and possibilities here, all crisscrossing and cross-pollinating.
My heart begins to beat again and I begin to feel alive.
The colour of life begins to return and hope to emerge and flow;
People see and treat each other as equals. No one is perfect, we all falter and make mistakes. This is natural, part of the great human condition.
But they have hope; hope in each other and in me.
Time passes naturally here; there are things to do, but also peace; time to pause, relax and ground oneself.
Time to touch base with reality and develop new perspectives; thoughts and feelings.
Time to make plans, collaborate, reach out to each other and the wider world.
I am not alone and the connection is vital.
I leave with hope alive in me; hope for myself, others and the world

b) "Ideal Crisis Care" by a SU

Crisis care should make us feel understood.

- Without understanding, we flounder.
    - "Trauma is when we are not seen and known," as Boston-based psychiatrist and author Bessel van der Kolk puts it.
    - Further, according to Sami Timimi, a UK-based author who writes from a critical psychiatry perspective, what matters most in mental healthcare is not diagnosing problems and prescribing medication, but developing meaningful relationships with sufferers with the aim of cultivating insight into their problems, so the right interventions can be individually tailored to their needs. I wholly agree with this.
- Most problems are created by the contexts in which people live and therefore require contextual solutions.
    - "People who are breaking down are often like canaries in a mineshaft," explains Peter Breggin, a critical psychiatrist located in the US, in the book Cracked: Why Psychiatry is Doing More Harm Than Good, written by James Davies. "They are a signal of a severe family issue. And sometimes the one who is breaking down is being scapegoated, sometimes they are the most sensitive, creative member of the family, sometimes they are the one person in the family with a really different personality. You don't know what is going on often, but with work you can see the dynamics that have developed in the family that are pulling things down."
- Understanding should start with thoughtful questions, such as: what has brought you here?

    - A crisis can be triggered by all sorts of situations and circumstances – work, family, life changes, illness, medication, relationships, finances, traumatic experiences.
    - It's important that, from the very beginning, there are genuine attempts at understanding *how* we have come to be in crisis.
- Dialogue, not monologue, is a useful route to understanding.
    - In open dialogue practice, dialogism highlights the importance of different viewpoints coming together to help illuminate the whole.
    - But, in my experience, people in crisis and their loved ones are routinely talked over, ignored and dismissed in ward rounds. This has to change.

Crisis care should make us feel regulated.

- At every possible stage, crisis care should be offered in an environment that is intentionally designed – e.g. with colour theory and adaptive lighting – to be calming and restorative.
- In times of crisis especially, we need to learn how to regulate our emotions, soothe ourselves and manage distress.
    - While crisis medications typically flatline our emotions, a healthier alternative would focus on guiding us towards the emotional flexibility and maturity to contain our emotional experiences.
    - Emotional regulation is a muscle that is strengthened by practice. Crisis care should establish the reps, sets and emotional 'workouts' to bring about positive change.
        - Topics could cover acceptance, self-soothing, self-talk, distress tolerance, connection and co-regulation.
        - Techniques could include journalling for safety, symptoms, self-love and hope; and mantras for healing and change.
- Crisis care should also teach us how to nourish our bodies.
    - I have found functional medicine – e.g. working to bring biomarkers into functionally optimal ranges vs NHS ranges, which tend to indicate lack of disease rather than health – to be especially helpful in resolving the physical issues – e.g. digestive health issues or new problems created by medications – that usually accompany crises.
    - Imagine how beneficial it would be if professionals took blood, stool and hormone tests, interpreted them and gave personalised recommendations on supplements – e.g. magnesium, L-theanine – and protocols – e.g. light management, grounding techniques – to restore wellbeing.
    - Techniques that assist with lymphatic drainage and myofascial release – e.g. dry skin brushing, gua sha, yin yoga, foam rolling – would also be welcome.

Crisis care should make us feel whole.

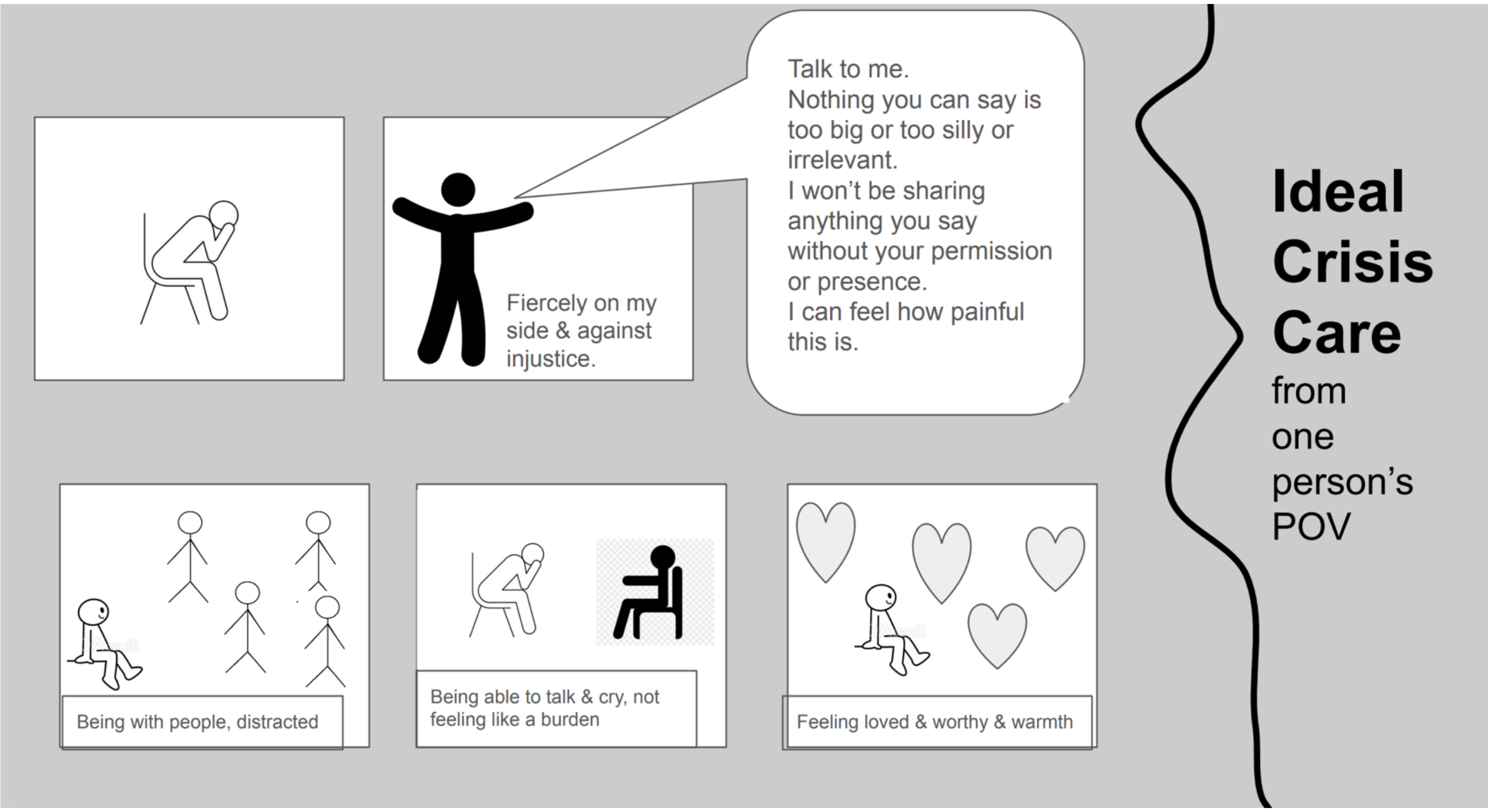
- Too often, crisis care focuses on fixing or banishing what is broken – e.g. a 'faulty' mind – when it should aim to help us integrate our true selves.
    - In his book The Myth of Normal, the Canadian physician Gabor Maté writes that healing is closer to self-retrieval than self-improvement.

    - In crisis, therefore, the question shifts from "How do I get rid of this?" to "What is this for? Why is this here?"
    - Agency, then, is gained through acceptance and understanding.

Crisis care should make us feel hopeful.

- A lot of the medical language around crisis – e.g. psychosis, bipolar disorder – takes a limited and limiting view of our experiences, which in turn shrinks our understanding of recovery.
    - It is vital that we find new metaphors for crisis that better reflect our experiences, unlearn social conditioning about what it means to be "sick" and create more hopeful realities.
    - Indeed, as Boston-based psychiatrist Nassir Ghaemi argues, in times of crisis, we are better off being led by mentally ill leaders than by mentally 'normal' ones.
        - "In the storm of crisis, complete sanity can steer us astray, while some insanity brings us to port," Ghaemi writes in his book A First-Rate Madness.
        - As the early-twentieth-century German psychiatrist Ernst Kretschmer says, insanity is not a "regrettable … accident" but the "indispensable catalyst" of genius.
- A big part of recovering from any crisis is not just recovering from what happened, but from how it changed your view of the world.
    - Healing from crisis demands that we accept that the world is not as safe as we thought it was, but we must not lose hope that there are ways of finding safety.
    - We need to grieve what we have lost and build a new worldview, one that inspires hope. Crisis care should help us do that.
- Hope also springs from meaning, something that is typically overlooked in crisis care.
    - The Sri Lankan anthropologist Gananath Obeyesekere talks about the crucial role of culture in handling people's distress, giving people words, giving people paths, giving people rituals through which they can find some peace in this world.
    - Ideally, crisis care should be infused with spiritual meaning, with whatever brings us greater direction, understanding, courage and purpose.
- And, finally, we should be able to draw hope from the resources we are connected to in crisis.
    - I have met multiple clinical psychologists on wards who could not recommend a single relevant book, at times when I was desperate to make sense of what I was going through and implement changes to aid my recovery.
    - This spurred me to create a free library of mental health resources online, the library I longed for when I was first sectioned: https://cityoflunaria.com/mental-health-library
    - Crisis care should include aftercare that goes beyond a care co-ordinator visiting your home to check you're taking your medications.
    - Providing information on supportive resources doesn't just give a much-needed sense of safety. It gives hope of post-traumatic growth beyond the confines of inpatient settings.

c) Ideal Crisis Care from Staff member



d) "Freedom Is a Place" by staff

“I was stuck with the conversations had and this quote from Ruth Wilson Gilmore came to mind randomly. It speaks to more the material conditions (i.e. housing, accessibility, space etc) needed to be free rather than a specific location. I felt we were trying to figure this out in the focus group – like what is needed for someone to be free and does that necessarily mean they no longer experience crisis’s, which is why this quote came to mind. I also adore how in this quote it speaks of freedom as not an abstract concept but something tangible and real albeit shaped by power it still is something in-reach for all of us. I thought about how this is anti-carceral in its very nature because how can someone confined have the material conditions needed to feel free and it brought me back to imagination – can we carve out a space of freedom within our inner worlds to sustain and nourish us until we can resist plus eventually thrive in and out of those conditions. Hence the imagery behind the cage and the dreamcatcher being the key portal to this inner world. I hope this stream of consciousness makes sense, feel free to let me know if it isn’t.”

e) Imagined Care by a SU

“If I can leave with an overall summary of our time can it be this?

‘Why do we accept the dominance of an economic system that assumes scarcity, and actively harms what we value? Can we not embrace an alternative to the usual growth-focused model? A ‘gift economy’ mode of exchange has been marginalised in industrialised cultures, but it was and is prevalent in many indigenous societies. Its aim: to maintain beneficial relationships, cultivate abundance and promote mutual thriving.’

On my contribution to my creative piece I would like to add an…[image] of me dancing!! Again, having thought a great deal about how I would like to contribute to this element, dance is something I loved as a child/adolescent and is something I rarely do now. I always wanted to be a Royal ballet dancer but alas, circumstances did not allow? I adore the ballet and just dance in general and it reminds me of freer easy times? I used to dance all the time at home pre "problems"?”

Appendix W = Reflective Journal Excerpts

Abolition

I was thinking about the role of abolition in the work I am doing. Think about the inherent contradiction between humanising services that might by their very nature be carceral- how can you improve something that is so harmful? (And should you?)

Wonderings at the start of the project

I am intrigued to see the differences in perspectives of SU and staff. In a way I wonder how able staff will be to see or analyse some of the things going on, given the proximity to the situation and their own role within the systems that cause harm. Being close to something (anything) can limit how much of it we are able to see. What tools would be helpful for supporting them to imagine? Maybe starting with prompts unrelated to crisis care? I'm also interested to see how staff resist these systems, and how/if they challenge the status quo. How to ask about alternatives without it feeling like a crisis of individuals- staff also subject to the conditions of carcerality. Think about Fanon and the fact that oppression harms everyone, links to recent reading of Undercommons- around not needing help but work together for collective liberation.

Reflections During Recruitment

Conflict in response to the person from HJL (politely) calling me an 'agent of the state.' Feel very defensive about that, but then question my defensiveness. Is it denial? On one hand I really understand the need to create spaces without staff, these are essential- staffs voices often dominate SU's, and SU need safer spaces, on the other I wonder if it ignores some of the nuance- staff also have lived experience. Some SU have very carceral views, it's not just staff. I don't really know what I'm wishing for here..

Unsure of how I can speak to the people I am recruiting from – wary of being too critical of inpatient services, whilst also being honest. How not to speak in nerdy academic jargon and not to be critical of people who don't think like that, but instead think of ways to broaden the conversation.

Feeling comfortable when people praising my work, or when I I am in spaces where I think people are more positivist/carceral in their approach- I feel good/smug about my studies. Do I avoid spaces where that isn't the case? Watch that.

Reflections Following First SU focus group

"The canary in the coal mine" – Participant quote. Think about the role of visions and experiences not to be something muted or suppressed, but something to be listened to and respected. Made me think to the cross-cultural study into experiences of voice hearing in the India, Ghana and USA, how people attributed meaning so differently depending on cultural context.

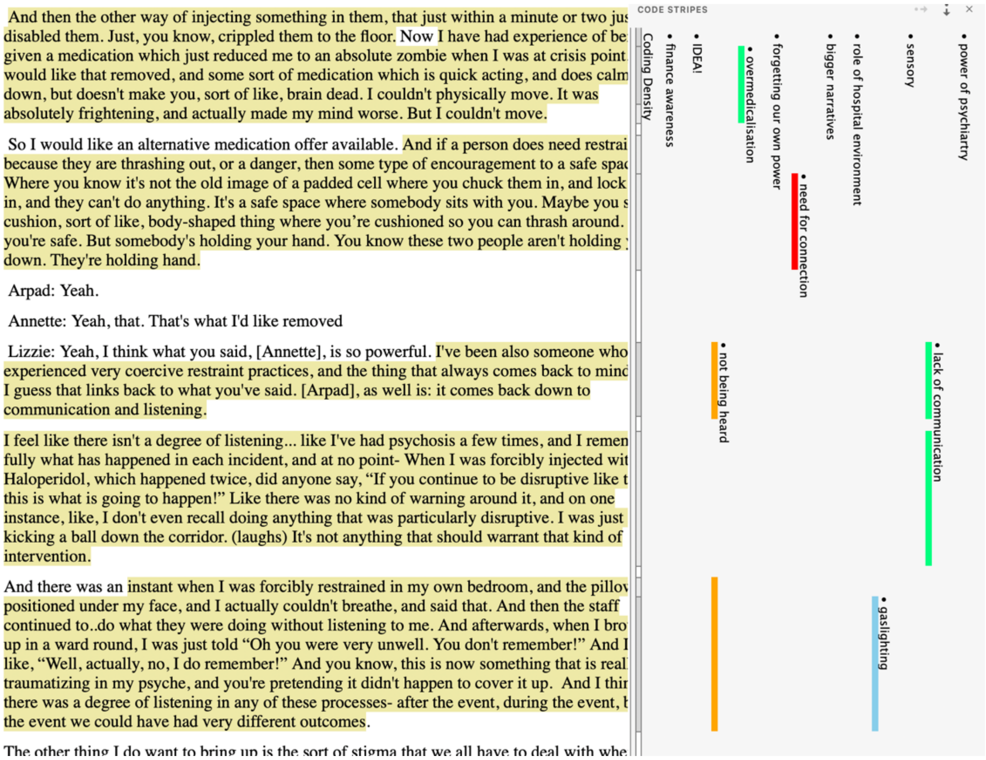
Crushing role of medication, how all identified with the notion of medication purely as a plaster for their experiences, rather than something that sorted anything.

People's hope and value of the speculative and imagination really touched me. Made me think perhaps I am on to something as it galvanised a lot of thought and discussion. Really struck by everyone's openness, how free with how open people were and the generosity of spirit to me, the others in the group and the to the world more broadly.

Speaking about the need for space, for the pressure to stop. Wonder how in the current climate how we create that space- is it possible. No wonder so many alternatives focus around the need to be removed from society and retreat. Discussions circling around empathy, connectedness with others, the need for collaboration and community.

I wonder what the group with staff will be like? Less connected?

Appendix X: Examples of Coded Transcripts



And then the other way of injecting something in them, that just within a minute or two jus
disabled them. Just, you know, crippled them to the floor. Now I have had experience of be
given a medication which just reduced me to an absolute zombie when I was at crisis point
would like that removed, and some sort of medication which is quick acting, and does calm
down, but doesn't make you, sort of like, brain dead. I couldn't physically move. It was
absolutely frightening, and actually made my mind worse. But I couldn't move.

So I would like an alternative medication offer available. And if a person does need restrai
because they are thrashing out, or a danger, then some type of encouragement to a safe spac
Where you know it's not the old image of a padded cell where you chuck them in, and lock
in, and they can't do anything. It's a safe space where somebody sits with you. Maybe you s
cushion, sort of like, body-shaped thing where you're cushioned so you can thrash around.
you're safe. But somebody's holding your hand. You know these two people aren't holding
down. They're holding hand.

Arpad: Yeah.

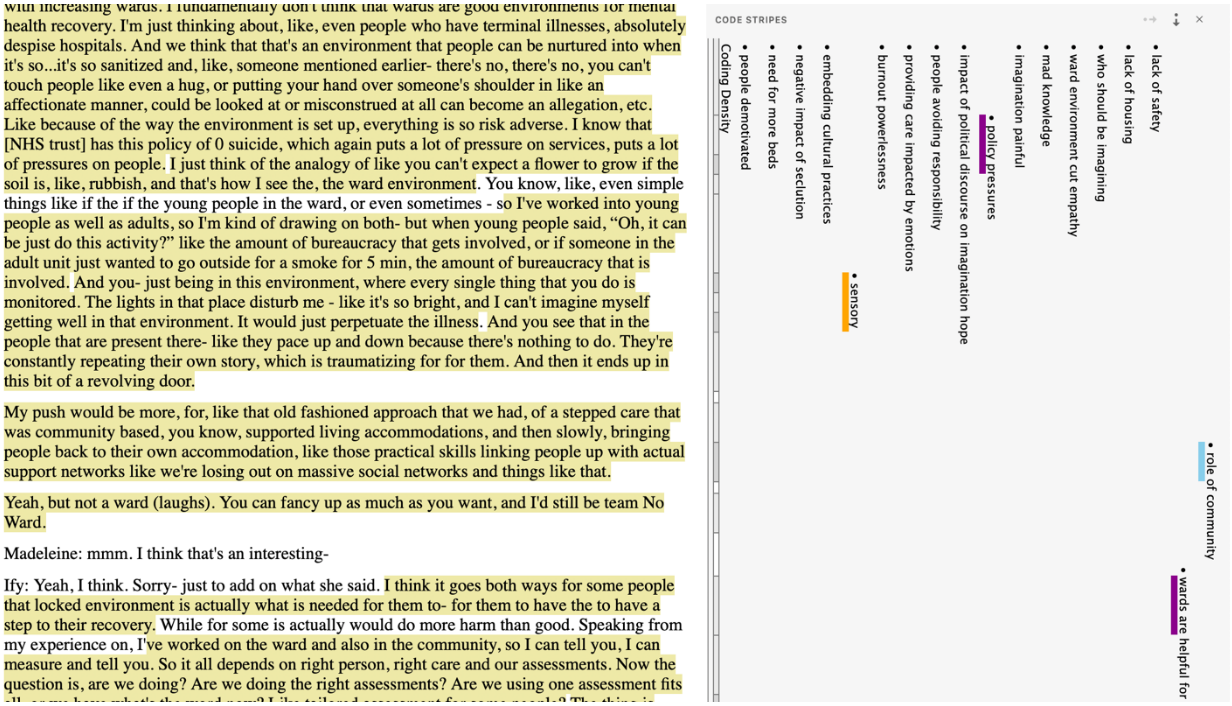
Annette: Yeah, that. That's what I'd like removed

Lizzie: Yeah, I think what you said, [Annette], is so powerful. I've been also someone who
experienced very coercive restraint practices, and the thing that always comes back to mind
I guess that links back to what you've said. [Arpad], as well is: it comes back down to
communication and listening.

I feel like there isn't a degree of listening... like I've had psychosis a few times, and I remen
fully what has happened in each incident, and at no point- When I was forcibly injected wit
Haloperidol, which happened twice, did anyone say, "If you continue to be disruptive like t
this is what is going to happen!" Like there was no kind of warning around it, and on one
instance, like, I don't even recall doing anything that was particularly disruptive. I was just
kicking a ball down the corridor. (laughs) It's not anything that should warrant that kind of
intervention.

And there was an instant when I was forcibly restrained in my own bedroom, and the pillov
positioned under my face, and I actually couldn't breathe, and said that. And then the staff
continued to..do what they were doing without listening to me. And afterwards, when I bro
up in a ward round, I was just told "Oh you were very unwell. You don't remember!" And I
like, "Well, actually, no, I do remember!" And you know, this is now something that is real
traumatizing in my psyche, and you're pretending it didn't happen to cover it up. And I thir
there was a degree of listening in any of these processes- after the event, during the event, b
the event we could have had very different outcomes.

The other thing I do want to bring up is the sort of stigma that we all have to deal with whe



with increasing wards. I fundamentally don't think that wards are good environments for mental health recovery. I'm just thinking about, like, even people who have terminal illnesses, absolutely despise hospitals. And we think that that's an environment that people can be nurtured into when it's so...it's so sanitized and, like, someone mentioned earlier- there's no, there's no, you can't touch people like even a hug, or putting your hand over someone's shoulder in like an affectionate manner, could be looked at or misconstrued at all can become an allegation, etc. Like because of the way the environment is set up, everything is so risk adverse. I know that [NHS trust] has this policy of 0 suicide, which again puts a lot of pressure on services, puts a lot of pressures on people. I just think of the analogy of like you can't expect a flower to grow if the soil is, like, rubbish, and that's how I see the, the ward environment. You know, like, even simple things like if the if the young people in the ward, or even sometimes - so I've worked into young people as well as adults, so I'm kind of drawing on both- but when young people said, "Oh, it can be just do this activity?" like the amount of bureaucracy that gets involved, or if someone in the adult unit just wanted to go outside for a smoke for 5 min, the amount of bureaucracy that is involved. And you- just being in this environment, where every single thing that you do is monitored. The lights in that place disturb me - like it's so bright, and I can't imagine myself getting well in that environment. It would just perpetuate the illness. And you see that in the people that are present there- like they pace up and down because there's nothing to do. They're constantly repeating their own story, which is traumatizing for for them. And then it ends up in this bit of a revolving door.

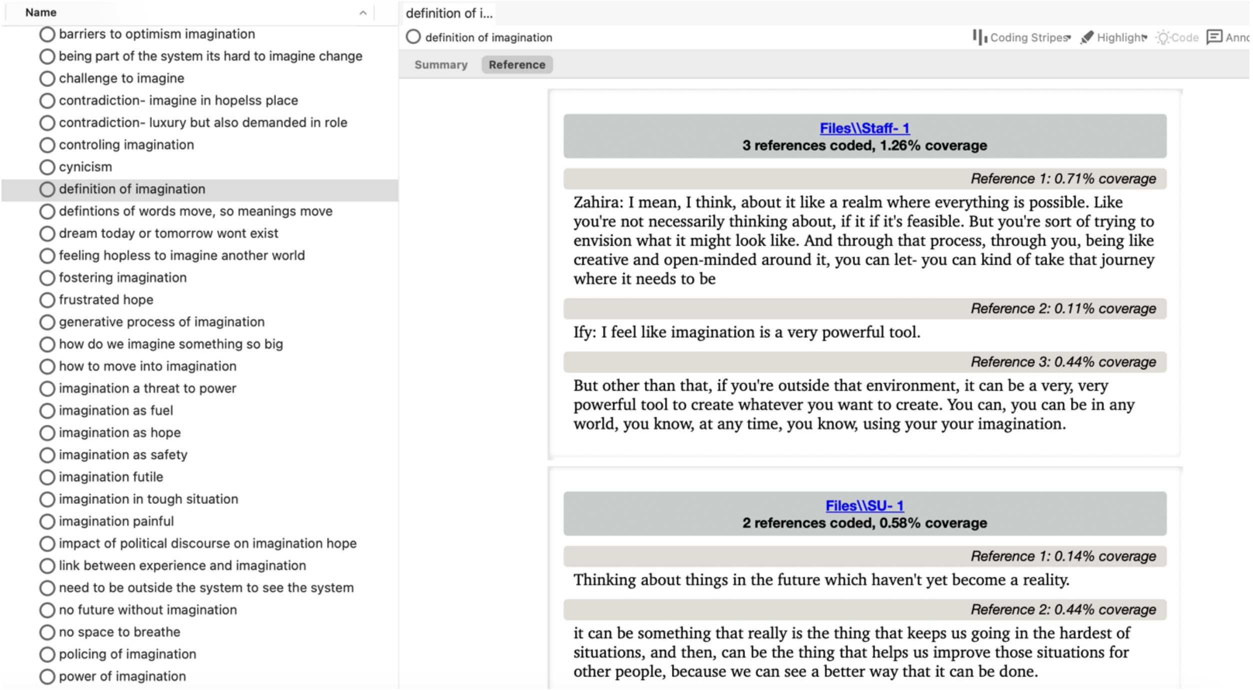
My push would be more, for, like that old fashioned approach that we had, of a stepped care that was community based, you know, supported living accommodations, and then slowly, bringing people back to their own accommodation, like those practical skills linking people up with actual support networks like we're losing out on massive social networks and things like that.

Yeah, but not a ward (laughs). You can fancy up as much as you want, and I'd still be team No Ward.

Madeleine: mmm. I think that's an interesting-

Ify: Yeah, I think. Sorry- just to add on what she said. I think it goes both ways for some people that locked environment is actually what is needed for them to- for them to have the to have a step to their recovery. While for some is actually would do more harm than good. Speaking from my experience on, I've worked on the ward and also in the community, so I can tell you, I can measure and tell you. So it all depends on right person, right care and our assessments. Now the question is, are we doing? Are we doing the right assessments? Are we using one assessment fits

Appendix Y: Grouping Codes



- ○ barriers to optimism imagination
- ○ being part of the system its hard to imagine change
- ○ challenge to imagine
- ○ contradiction- imagine in hopelss place
- ○ contradiction- luxury but also demanded in role
- ○ controling imagination
- ○ cynicism
- ○ definition of imagination
- ○ defintions of words move, so meanings move
- ○ dream today or tomorrow wont exist
- ○ feeling hopless to imagine another world
- ○ fostering imagination
- ○ frustrated hope
- ○ generative process of imagination
- ○ how do we imagine something so big
- ○ how to move into imagination
- ○ imagination a threat to power
- ○ imagination as fuel
- ○ imagination as hope
- ○ imagination as safety
- ○ imagination futile
- ○ imagination in tough situation
- ○ imagination painful
- ○ impact of political discourse on imagination hope
- ○ link between experience and imagination
- ○ need to be outside the system to see the system
- ○ no future without imagination
- ○ no space to breathe
- ○ policing of imagination
- ○ power of imagination

○ definition of imagination

Files\\Staff- 1
3 references coded, 1.26% coverage

Reference 1: 0.71% coverage

Zahira: I mean, I think, about it like a realm where everything is possible. Like you're not necessarily thinking about, if it if it's feasible. But you're sort of trying to envision what it might look like. And through that process, through you, being like creative and open-minded around it, you can let- you can kind of take that journey where it needs to be

Reference 2: 0.11% coverage

Ify: I feel like imagination is a very powerful tool.

Reference 3: 0.44% coverage

But other than that, if you're outside that environment, it can be a very, very powerful tool to create whatever you want to create. You can, you can be in any world, you know, at any time, you know, using your your imagination.

Files\\SU- 1
2 references coded, 0.58% coverage

Reference 1: 0.14% coverage

Thinking about things in the future which haven't yet become a reality.

Reference 2: 0.44% coverage

it can be something that really is the thing that keeps us going in the hardest of situations, and then, can be the thing that helps us improve those situations for other people, because we can see a better way that it can be done.

Appendix Z- Thematic Map