



ORIGINAL ARTICLE

Family expectations of inpatient mental health services for adults with suicidal ideation: a qualitative study

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ABSTRACT: Involvement of family members of adults with suicidal ideation is a key area of improvement in inpatient mental health services. To support family involvement in this context, it is crucial to understand what care and treatment family members expect for their relative. This qualitative study based on grounded theory involved interviews with 14 family members, including partners, parents, adult children and siblings. The family members' expectations of care and treatment in inpatient mental health services were captured by the core element 'Struggling to remain hopeful while looking through the lens of uncertainty'. This core element interacted with four sub-elements: assuming safety as a priority, looking for a healing approach and environment, counting on continuity of care and wanting to be involved and supported. The family members fluctuated between hope and uncertainty depending on whether their expectations were met or unmet. Unmet expectations were common and underpinned by a sense of being marginalized during the admission of their relative with suicidal ideation. Mental health professionals, including nurses, can be more empathetic towards the family members and attuned to their expectations. This can underpin partnerships that help families to deal with their feelings of uncertainty and disempowerment. Such partnerships can flourish in recovery-oriented mental health services that allow meaningful family involvement.

KEY WORDS: family, mental health services, professional-family relations, qualitative research, suicidal ideation.

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INTRODUCTION

Leading theories concerning suicide, such as the Three-Step Theory (Klonsky & May 2015) and the Interpersonal Theory (Van Orden *et al.* 2010), emphasize the particular interpersonal nature of suicide. These theories posit that a person's interactions with family members represent both risk and protective factors for suicide. Whereas social isolation and family conflict can increase suicide risk, family connectedness and support can decrease suicide risk and are identified as reasons for living (Bakhiyi *et al.* 2016; Van Orden *et al.* 2010). Moreover, family can play a vital role in a person's recovery from suicidal ideation by demonstrating (emotional) availability, sharing activities

and experiences, and staying connected in everyday life (Sellin *et al.* 2017). Due to the potential benefits of family involvement, it is now emphasized upon in a range of policies, including practice guidelines and quality indicators for suicide prevention and treatment of suicidal ideation (NICE 2019; Setkowski *et al.* 2020; Wasserman *et al.* 2012).

Background

The recovery model is being adopted into the delivery and design of many mental health services (MHS). This model emphasizes the multidimensional nature of recovery, which can be influenced by clinical (e.g. symptom reduction), personal (e.g. individual responsibility) and social aspects (e.g. stigma, family relations) (Lloyd *et al.* 2008; Slade *et al.* 2014). Within the recovery philosophy, upcoming strength-based and community-oriented approaches highlight the need to transcend patient-professional relationships and involve family members in care and treatment (Grant *et al.* 2015; Thornicroft *et al.* 2016; Ward *et al.* 2017). Family members can play an important role in various areas and stages of care and treatment for people with suicidal ideation. They can provide valuable information about their relatives (Wasserman *et al.* 2012), engage in safety planning (Stanley & Brown 2012) and offer support to reduce their relatives' loneliness (Sellin *et al.* 2017). Furthermore, they can support continuity of care by enabling their relatives' access to care, follow-up care and community integration (Dransart & Guerry 2017; Hom *et al.* 2015).

While benefits of family involvement are emphasized upon, the literature also underlines the complexity of involving family members in care and treatment. Family involvement can be constrained by the stigma attached to suicidal ideation. For people with suicidal ideation, stigma is associated with experiences of feeling alone, misunderstood and burdensome; experiences that might refrain them from talking about suicide with their family and mental health professionals (MHP) (Frey *et al.* 2016). Stigma is also attached to family members who might experience shame about having a 'suicidal relative' and find it difficult to share their feelings or ask for professional help (McLaughlin *et al.* 2014). Simultaneously, the literature highlights the burdens faced by family members when caring for a relative. They can experience a relative's suicidal crisis as traumatic; it can evoke personal feelings of guilt and helplessness, as well as anxiety regarding possible suicide (Buus *et al.* 2014; McLaughlin *et al.* 2014).

Moreover, suicidal crises can adversely affect family relationships (McLaughlin *et al.* 2014). This can create barriers for family involvement, including confidentiality boundaries (e.g. patient refuses family involvement) and the deterioration or disappearance of family support (Grant *et al.* 2015; Nosek 2008).

In inpatient MHS, family involvement has been conceptualized in terms of receiving practical and emotional support from MHP, having a voice in care planning and goal setting (McLaughlin *et al.* 2016) and being involved in their relative's recovery (Sellin *et al.* 2017). Moreover, Talseth *et al.* (2001) found that relatives of patients with suicidal ideation desired to 'be met' by MHP, reflecting their expectations of being acknowledged as human beings, trusting the MHP and participating in treatment. Partnerships with MHP can foster family members' hope and resilience, enable positive caregiving experiences and make them feel recognized as valid representatives (Dransart & Guerry 2017; Foster *et al.* 2016). However, family involvement in MHS often reflects a rhetoric-reality gap. Although many MHS have policies regarding family involvement, they are being poorly enacted (Martin *et al.* 2017). Particularly, family involvement is impeded in clinical cultures where professional-centred practices and medicalized approaches of risk assessment and management prevail (Foster *et al.* 2016; Ward *et al.* 2017). This is seen among MHP who solely interact with family members to assess a patient's individual suicide risk or MHP who steer the content of a safety plan based on their own views, rather than the views of patients and their families (Morrissey & Higgins 2019; Vandewalle *et al.* 2019).

Family members may express dissatisfaction with the services provided to their relatives with suicidal ideation, and negative experiences concerning their own interactions with MHP including poor information and support, and exclusion from decision-making surrounding care and treatment (Dransart & Guerry 2017; Talseth *et al.* 2001). Such incidents suggest that family members and MHP may have different expectations related to care, treatment and family involvement in MHS (Landeweerd *et al.* 2017). To enable family involvement in inpatient MHS, it is necessary to understand what care and treatment family members expect for their relative. This applies especially to family members of adults with suicidal ideation, whose perspectives remain largely absent in research (Grant *et al.* 2015). Therefore, this study aimed to develop an understanding of family members' expectations of care and treatment for their relative. This understanding

can enable MHP and policymakers in inpatient MHS to build partnerships with families and include their perspectives into daily practice.

METHODS

Design

This qualitative study was based on grounded theory, involving the constant comparison method, memo writing and cyclic processes of data collection and analysis (Glaser 2002; Hallberg 2006). This design was appropriate to develop a conceptual understanding of family members' expectations of inpatient care and treatment for their relatives with suicidal ideation. Moreover, it allowed a contextualized understanding of the interaction between the family members' expectations and their own needs and experiences surrounding their relatives' suicidal ideation and behaviour (Hjelmeland & Knizek 2010).

Participants

Family members were recruited via adult patients in seven wards of two inpatient MHS, providing psychiatric and psychotherapeutic services in Flanders (Belgium). A stepwise recruitment procedure was deployed. Contact persons employed in the inpatient MHS were fully informed about the study. They facilitated group meetings where the researchers explained the study verbally and in writing to the patients and clarified any questions. The inclusion criteria for patients were: (i) 18 years and older, (ii) admitted to an inpatient mental health service and (iii) experienced suicidal ideation in the past year, which is described as thinking about, considering or planning suicide (Klon-sky *et al.* 2016, p. 309).

Patients who met these criteria could invite family members based on the following inclusion criteria: (i) a close family member, (ii) 18 years and older, and (iii) able to speak Dutch. Patients were assured that inviting family members was non-compulsory. This was important because they may not want to inform family about their condition as a result of shame and stigma surrounding suicidal ideation and the use of inpatient MHS (Frey *et al.* 2016; Hom *et al.* 2015). Patients forwarded their family members' contact details to the researchers via the contact persons. Subsequently, the researchers approached the potential participants over email or phone to schedule an interview. Fourteen family members were recruited, including partners,

TABLE 1 Demographic characteristics of the participants

	<i>N</i> = 14
Gender	
Female	10
Male	4
Age (years)	
20–29	4
30–39	3
40–49	2
50–59	3
≥60	2
	range 23–66; mean 42
Highest level of educational attainment	
Secondary education	4
Undergraduate (e.g. bachelor)	6
Master	4
Family relationship	
Partner	5
Parent	3
Adult child	3
Sibling	3

parents, adult children and siblings. All family members had roots in Belgium. Their demographic characteristics are presented in Table 1.

Ethical considerations

The Ethical Committees of the participating hospitals approved this study (B670201838003). Permission was obtained through informed consent from the hospital directors. All participants were informed about the study through an informed consent form and face-to-face interaction.

They were assured that participation was voluntary and confidential and that they could withdraw from the study at any time. Moreover, each participant was assigned a number to protect their identity and to ensure that they could share and reflect upon their perspectives freely during the interviews. All interviews ended with debriefing questions to offer participants an opportunity to express any distress evoked during the interviews. All participants provided written and verbal informed consent prior to participation.

Data collection

Individual semi-structured interviews were conducted between November 2018 and June 2019. An interview guide with open-ended questions was developed upon an explorative literature search and discussion with the research team. It was used in a flexible manner, that is,

the number, order and focus of questions varied according to the participants' stories (Morse 2015). The interview guide contained topics related to the family members' expectations of care and treatment, and their own needs and experiences regarding MHS and their relatives' situations. The researchers prioritized openness and reflexivity in collecting the data to ensure that relevant variations in the participants' perspectives could emerge (Morse 2015). The interviews were conducted at the participant's preferred location (home or private hospital room). They were 1 to 2.5 hours long, audio-recorded and transcribed verbatim. The transcripts were not returned to the participants because their individual revisions are unlikely to influence theory development (Thomas 2017).

Data analysis

The analysis was performed by four authors who have theoretical sensitivity to conceptualize the data (Glaser 2002). They have expertise in methodological and substantial areas, including qualitative research, mental health and patient and family participation. The analysis was initiated by two authors. They read the transcripts repeatedly, added memos to retain their reflections and engaged in open discussions about the preliminary insights. This enabled them to immerse themselves in the study context and understand the content as a whole. Following this, they initiated a coding process in NVivo 12 to capture the diverse meanings of the data and encourage detailed analyses. The authors compared their codes to elaborate their interpretations of the data.

Central to the credibility of the analysis was the consistent application of the constant comparison method. This method supported the researchers to seek variations and connections across the data and develop the concepts (Hallberg 2006). Member checks were not used since they are not recommended for analyses focused on developing theories and concepts—the building blocks of theories. Participants may not understand or be aware of abstract conceptual insights that go beyond describing their particular experiences (Glaser 2002; Thomas 2017).

During the analytic process, regular discussions were held with two other authors who read some of the transcripts. The four authors shared their interpretations and fostered reflexivity towards assumptions that could distort valid interpretations. These processes of triangulation were crucial to deepen initial insights and verify that the concepts were grounded in the data

(Morse 2015). This resulted in a conceptual framework of core and sub-elements that were considered again in iterative dialogue with the interview data.

FINDINGS

The analysis revealed one core element and four sub-elements that captured a dynamic interplay between the family members' expectations of care and treatment, and their own needs and experiences regarding inpatient MHS and their relatives' situations. Table 2 provides an overview of the conceptual structure.

Struggling to remain hopeful while looking through the lens of uncertainty

The process underlying the family members' expectations of care and treatment was captured by 'Struggling to remain hopeful while looking through the lens of uncertainty'. Remaining hopeful referred to longing for a life without suicidal ideation and placing a conditional confidence in the MHP to improve their relatives' condition. Uncertainty reflected the family members' fluctuating emotional distress regarding their relatives' suicidal ideation and behaviour and their perception of what happened in the inpatient MHS.

Participant 11, sister: 'In the beginning, when he was admitted, I was uncertain: "what will happen to him?" but I also had hope: "he will make progress and stay in a safe environment."

Participant 6, father: 'He made a suicide attempt in the hospital. They found him just in time... but now we live in continuous uncertainty.'

The family members fluctuated between hope and uncertainty depending on whether their expectations of care and treatment were met or unmet. When family members perceived their expectations as met, it increased their hope and decreased their uncertainty. Conversely, when they perceived that their expectations were unmet, it thwarted their hope and increased their uncertainty. Unmet expectations were common and underpinned by a sense of being marginalized. Family members felt that they were not at the centre of the MHP's attention, and they had limited control—and were left unknowing—about what happened in the MHS.

Participant 3, sister: 'I hope they understand that her situation is very critical. I expect that they keep her safe and have a treatment plan, which I can follow. But

TABLE 2 Overview of the conceptual structure

Core element			
Struggling to remain hopeful while looking through the lens of uncertainty			
longing for a life without suicidal ideation and behaviour experiencing emotional distress regarding their relative's condition feeling uncertain about what happens in the inpatient MHS placing a conditional confidence in the MHP feeling marginalized during their relative's admission			
↓	↓	↓	↓
sub-element 1	sub-element 2	sub-element 3	sub-element 4
Assuming safety as a priority	Looking for a healing approach and environment	Counting on continuity of care	Wanting to be involved and supported
expecting ... • suicide risk will be minimized • safety routines are applied consistently • MHP observe their relative • MHP check their relative • MHP impose freedom restrictions when necessary (e.g. ward leave) • prevention of dangerous events on the ward (e.g. due to other patients)	expecting ... • suicidal ideation will improve • sufficient/intensive conversations between their relative and MHP • a healing environment (e.g. diverse therapies, quiet and green location) • treatment is more than medication • respect for a relative's rest/privacy • a homely atmosphere/personal approach of their relative	expecting ... • prompt access to inpatient MHS • effective intake interviews • well-informed MHP who cooperate to improve their relative's condition • admissions that offer family respite • MHP prepare their relative's discharge and reintegration • MHP extend admissions or propose service transitions when necessary	expecting ... • information: the relative's condition • information: the ward/ their relative's care and treatment • to be involved in decision-making (e.g. discharge) • dialogues that support the family understanding/contribution • to be heard and acknowledged as a family member

MHS, mental health services; MHP, mental health professionals.

I am actually very uncertain about all that. They do not involve me, and I do not know what is happening.'

Participant 2, mother: 'I asked them [the MHP] many times: "if you know anything, please tell me", but I never get a clear response. Being left uninformed is like an emotional roller coaster: I try to remain hopeful, but I am left in uncertainty.'

The core element interacted with four sub-elements. The family members' hope and uncertainty determined their expectations of care and treatment in inpatient MHS; including 'assuming safety as a priority', 'looking for a healing approach and environment', 'counting on continuity of care', and 'wanting to be involved and supported'.

Assuming safety as a priority

Safety was a primary expectation of all family members. Most of them highlighted their experiences of being confronted with their relatives' suicide attempts. These experiences evoked intense feelings of anxiety that made them constantly vigilant and controlling to prevent their relative's suicide. While family members living together felt they could no longer leave their relatives at home, others ensured accessibility and

regularly contacted their relatives to check their mood. This uncertainty could become intolerable, as they felt highly responsible and helpless in a 'no-longer-safe situation'.

Participant 7, partner: 'My only responsibility was to keep him alive. I strived to help him by going for walks, chatting... but that was not helping any longer. He was no longer safe with those suicidal thoughts. I had no choice other than hospitalisation.'

Family members expected that the safe environment of inpatient MHS would minimize their relative's suicide risk, making their own uncertainty more tolerable. They granted the presence and consistency of safety routines. Although they believed that restraints were 'not pleasant' for their relatives, suicidal ideation was a good reason to impose them. In contrast, some felt that restraints could be too strong and enacted too quickly. They asserted that, when possible, discussion with their relative regarding the most desirable intervention should be prioritized. Most family members, however, perceived that their relatives with suicidal ideation had too much freedom. They could not understand why their relatives were allowed to leave the MHS early in the admission or unsupervised.

Participant 9, daughter: 'My mother has suicidal tendencies and yet she was sent home... That must not be allowed! They must keep her inside and exercise more control over her.'

Participant 2, mother: 'I am very anxious that something will happen. And then, those restraints and observations in the hospital offer me some reassurance: "okay he is safe."

Family members raised concerns regarding MHP who did not, or inadequately, performed bag or room checks to prevent their relatives from bringing along medications or lethal means they could use to attempt suicide. This induced uncertainty and a loss of confidence in the MHP since such actions appeared to contravene safety, making family members think that their relatives' conditions were not taken seriously. Additionally, their perceptions of other patients in the ward also impacted their expectations. Some expressed being unaware about the other patients' mental state, which reinforced concerns regarding potentially dangerous events. However, others drew confidence from the perception that their relative's roommate would provide social control that reduces opportunities for suicide.

Participant 14, partner: 'She could do anything she wanted ... she had a belt ... and no one checked on her. Yes, after her suicide attempt, a nurse did check her room. But that was funny. She checked the cupboard, and I thought to myself, there is another cupboard under the sink... and she did not even lift the mattress!'

Looking for a healing approach and environment

Family members looked for MHS that prioritized a healing approach and environment. This allayed uncertainty surrounding their relatives' situations and permitted them to envision a future without suicidal ideation. Their expectations were contextualized within their own caregiving experiences. They tried to offer closeness to their relatives (e.g. by listening, giving hugs) or distracted them through humour, joint activities or even buying a dog. Despite doing everything in their power, they were often confronted with the sense of being unable to improve or even stabilize the situation. Family members then placed confidence in the MHP to work towards healing. They believed that conversations with their relatives were crucial. While most family members felt that their relatives had insufficient conversations with the MHP, others questioned whether these conversations were intensive enough. They insisted that MHP go beyond listening and truly encourage their relatives to alter their thinking and

distract them from their suicidal ideation. Therefore, family members also appreciated it when the MHS included a broad repertoire of therapies and was located in a quiet and green environment.

Participant 13, sister: 'She said to me: "they [the MHP] mainly listen". While I know that being listened to is very important for her, I also thought that she needed a step further. They should question her and let her truly reflect on her thoughts.'

Furthermore, family members expressed mixed feelings regarding medications. While medications helped overcome difficult periods, they were considered as an easy solution. Medication did not truly alter their relatives' thinking and some hoped that its administration would be discontinued, especially given their concerns regarding drug dependence.

Participant 3, sister: 'Although I know that medication is helpful when she is deeply troubled by those problems, she is not actually learning to explore or deal with her thoughts. I find taking medication too easy and she depends on it. If she has to function on antidepressants, then I believe that therapy has not been completed properly.'

Additionally, family members expressed negative feelings regarding multi-bed rooms. Since they considered rest and privacy as important, they believed that multi-bed rooms prevented their relative's healing process, and that frequently observing others' miseries would add to their distress. Alternatively, some expressed that peer interactions could offer their relatives a sense of belonging and being understood.

Participant 4, partner: 'Three or four men stay in the same room. He needs his night's sleep after a day full of therapies. When there are individuals who, for instance, have to throw up every night because they think they must lose weight, then he cannot sleep as he should.'

Family members expected a personal approach. They appreciated the MHP who ate together with their relatives or spontaneously visited them for a chat. They considered such initiatives important as they reflected a homely atmosphere where the MHP could connect with and talk to their relatives. However, some did not experience this personal approach during their visits. They perceived that the MHP approached their relatives as a number through distant and cold interactions and lacked engagement to improve their relatives' conditions by offering intense treatments. This undermined their confidence in the MHP and thwarted their

hope that their relatives' suicidal ideation would improve.

Participant 5, daughter: 'I do not think the care was personal enough. I mean, mom was just lying there in bed. They came to give a pill and went to the next patient.'

Counting on continuity of care

Family members counted on the continuity of care. Regarding access to care, family members living together were frequently referred to multiple intake interviews with their relatives. Some found this disturbing because they had to repeat their emotionally charged stories. They questioned why this information was not shared among the MHP. Moreover, some were disillusioned by intake interviews resulting in refusal of admission; the MHP did not grasp the severity of the situation and they had to search for help elsewhere.

Participant 10, partner: 'We waited for an hour. Then, a nurse and a psychologist asked the same questions to my wife: "Do you have thoughts about attempting suicide?", "Do you have trouble sleeping?" We waited a bit and then the ward's psychiatrist asked us all those questions for the fourth time. This was very disturbing!'

Family members also encountered waiting periods that were a source of profound uncertainty. They felt that their 'lives came to a halt'; they did not know how long the situation would continue and felt anxious and highly responsible regarding the possibility of suicide. Moreover, waiting time was equal to loss of time. Family members believed that if their relatives would have been admitted earlier, they could have made progress already or deterioration of their condition could have been prevented. Based on this view, family members appreciated it when their relatives were readmitted promptly in case of emergency.

Participant 1, partner: 'If he would have been admitted to the right ward straightaway, he would never have never been so deeply affected... The 3-week waiting period at home was a nightmare... it is like your life comes to a halt... It is very serious for those with suicidal thoughts, but I dare to say that it is just as hard for the whole family to live in such a situation.'

Family members felt more certain about the continuity of care when the MHP were well-informed about their relatives. For example, some noticed that the nurses were aware of the difficulties that their relatives experienced in therapy, although these nurses did not

provide it. Such experiences assured them that the MHP cooperated adequately to improve their relatives' conditions. Simultaneously, the continuity of care provided respite to the family members. Some considered this was necessary given the exhaustion resulting from their daily involvement and the anxieties they faced. Then, family members could take some time off for themselves without giving up their responsibilities of providing closeness and support, visiting and picking up their relatives (e.g. weekends) or performing household activities.

Participant 7, partner: 'I noticed that when something had been discussed with the psychologist or the psychiatrist, the nurses were also aware of it. There is good cooperation and they have meetings to discuss everything. I feel they are interested in his healing and what he is going through. So, I am confident that they want the best for him.'

Participant 4, partner: 'I am always restless and anxious, at home, at work... and then his admission created a moment of rest, to take some time off for myself. Because I knew: "they will take care of him".'

When their relative's condition improved, family members expected that the MHP would prepare their relatives to regain a normal level of functioning, for example, by encouraging activities to do at home. However, they often perceived insufficient support for such reintegration. Similarly, when family members observed no, or only limited, signs of improvement at discharge, they counted on the MHP to extend the admission or refer to another setting.

Participant 13, sister: 'The reality became something very far away for her. I believe the MHP could have done more to support her reintegration, such as encouraging her to do things or offering her responsibilities.'

Participant 11, sister: 'If his condition improves, I hope they will say: "he can go home". But then I expect that they organise some follow-up care, perhaps from a therapist.'

Family members often experienced that admission periods were restricted, and follow-up care was not organized, which increased their uncertainty, especially for the ones who felt marginalized in discharge decision-making. They lost confidence in the MHP who, according to them, handled the situation inadequately. Moreover, their unmet expectations could reinforce burdensome responsibilities. Although the family members felt ill-equipped to keep their relatives safe and respond to their suicidal ideation, they had to continue

caring for their relatives whom they considered fragile. In these circumstances, they felt left to themselves in taking responsibility and searching for appropriate follow-up care.

Participant 12, mother: 'There is no continuity at all. You fall from full admission into periods without care or treatment. That really cannot be good... Then I started searching for hours and hours. I wanted to organise the best follow-up care for her.'

Wanting to be involved and supported

Family members wanted to be involved and supported with respect to 'what is happening'. Primarily, they needed information from the MHP about their relatives' condition (e.g. suicidal ideation) and its prognosis, and also to address their sense of 'being thrown into it'. Regarding their relatives' admissions, they often lacked information regarding the items to be brought from home, the ward routines and treatments, and the rationale behind the MHP's decisions (e.g. ward leave). Being informed enabled the family members to be confident regarding the events on the ward and to remain hopeful about a life without suicidal ideation.

Participant 8, son: 'They could have offered more information about what mom is going through and what I could do about it. Perhaps receiving a weekly report of her progress in therapy would assure me that she is okay.'

Being deprived of information perpetuated uncertainty and struggle for hope. Moreover, it triggered their sense of being marginalized, indicating that the MHP were not accessible, only referred to confidentiality boundaries, and gave them no control over what was happening to their relatives. Consequently, they felt forced to use their own strategies to gather information, such as consulting relatives or searching the internet. Such perspectives were common among family members who were not longer invited after the initial intake interview and for those not living together with their relatives, like siblings, who had to take all initiative to be involved.

Participant 12, mother: 'We [as parents] do not always understand what is happening. But all they do is give vague answers and refer to confidentiality boundaries. That is very confronting, because we are the ones who are stuck in this situation.'

Participant 14, partner: 'I arrived at that hospital and I really felt thrown into it. I had to look things up on the internet, but that was not the same as an MHP would have indicated: "This is a daily schedule of how we

work here and those are the things that you should bring with you for the first few days."

Family members desired constructive dialogues with the MHP. Some referred to the MHP who invited them to ask questions and share their views regarding their relatives' situation. Moreover, these MHP shared insights that helped them gain knowledge of—and empathize with—their relatives' situations. For example, some family members started to reframe their stigmatized views or demonstrated more respect towards their relatives' engagement in intense treatments.

Participant 10, partner: 'Now it is easier for me to understand and empathize with her situation because I know why she has suicidal thoughts. I used to have no context, so her expressions were just, yeah, "really crazy". I used to say that I was married to "a psychiatric patient". Now I am able to see it in a much more positive way.'

Others believed that they did not receive any constructive input, and the MHP's communication style made them think of themselves as 'falling short' and guilty of their relatives' problems. Such encounters were challenging for those family members who already felt highly responsible for their relatives, and powerless in making helpful contributions. Additionally, some encountered MHP who only approached them as 'a source of information' regarding their relatives' suicidal ideation and thereby did not truly attune to their needs.

Participant 1, partner: 'I never felt truly heard. Do you know what they wanted to hear from me? The same questions were asked repeatedly: "What do you observe about your partner? Do you see any change?" Yes, that's it. They did not ask me about how I was doing.'

Family members indicated that they had few opportunities for relief, such as those who deliberately refrained from sharing responsibilities with others or repressed their distressing feelings to avoid triggering their relative's suicidal ideation. While most family members sought professional help to handle their emotional distress, it was not obvious for them to discuss their emotions with the MHP who treated their relatives. Then, they sometimes met MHP who were open and sensitive to their experiences, listened to their concerns and asked whether they needed support. These initiatives provided a space for the family members to vent their emotions and feel acknowledged as supportive relatives.

Participant 4, partner: ‘That therapist says the same things as others, but in a way that makes me feel, “Okay I know I am falling short on this, but I can improve”. I like that style. When I speak to this other MHP it is like “You are falling short”, which makes me feel guilty.’

Participant 6, father: ‘She [a MHP] offered me space to share my story, to talk about how I experienced his situation. This made me feel heard and involved from the beginning.

DISCUSSION

The family members’ expectations of care and treatment in inpatient MHS for their relatives with suicidal ideation were captured by: ‘Struggling to remain hopeful while looking through the lens of uncertainty’. This core element interacted with four sub-elements: assuming safety as a priority, looking for a healing approach and environment, counting on continuity of care and wanting to be involved and supported.

The findings show that family members may feel trapped in an uncertain and disempowering situation; they feel helpless and anxious about suicide and experience burdensome responsibilities. This situation determines their expectations of inpatient care and treatment, including that MHP should protect their relative from suicide by imposing restraints. However, this expectation might contradict with collaborative approaches that highlight self-management of suicidal ideation (Stanley & Brown 2012) and transformations from custodial to recovery-oriented care (Slade *et al.* 2014). Whereas guidelines recommend suicide prevention strategies (e.g. reducing access to lethal means), imposing restraints on patients can produce negative outcomes, such as feeling emotionally unsafe, isolated and disempowered (Berg *et al.* 2017; Wasserman *et al.* 2012). Such balanced considerations were limited in the family members’ expectations, which might reflect cultural stigma beliefs, including that patients are incapable of managing suicidal ideations and that inpatient MHS serve as containment systems (Slemon *et al.* 2017).

Conflicts may occur when different views and expectations remain undiscussed. Family members might perceive that leaving the ward contravenes safety, while MHP encourage ward leave because it holds a therapeutic potential by nurturing social connectedness and mobilizing a person’s responsibilities, strengths and resources (Barlow & Dickens 2018). Such conflicts can result in unmet expectations that make family members

lose confidence in the MHS and the MHP. Moreover, the conflicts persist when family members remain trapped in their uncertain situations and feel marginalized with limited control over what is happening to their relative. They struggle to remain hopeful because they are unable to gain information, understand the rationale of decisions or encounter MHP who lack engagement in helping them to understand their relatives’ situations. Contrarily, family members valued the MHP who provide emotional support and engage them in constructive dialogues that enable their understanding. Based on such support, family members can find ways to overcome feelings of uncertainty and disempowerment and remain hopeful regarding their relatives’ recovery (Nosek 2008; Sellin *et al.* 2017). These insights signal a need for social network approaches, such as open dialogue, that encourage openness towards different expectations and shared-decision-making in care and treatment. Moreover, open dialogue might challenge cultural stigma beliefs, and inspire efforts to connect with and empower a patient’s support system within and beyond inpatient MHS (Seikkula *et al.* 2011).

Strength-based approaches should be prioritized to engage with family members and endorse their caring role (Grant *et al.* 2015). This orientation is crucial because the findings and related evidence highlight that family members might be involved as a ‘source of information’ or as an ‘extension of the surveillance network’ (Morrissey & Higgins 2019). However, when family members are pulled into professional- and custodial-oriented roles, this undermines their caring and nurturing presence (Sellin *et al.* 2017). Simultaneously, family members’ expectations should be considered alongside the patients’ needs. While the findings underscore the importance of motivating patients towards family involvement, one should also consider that family involvement is not synonymous with helpful support. People with suicidal ideation express that their relatives’ continuous observations constrain their privacy and autonomy (Fogarty *et al.* 2018) and that their stigmatizing statements make them feel burdensome and inclined to hide their suicidal ideation (Frey *et al.* 2016).

Therefore, collaborative approaches that contribute to a better understanding between all parties are important. Given their safety concerns, family members can be involved in safety planning to mobilize resources and enable shared agreements about safety. Moreover, safety planning offers a space for family

members to share understanding of their living situation and gain a capacity to detect (e.g. warning signs), respond to, and cope with their relatives' suicidal ideation and behaviour (Stanley & Brown 2012). Additionally, education programmes in face-to-face or online formats might facilitate family involvement and empower them to make helpful contributions (Grant *et al.* 2015). Reflecting the findings and related evidence, education programmes can include knowledge and lived experiences of suicidal and recovery processes, the impact of restraints, and a focus on decreasing stigma and supporting family resources (Foster *et al.* 2016; Grant *et al.* 2015). For example, Sun *et al.*'s education programme (2014) included both perspectives of people living with suicidal ideation and caring experiences of family members. This programme enabled family members to understand their relatives' suicidal ideation and helped them to manage their uncertainties, develop positive attitudes and increase their caring ability.

Several findings can be associated with organizational cultures that inadequately include family perspectives or foster narrow interpretations of family involvement. This is evident among family members who feel marginalized during their relatives' admission including those who need to take all the initiative to be involved or gather some information. These findings suggest that inpatient MHS should more fully establish recovery-orientated cultures and structures that enable meaningful family involvement (Sellin *et al.* 2017; Ward *et al.* 2017). Moreover, leaders should consider family members' expectations regarding the context of inpatient MHS; they appreciated a homely atmosphere, a quiet and green environment, and were critical towards multi-bed rooms. These perspectives should not be overlooked, given that family involvement relates to the design of MHS, including a welcoming entry and informal meeting places for patients and their families (Liddicoat *et al.* 2020). Furthermore, the family members' expectations regarding continuity of care warrant attention. They commonly experienced difficulties regarding access to care (e.g. waiting lists), exclusion from discharge-related decisions, and burdensome responsibilities to arrange follow-up care. Such insights are significant as discharge from inpatient MHS is associated with an increased risk of suicide (Walter *et al.* 2019). Clearly, there is a need for well-coordinated care pathways that encourage accessibility of MHS and support families in seeking help, attaining discharge readiness and providing care in their natural setting (Forchuk *et al.* 2020; Hom *et al.* 2015).

Methodological and contextual considerations

Efforts were made to establish a heterogeneous sample (e.g. different family members of varying ages), and the recruitment strategy allowed the researchers to obtain a detailed and coherent picture of the care and treatment family members expect for their relative in inpatient MHS. However, discussion is needed in terms of methodological and contextual aspects that influenced the findings or restricted the possibilities to reach a fuller theoretical understanding.

First, the selection effects of recruiting close family members via patients must be considered. The findings may not account for family members of patients who do not access inpatient MHS (e.g. due to stigma) (Hom *et al.* 2015) and family members who are unsupportive, or with whom patients experience shame or perceived burdensomeness (Van Orden *et al.* 2010). For example, in contrast to supportive family members, distant family members might not want to be involved (Nosek 2008). Negative case analysis by exploring the influence of unsupportive family relationships could have provided alternative explanations that enhanced the understanding of the supportive family members' expectations (Morse 2015).

Second, the findings emerged in a country that encounters challenges to achieving deinstitutionalization while simultaneously addressing fragmentation of MHS (Nicaise *et al.* 2020). In this context, recovery-oriented and community-based care models have gained attention, but it remains challenging to implement these models in ways that are not professionalized and acknowledge the value of family involvement (De Ruysscher *et al.* 2020). In regions with a longer tradition of recovery-oriented and community-based care, family members might express more positive experiences surrounding continuity of care and their involvement in inpatient MHS, and their expectations of safety might be less subjected to cultural stigma beliefs (Slemon *et al.* 2017).

Third, cross-cultural differences were not considered. The sample only included Dutch-speaking family members with Belgian roots, despite the fact that the country's population is multilingual and multicultural. This precluded the researchers from grasping differences in family expectations of care and treatment in inpatient MHS depending on their cultural background. Further research can include family members with diverse cultural backgrounds to better understand socio-cultural influences. This is important because studies in, for instance, African and Asian cultures

suggest that family members' perspectives regarding a relative's suicidal ideation, and their treatment and recovery, are influenced by spiritual and religious aspects and a socio-cultural landscape that proscribes suicide (attempts) (Asare-Doku *et al.* 2017; Sun *et al.* 2008).

CONCLUSION

Understanding family members' expectations of care and treatment in inpatient MHS is essential in a rapidly changing mental healthcare context focusing on contextual and community-oriented approaches. Based on their hopes and uncertainties, family members expect inpatient MHS to be a setting in which their relatives' safety, healing and continuity of care are prioritized, and where they are involved and supported as family members. Mental health professionals, including nurses, can be more empathetic towards the family members and attuned to their expectations. This presents a foundation to resolve tensions and build partnerships with families that help them to overcome their uncertainty and disempowerment.

RELEVANCE TO CLINICAL PRACTICE

In inpatient MHS, an approach of connecting and collaborating with family members is needed. Such an approach goes beyond mapping the family system and requires MHP to discuss family expectations of care and treatment, and acknowledge their underlying hopes and uncertainties. Such interactions can increase awareness of different expectations and potential conflicts. For example, expecting that MHP impose restraints to limit suicide risk might conflict with their relative's autonomy and the MHS's care vision (Fogarty *et al.* 2018). Additionally, while MHP need to respect confidentiality boundaries, they must not use confidentiality as a standard excuse for not informing family members (Landeweerd *et al.* 2017). Thus, even when MHP cannot meet all family expectations, they are recommended to discuss and clarify their expectations as a way of developing and maintaining understanding between all parties. In inpatient MHS, mental health nurses can occupy an advantaged position to assist family members in finding ways to overcome their feelings of uncertainty and disempowerment. Nurses are familiar with the emotional demands of interacting with patients experiencing suicidal ideation and responding to their risks and problems in daily life (Morrissey & Higgins 2019; Vandewalle *et al.* 2019). They can draw

on these nursing fundamentals to recognize family burdens, offer helpful resources and motivate patients towards family involvement, for instance, in safety planning and risk assessment (Higgins *et al.* 2015; McLaughlin *et al.* 2014).

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The Ethical Committees of the participating hospitals approved this study (B670201838003).

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