

A qualitative study of staff experiences on an adult acute mental health inpatient unit:  
Implications for the development of psychosocial aspects of the service.

This is submitted for the degree of  
Doctor of Clinical Psychology  
at the University of Leicester

by

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May 2011

## Declaration

I confirm that this thesis is my own work except where otherwise stated. It has been submitted in partial fulfilment of the Doctorate in Clinical Psychology and has not been submitted for any other academic award.

A qualitative study of staff experiences on an adult acute mental health inpatient unit:

Implications for the development of psychosocial aspects of the service.

Shelley Parkin

### Thesis Abstract

Despite research demonstrating their effectiveness and recommendations of top-down guidance, little in the way of psychosocial services is being delivered within acute inpatient facilities in the UK.

The literature review compiled an up-to-date appraisal of research pertaining to the utility of psychosocial services within adult acute mental health inpatient facilities. Searching databases resulted in eleven studies being critically reviewed. Articles related to inpatients, staff and interventions aimed at the organisational level. Despite similar methodological limitations, psychosocial services positively impacted upon self-cognitions, symptoms, functioning and relapse. Staff training improved clinical practice and promoted feelings of staff empowerment. Organisational research demonstrated the need for stakeholder inclusion and supportive organisational structures, for long-term change. Barriers to change, including staff psychological distress and feeling unsupported were highlighted. Qualitative research is needed that further explores obstructions to change and improvement.

The research study explored experiences and priorities of staff working in adult acute mental health inpatient units, regarding the role of psychosocial services. The aim was to consider how this differs to and affects the implementation of national guidelines and scientific recommendations, with a view to making suggestions regarding effective implementation. Eight staff members participated in a semi-structured interview and data was analysed using grounded theory. Data emerged suggesting the ward to be isolated, with a lack of team work and effective leadership. The focus on medication encouraged hopelessness about patient progress and a lack of understanding about patients and their own feelings towards them. Staff felt powerless, unsupported and undervalued. They experienced a lack of professional confidence, performance anxiety and fear of change, resulting in overall ambivalence towards change and improvement. Training and therapeutic services for staff are needed, along with organisational consultancy, to increase effective team work, leadership and staff input into service development. Future research is considered.

### Acknowledgements

I would like to give my complete thanks to Dr Arabella Kurtz, for her expertise, encouragement and guidance throughout the research process. I would also like to thank Dr Nicholas Bunker for his practical help and support on the ground.

I am grateful to the Trust for allowing the project to proceed and I would like to thank the individual participants who made the research possible.

## Word Counts

Literature Review	6,467
Main Research Report	11,081
Critical Appraisal	3,598
Main text in total <sup>1</sup>	21,685
Appendices <sup>2</sup>	4,025
Whole thesis <sup>3</sup>	28,976

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<sup>1</sup> Includes literature review and research report abstracts and excludes tables, references and appendices

<sup>2</sup> Excludes mandatory appendices not included in the word count

<sup>3</sup> Excludes acknowledgements and mandatory appendices not included in the word count

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## **Section A**

### **Literature Review**

A review of the effectiveness of psychosocial services within acute inpatient mental  
health environments

Shelley Parkin

**1.0 Literature Review Abstract**

National guidance promotes the use of psychosocial services within inpatient facilities and recommends increasing skills of ward staff to deliver brief, evidence-based interventions. Little however is currently being delivered. The purpose of this review was to compile an up-to-date appraisal of research pertaining to the utility of psychosocial services within adult acute inpatient facilities. The databases PsycINFO, Medline and Web of Science were searched and the search engine Google was utilised. Eleven articles were selected for evaluation, based on selection criteria, and related to inpatients, staff and interventions with organisations. Methodological limitations concerned an absence of controlled studies and patient data, and a focus on quantitative methodology.

Psychosocial services were demonstrated to positively impact upon symptoms, functioning and therefore relapse. There were also more qualitative benefits for patients in terms of positive self-cognitions. Staff training resulted in increased knowledge and skills that impacted positively upon clinical practice and feelings of staff empowerment. Organisational research demonstrated the importance of including stakeholders and creating supportive organisational structures, including supervision and reflective practice, for long-term change.

The review highlighted difficulties, which affected staffs ability to implement psychosocial services. Aside from resource constraints, staff were unsupported and experiencing psychological distress. Qualitative research is needed to explore staffs experiences and priorities, to highlight obstructions to change and improvement. This would allow development of suggestions regarding how the implementation of top-down guidance and empirical recommendations can be facilitated.

Target Journal: British Journal of Clinical Psychology<sup>4</sup>

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<sup>4</sup> See Appendix A for Author Guidelines

## **2.0 Introduction**

The Sainsbury Centre for Mental Health (SCMH, 1998) published a report into the quality and effectiveness of acute inpatient care for working age adults in 38 services across England and Wales. The study gleaned the opinions of staff from nine hospital wards and tracked 215 patients throughout their stay. Although patients appeared to feel better upon discharge, many of their needs were not being met as an inpatient as services tended to focus on symptoms. Lending support to this is the statistic that almost 50% of patients are readmitted within the year (SCMH, 1998). More recently, the Healthcare Commission (HCC, 2008) conducted a review of all 69 NHS Trusts in England which provided mental health services to adult acute inpatients. Again services were found to be wanting in several areas, including a lack of psychological and social services.

The SCMh found an emphasis on medication rather than therapy and both the SCMh and the HCC highlighted a lack of multi-disciplinary team working within wards and across services. As a result, there was a lack of contact between patients and psychologists, occupational therapists and social workers. This had implications for the development of the care pathway and the provision of therapeutic input, including psychology, occupational therapy, art and psychosocial interventions. The HCC suggested this was partly attributable to staff not being trained in facilitating therapeutic environments and an over-reliance on the medical model. The HCC and the SCMh documented a lack of activities for patients generally with 30% of those sampled not taking part in any activity during their stay (SCMH, 1998). This has implications for ineffective resolution of frustrations and high levels of violence found in inpatient services (HCC, 2008).

In studies patients consistently report a lack of interaction with staff (Ryan, Hills & Webb, 2004; Janner, 2006). This too was described by the HCC and the SCMH. Patients referred to staff spending copious amounts of time in the nurse's office (SCMH, 1998). One-to-one time with staff is a Government recommendation (Department of Health: DoH, 2006, cited in Hosany, Wellman & Lowe, 2007) and the quality of this staff-patient relationship has been found to be fundamental in influencing positive patient outcomes (Richmond & Roberson, 1995).

Patients complained about staff being uncaring and unresponsive (SCMH, 1998). Staff reported colleagues as having a "hard" attitude towards patients and their practice was viewed as defensive and more akin to a custody environment rather than to one of rehabilitation (SCMH, 2006). Whilst patients claimed the ward environment to be the most important aspect of their stay, they reported staff negativity and what the HCC coined "inadequate customer service".

According to Lelliott (2006), the level of difficulty encountered by acute inpatient facilities has increased during the last two decades due to resources being directed towards community services. This has led to admissions for those whose distress is more severe and who present a higher risk to themselves and/or others. As a result, the role of inpatient environments is one of "risk management and containment" (Lelliott, 2006). This is supported by Muijen (1999) who labelled acute inpatient environments "atherapeutic", by virtue of the lack of psychological and social interventions.

## ***2.1 Rationale for Review***

Inpatients in England have reported being unhappy with their care. There is a focus on medication, despite up to 40% of patients with a diagnosis of schizophrenia, relapsing on medication (Johnson, Ludlow, Street & Taylor, 1987, cited in McCann &

Bowers, 2005). Medication is also linked with side-effects that are not associated with psychotherapy (Kern, Glynn, Horan & Marder, 2009) and many continue to experience ongoing symptoms including hallucinations and delusions (Kuipers, Garety, Fowler, Dunn, Bebbington, Freeman & Hadley, 1997). Medication is also less effective on negative symptoms, cognitive impairment and social difficulties, and therefore functional recovery (Kern et al., 2009).

The findings suggest that more is needed to stabilise patient's mental health and reduce distress. The SCMH (1998) and the HCC (2008) promote the use of psychosocial services within inpatient facilities. In essence, the more developed these aspects of a service, the better the care. Government documents now promote increasing skills of ward staff to deliver brief, evidence-based interventions (DoH, 1999, cited in Iqbal & Bassett, 2008). Little however is currently being delivered. The purpose of the current review was to compile an up-to-date appraisal of research pertaining to the utility of psychosocial services within adult acute inpatient facilities.

### **3.0 Method**

#### ***3.1 Databases and Search Terms***

An overview of the search process is presented along with a brief table (Table 1). Appendix B provides a description of the search results, including search terms and inclusion/exclusion criteria. The databases of PsycINFO, Medline and Web of Science were selected for their comprehensive range of journals pertaining to psychological phenomena. The Web of Science is also judged to be a good source for articles and journals not included in PsycINFO. To ensure the relevance of the search, terms related to the setting of the inpatient mental health ward, the adult population and types of therapeutic intervention. This included the use of broad search terms such as psychological/psychosocial interventions and more specific

terms including cognitive-behavioural therapy. Specific terms for interventions were employed in order to ensure the search had been comprehensive and to specifically search for research on interventions not already found by the use of broader terms. The search engine Google was also used to search for specific articles and authors.

### *3.2 Selection Criteria*

Full, published and peer reviewed journal articles, written in the English language were sought. Relevant review articles could not be found, and as the aim of the current review was to appraise empirical research within the area, research articles as opposed to audits were selected. Selection was also based on the use of robust outcome measures and a judgement based on a simple rating system according to whether the methodology was clearly depicted. The principal investigator looked for details regarding the population studied, including participant demographics; sampling technique; inclusion/exclusion criteria; method of allocation to conditions; and intervention being researched, including mode of delivery and duration. Also screened for, were details regarding method of data collection and analysis, including statistical tests employed and the reporting of effect sizes and power calculations. Those studies that met the majority of the selection criteria were included in the review. The population and setting were restricted to adult, inpatient mental health services, excluding studies with other populations and those solely researching outpatient and community settings. In addition, studies were required to investigate a specific psychological/social service, in order to enable precise appraisal of its effectiveness.

Only studies conducted in the UK were used, based upon the fact that the National Health Service in the UK was known and understood by the author. Research has increased in terms of rigour over time, therefore the search focused on

more recent research. Recent publication was ensured by searching the latest years available as demonstrated in Table 1 below. When searching Medline, the databases Journals @ Ovid full text, Ovid Medline 2007-11 and Embase 1996-2011 were searched. Regarding the Web of Science, the search was restricted to articles within the social sciences, due to the anticipated relevance of such articles.

### ***3.3 Procedure for Including and Selecting Studies***

#### ***3.3.1 Computerised search.***

The first search took place between the months of May-November 2009. This search was repeated during the months of September and October 2010, to ensure that no new relevant literature had been published. Another search took place during March 2011 as new material came to light.

#### ***3.3.2 Visual search.***

From the computerised search, all articles considered relevant were scrutinised by reading abstracts to gain an idea of their aims. The principal investigator ensured the focus of papers was on the adult inpatient mental health environment, and that a specific psychosocial service was being researched. Those studies which did not conform to these criteria were immediately excluded.

#### ***3.3.3 Full text retrieval.***

Articles deemed relevant to the review based on their abstracts, and available in full text, were printed for full reading. Some articles were unavailable in full text; however the author found much duplication in terms of studies and findings. The impact of omitting these studies therefore should have been minimal. The full quality checks regarding methodology outlined on the previous page were carried out at this stage. Articles that were rated as meeting the most criteria were included in the current review. Few studies were considered methodologically robust. Eleven

articles were used as central empirical studies and the remainder for background information.

**Table 1:** Summary of search outcome

Database	Date range	Relevant papers
PsycINFO	2000-present	12
Medline	1996-2011	1
Web of Science	Latest five years	0
Google		1

### **3.4 Data Extraction**

Data relating to aims, sample, methodology and results, were extracted from each of the eleven articles. A data extraction form (Appendix C) aided in the comparison and critical evaluation of each.

### **3.5 Data Synthesis**

Considering the multi-factorial and heterogeneous nature of inpatient environments and psychosocial services, a narrative review of the literature is presented.

## **4.0 Results**

The following review of empirical and theoretical literature highlights how a psychosocial service can benefit both staff and patients within an inpatient mental health unit. Psychosocial services cover a broad spectrum including structured psychosocial interventions. To aid clarity, studies are presented in three main categories, according to the target of the intervention. The review used research whose sample included acute inpatient services wherever possible, however some



research pertains to inpatient mental health environments generally. Table 2 presents a summary of the main features of each study included.

**Table 2:** Summary of main study features

Studies	Main findings	Strengths/weaknesses
<b>Interventions with Patients:</b>		
Kuipers et al., (1997)	CBT reduced psychosis symptoms	-RCT, pre/post design, robust measures, large sample, long follow-up. -Self-reports.
Dodd and Wellman (2000)	CBT reduced anxiety and functional impairment	-Robust measures, pre/post design. -Incomplete assessment data.
Drury et al., (1996)	CT reduced psychosis symptoms and conviction in delusions	-RCT, pre/post design, good sample and follow-up. - Possible response bias.
Chiesa and Fonagy (2000)	Psychodynamic therapy improved psychological health and functioning	-Robust measures, large sample, pre/post design, long follow-up, control group. -Non-randomisation.
York (2007)	Mindfulness led to positive self-cognitions	-Quality checks. -No negative cases or explanation of theme development.
<b>Interventions with Staff:</b>		
Richards et al., (2005)	Improved practice and patient engagement in therapy.	-Mixed methods, pre/post design. -Unclear teaching.
Hosany et al., (2007)	SFBT training improved clinical practice.	-Pre/post design, moderate follow-up. -Self-reports.
Ferraz and Wellman (2009)	SFBT training improved clinical practice	-Pre/post design, good follow-up, large sample. -Self-reports, low response rate.
Stevenson et al., (2003)	SFBT training improved clinical practice	-Pre/post design, good sample, multiple outcome measures, patient data. -Self-reports, low response rate.

<b>Interventions with Organisations:</b>		
Bowers et al., (2006)	Reduced conflict but not containment	-Pre/post design, robust measures, long follow-up. -No control group, low response rate.
Bowers et al., (2008)	Reduced conflict and containment. Not statistically significant when analyses included control groups.	-Pre/post design, control groups, long follow-up. -Low response rate, one outcome measure.

#### *4.1 Psychosocial Services for Inpatients*

##### *4.1.1 Cognitive and cognitive-behavioural therapy (CBT).*

Kuipers, Garety, Fowler, Dunn, Bebbington, Freeman and Hadley (1997)

researched the effects of CBT upon symptoms and functional recovery with “medication resistant” psychosis. Sixty patients from inpatient and community settings were randomly allocated to a treatment group consisting of case management, medication and CBT, or a control group comprising just case management and medication. Treatment lasted nine months. Therapy included developing an alternative understanding of patient’s difficulties, challenging beliefs about hallucinations and delusions and developing coping strategies.

Patients were assessed for anxiety, depression and symptoms of psychosis, with a range of standardised measures. Compared to controls, the treatment group showed a statistically significant reduction in symptoms of hallucinations and delusions of 25%. Furthermore, 50% were treatment responders, compared to only 31% of controls. Additionally, one person became worse, compared to three in the control group. No statistically significant effects were found regarding depression, functioning and degree of belief in delusions.

Using a randomised controlled trial added to the study's rigor as did the large sample. Progress was measured at baseline and regular follow-up periods and the authors used a battery of assessments to capture information relating to symptoms, functioning, cognitive and emotional factors. Some patients however thought that those gathering assessment data were part of the therapy team. It is possible that patient's responses were affected by a desire to avoid criticising the researchers.

The immediate environment of an individual could have implications for treatment outcomes, yet the authors did not relate outcome to context. There is also little explanation of why depression and degree of conviction in delusions did not produce significant results. The authors highlighted that progress may have been facilitated by medication changes; however they report that symptom reductions were facilitated by cognitive changes, including reductions in delusional thinking. Additionally, as the sample was diagnosed with medication resistant psychosis; it may be unlikely that patients spontaneously began to respond to medication. Inclusion of qualitative patient data may have aided understanding of how much of the statistical improvement was attributable to CBT.

Dodd and Wellman (2000) reported on the effectiveness of an anxiety management group run by nurses on acute inpatient mental health wards. Nurses were taught CBT techniques and supervised by a nurse specialist. Wards across five units incorporated the three session intervention into a pre-existing relaxation group. Patients were introduced to a cognitive model of anxiety and taught how to identify and manage their anxious feelings. The authors assessed outcome using The Beck Anxiety Inventory (Beck, 1987) and an adapted version of the Activities of Daily Living (ADL). There were statistically significant reductions in anxiety and functional impairment, and staff and patient feedback was positive.

Organisational pressures including low staffing was a barrier to the development of psychological practice on one ward, reducing the sample to twenty-three patients. Assessment data was incomplete and the inclusion criterion was a subjective feeling of anxiety. It was therefore unclear how many were clinically anxious, which may have contributed to the wide variability in anxiety scores. This could skew results, misrepresenting the effectiveness of the programme. The authors also referred to using a modified version of the ADL. It is not clear whether the adapted version had been tested for reliability and validity. Overall however, the study seemed to suggest the benefits of short-term, cost-effective therapeutic interventions (Dodd & Wellman, 2000) that can be delivered within a short acute inpatient stay.

Drury, Birchwood, Cochrane and Macmillan (1996) researched the effects of cognitive-therapy on positive symptoms of psychosis, with forty acute inpatients. Participants were selected using stratified sampling and randomly allocated to either an experimental or control condition. The experimental group received individual and group cognitive-therapy. There were also two sessions for families regarding how they can support the patient. The control group received structured activities including space to listen to music and informal support described as listening “sympathetically”.

Patient progress was monitored weekly for six months and re-assessed at nine months. Measures were a self-reported belief in and preoccupation with delusions and a measure of symptom severity. The latter was completed by one of the authors and rates the severity of symptoms including hallucinations and delusions. A sample of these was re-rated by fellow authors to increase reliability.

Both groups showed a statistically significant decrease in positive symptoms, and conviction in and preoccupation with beliefs. At weeks seven and twelve there was a statistically significant difference between the two groups with those in the experimental group decreasing faster and to a greater extent. At nine months 95% and 44% of the experimental and control group respectively, reported experiencing no hallucinations or delusions. Although disorganisation symptoms and negative symptoms reduced in both conditions, there were no statistically significant differences between groups.

This was a robust study methodologically. The authors employed a good sample and performed quality checks to ensure reliability of method. There were high correlations between the two measures, ranging from 0.86-0.98. The participant groups were also matched on variables including age and gender and after controlling for outliers, both groups were receiving comparable levels of medication, administered by staff unaware of group allocation. This increases the likelihood that effects were due to the cognitive-therapy.

It is unclear whether patients were aware of the author's connection with the research and therefore response bias in the form of social desirability cannot be ruled out. It would have been useful to have supported the results with data from clinicians and family members. Furthermore, the authors did not explain the lack of statistically significant differences between groups regarding disorganisation symptoms and negative symptoms.

#### ***4.1.2 Interventions based on psychodynamic principles.***

Chiesa and Fonagy (2000) researched the effectiveness of psychosocial services for patients with a diagnosis of personality disorder. Ninety patients were allocated to one of two conditions. The first was a standard inpatient stay of 11-16

months. The second was a reduced inpatient stay of 6 months, with follow-up outpatient intervention lasting 12-18 months, alongside six months outreach support. Whilst an inpatient, patients received a “socio-therapeutic programme” and twice weekly psychoanalytic psychotherapy. Measurements were taken at baseline and at six and twelve months.

Outcomes were measured according to an assessment of mental health and social adjustment. The Global Assessment Score (GAS; Endicott et al., 1976) provides a rating of psychological health and functioning, including social functioning. The Social Adjustment Scale (SAS; Weissman, 1975) rates adjustment in areas of work, family, marriage, sex, and social leisure activities. Both were completed by a rater. The Symptom Check List (SCL-90; Derogatis, 1983) is a self-report of psychosomatic symptoms and interpersonal functioning. Improvement for the sample as a whole was statistically significant on all three outcome measures. At twelve months those in the second condition demonstrated reliable statistically significant improvements above those in the inpatient condition alone, for both the GAS (at 6 and 12 months) and SAS (at 12 months).

The authors demonstrated that psychoanalytic psychotherapy was beneficial to inpatients and out-patients with the latter gaining the most benefit. Methodologically, the sample was large and the design was prospective with a lengthy follow-up, increasing the reliability of the results. The authors took precautions to guard against bias in measuring progress. The GAS and the SAS were completed by raters and 20% of these interviews and those concerning diagnostic categories were audio-taped and transcribed. These were rated by others unconnected to the study, achieving inter-rater reliability that ranged from 0.78-0.79 for the SAS and GAS respectively.

Patients may have been unusually functional for an inpatient sample. Two thirds had qualifications above GCSE level and were described as holding professional or non-manual skilled occupations. This may have increased the chance of treatment success and limits the ability to generalise results to other inpatient populations. Patients were allocated to conditions according to whether they were able to access outreach therapy, based upon where they lived. Not randomising patients to conditions leaves the method open to possible bias. This was acknowledged by the authors.

The authors proposed that spontaneous improvement was unlikely based upon high baseline measures and previous lack of treatment progress. As out-patients, however, patients received support with daily living. It is difficult to determine what effects are attributable to this support and what is attributable to the therapy for this group. Scores on social functioning (SAS) only became significant between groups at twelve months when those in the second condition were living in and receiving support in the community. Scores may have been further advanced by increased opportunity for social interaction. This highlights the possible unsuitability of the SAS for studies comparing inpatients and outpatients. Furthermore, the nature of the socio-therapeutic component of the inpatient service was not specified and therefore its contribution to outcomes cannot be evaluated.

The authors suggested that a phased retreat of services may have been more effective as 70% of patients had a diagnosis of borderline personality disorder. They hypothesised that the abrupt end associated with standard inpatient care may be particularly traumatic for this group. They also reported that planned shorter inpatient stays may increase staff tolerance and focus and motivate them to meet patient's needs. The authors argued that this could strengthen the therapeutic alliance which

has been demonstrated as crucial for positive patient outcomes. One implication of this is potentially better outcomes in acute care where duration of stay is usually shorter.

#### ***4.1.3 Mindfulness therapy.***

York (2007) qualitatively explored acute inpatients' experiences of participating in a weekly mindfulness group. Patients were taught basic mindfulness techniques including breathing exercises and increased awareness of thoughts and feelings. Semi-structured interviews with eight patients were analysed using thematic analysis. Ten themes emerged relating to reduced worry and development of a more positive identity. Participants felt able to separate themselves from their cognitive symptoms and found relief from focusing on the present. Some commented on their increased ability to focus their thoughts and felt more relaxed generally. Participants reported increased acceptance of themselves and their thoughts and had more awareness of how their body felt. Most participants reported using techniques outside the group and intended to continue after discharge.

Some patients had difficulty understanding some of the concepts and as a result misunderstood some aspects. Some believed for instance, that mindfulness was about controlling thoughts as opposed to observing them. On the whole however, the research suggested that patients in acute stages of distress can understand and benefit from the model. Explanation of how the author developed themes and categories would have strengthened findings. It is not known how many interview themes emerged from and there was no reporting of negative cases. As a result, it is difficult to weigh the evidence, reducing the transparency of the analytic process. Peer review of codes however is reported, reducing researcher bias and increasing the reliability of findings.



## *4.2 Psychosocial Services for Staff*

### *4.2.1 Teaching to improve nursing care.*

Richards, Bee, Loftus, Baker, Bailey and Lovell (2005) reviewed the effects on practice of an 18-day educational programme for nurses on three acute mental health inpatient wards within different organisations. The teaching was designed to increase the quality of nursing activities. Data was analysed quantitatively, using nursing records and qualitatively using a thematic analysis of patient interviews.

Increased patient engagement in CBT was statistically significant. Levels remained low however, particularly on one ward which only rose from 1.2-5.9%. “Purposeful talking” in one-to-one sessions also remained low. There was a statistically significant improvement in the amount of psychological, physical and social information within assessments, and care plans were significantly more likely to be tailored towards individual patients. Most goals however related to nursing needs and patient inclusion in their care showed a statistically significant decrease. Furthermore, interviews with patients revealed that relationship difficulties with named nurses persisted from baseline to follow-up. They confirmed low involvement in care plans and engagement in recreational rather than psychological activities.

There was a good mix of staff and patient data, providing a more reliable assessment of the effects of staff training upon care provided. The authors also used an ex-service user to gather patient data, reducing the possibility of biased responding. The authors presented themes from the qualitative analysis and information regarding the number of interviews in which themes emerged. This transparency contributed to the strength of the evidence.

There was no statistically significant reduction in illness severity and length. This may be partly accounted for by the low uptake of CBT and lack of influence over

their care. There are methodological limitations to consider. It was not clear what the teaching involved preventing replication. It was also unclear how long the follow-up period was, limiting the reliability of findings. In addition, the authors did not outline what “purposeful talking” related to and how it was measured. The research highlighted difficulties implementing services more psychological in nature, however no attempt was made to explain this.

#### *4.2.2 Training in solution-focused brief therapy (SFBT).*

Hosany, Wellman and Lowe (2007) conducted a pilot study within two acute mental health admission wards. They evaluated the effects of nurse training in SFBT upon staff-patient interactions. In contrast to the model most medical practitioners are socialised in (Hosany et al., 2007), solution-focused therapy concentrates on strengths, solutions and future goals, rather than weaknesses and difficulties.

Baseline measurements of the quality of one-to-one sessions were evaluated quantitatively with self-reports. These were completed by thirty-six staff and were repeated at two weeks and three months post-training. Statistically significant results were found for the use of specific solution-focused questioning techniques and a reduced focus on problems. Staff reported feeling more confident in their interactions and felt patients were more engaged. Staff empowerment may have been influenced by the approach lending structure to sessions, highlighting the benefits of teaching techniques rather than just principles.

Most outcomes were statistically significant and improved clinical practice. The authors measured outcomes at two time points post-training; a longer follow-up however, would have increased reliability of results further. It was not specified how many nurses completed follow-up measures or how perceived level of confidence and patient engagement were assessed. Reduced focus on patients’ problems may have

had limited value to patients in practice, as results relating to a focus on patient's strengths, resources and goals did not produce significant results. There was also no difference pre and post-training relating to an emphasis on finding solutions. This highlights the difficulty of reliance upon self-reports which cannot be verified, compounded by the absence of patient data.

The authors attributed the lack of significant findings for some outcomes to the sample size and a ceiling effect, as some staff were familiar with the approach by virtue of previous "introductory training". It is unknown how long ago the training was conducted and no attempt was made to compare those who were and were not familiar with the approach. It is therefore not possible to support or refute this claim and further explain the results. The authors acknowledged that the study may be underpowered but reported that one of their aims was to generate effect-size data for future studies.

Ferraz and Wellman (2009) built upon the findings of Hosany et al. (2007). Two days' training was delivered to sixty-six participants comprised of voluntary sector workers and acute inpatient nurses. Outcomes were measured via staff self-reports at three and six months. Results demonstrated that staff focussed less on patients' problems but the results did not achieve statistical significance. A focus on patients' strengths and goals achieved statistical significance at six months. The use of specific questioning techniques also demonstrated a statistically significant increase. A focus on finding solutions and using praise and reward were not statistically significant. The authors attributed this to a ceiling effect as baseline measurements were high.

The authors replicated the overall findings of Hosany et al. (2007) in that training staff in brief and cost-effective training has positive implications for clinical

practice. An additional feature of this study was the provision of clinical supervision where skills were modelled and staff were supported to develop skills and confidence. This would have increased the chance of success. This was a more robust study than that conducted by Hosany et al. (2007). Ferraz and Wellman sought to attend to some of the limitations of their predecessors. There was a larger sample and a longer follow-up increasing the reliability of results. The authors also refined questionnaires used by Hosany et al. (2007) and piloted them, again increasing their reliability.

A danger associated with the use of questionnaires is a low response rate (Robson, 2002). Thirty-nine (59%) and thirty-three participants (50%) returned completed questionnaires at three and six months respectively. This must be taken into account when evaluating results. It is possible that those who did not respond were not using the skills, which would reduce the effectiveness of the training. Again results were limited by an absence of patient data.

Stevenson, Jackson and Barker (2003) also investigated the effects upon practice of 2.5 days' staff training in solution-focused practice. Twenty-three staff and fifteen patients participated. Change was measured quantitatively via patient reports, staff knowledge tests, case reports, audits of clinical notes and a staff questionnaire evaluating impact upon practice. Fewer than 50% of staff completed both pre and post-knowledge tests or passed the audit. Staff knowledge however increased significantly and case reports demonstrated the transfer of skills to clinical practice. Patients reported feeling more accepted by staff and positive about their future and felt sessions were more focused on finding solutions. It is therefore likely that time constraints rather than lack of commitment prevented staff from completing outcome measures.

A more rigorous exploration of patient experiences needs to be conducted to support staff reports and ensure positive outcomes for patients. This is particularly important considering the low numbers of staff who completed outcome measures. A good range of measures was used however, with staff having to actively demonstrate knowledge and use of skills. Reduced reliance on self-reports increased reliability of results.

#### *4.3 Psychosocial Interventions with Organisations*

Inpatient psychiatric services tend to be hierarchical and competitive. Such organisational structures can encourage staff to feel insecure and undervalued (Jones, 2008). Baker, O'Higgins, Parkinson and Tracey (2002) overcame organisational barriers to the development of psychosocial interventions, by including staff and building organisational structures to support the implementation of skills.

Bowers, Brennan, Flood, Lipang and Oladapo (2006) demonstrated that services can achieve more by creating organisational support. The reporting of this study was separated into three papers, authored by Bowers et al. (2006); Flood, Brennan, Bowers, Hamilton, Lipang and Oladapo (2006); and Brennan, Flood and Bowers (2006). Bowers et al. commented on the "process of change" designed to reduce conflict and containment and increase therapeutic services within two acute mental health wards. The authors referred to containment as actions such as sedation and restraint. The project spanned one year and was based upon the philosophy that to have low containment and conflict, there needs to be a ward structure with rules and routines and staff need to have a positive view of patients and be able to regulate their emotions in response to them.

Two wards volunteered to participate in the project. The facilitators, two nurse specialists, set up patient reviews, supervision and reflective practice sessions.

All proposed changes were negotiated with staff including the methods by which they achieved changes. Building on existing skills, staff were encouraged to reflect upon their interactions with and develop empathy for patients. Ward managers were educated on running therapeutic groups and maximising staff-patient engagement.

Conflict and containment were measured pre and post-intervention using the Patient-staff Conflict Checklist Shift Report (PCC-SR), which measures the frequency of incidents. This was completed each shift for three months pre-intervention and at one year post-intervention. The authors also collected information regarding staffing levels and official incident reports. They also used a battery of measures to collect information about ward atmosphere, attitudes towards patients, burnout, ward structure, job satisfaction and staff-patient interactions.

Pre-intervention, the authors reported that compared with findings from previous research, the attitudes of staff towards patients were comparable, burnout was lower but comparable to that reported in the test manual (Maslach Burnout Inventory; Maslach & Jackson, 1981), job satisfaction was lower and ward atmosphere was also rated as lower. There were no statistically significant changes regarding these measures pre and post-intervention. Ward atmosphere did however improve. This was measured by staff's perceptions of patient autonomy, orientation towards discharge and support in relationships between patients, and between staff and patients.

Conflict, demonstrated by aggression, self-harm and absconding, significantly reduced and increases in staff-patient interaction also achieved statistical significance. The authors reported that this was indicative of increased positive appreciation and understanding of patients, enhanced staff emotional regulation and increased structure and routine. This may be a tenuous link considering that no statistically significant

differences on other measures were found. There was no change in methods used to contain patients, which the authors suggest may have been affected by reduced staffing levels during the intervention.

There was a reported low response rate of 56% on the PCC-SR; however to check the validity of the measure, the authors compared staff reports with officially reported incidents and statistically significant correlations were found. The authors used many outcome measures but information about findings was brief. The inclusion of qualitative staff and patient data would have been useful to confirm improvements. The long follow-up however increased the reliability of the results. The authors reported that they used the Ward Structure questionnaire, which was a new measure without available norms. It was not known whether it was devised by the authors and therefore its validity is unclear.

Flood et al. (2006) and Brennan et al. (2006) reported direct challenges from staff in the form of resistance, suspicion and power struggles. They found it difficult working with staff who were burnt-out and “apathetic and blinkered” as a result. Despite these challenges and reduced staffing levels during the intervention, improvements were made by encouraging change through bottom-up processes, thereby empowering staff and creating organisational support.

Bowers, Flood, Brennan and Allan (2008) replicated their 2006 research to specifically address difficulties reducing containment. As a result, only the PCC-SR and official incident records were used. The method and procedure were replicated, however this time three wards volunteered to participate and five wards were used as controls. During the intervention one ward was replaced as the ward manager was relocated. The authors felt that the resulting shorter intervention on this new third ward would impact upon results. Consequently, it was not included in the analysis.

Pre and post-analyses of the two experimental wards revealed statistically significant reductions in both conflict and containment. When control wards were included however, there was no statistically significant effect for the intervention.

Based on a statistically significant effect before analyses included control groups and power calculations of others, the authors felt that the sample size in the experimental group was not large enough to detect change. This could have been compounded by a low response rate of 58% and removing the third ward from analyses. Although further research is needed, preliminary results suggest that processes of change involving staff and changes at the organisational level can produce widespread improvements.

## **5.0 Discussion**

### ***5.1 Synthesis of Findings***

This section is presented according to the target of the intervention. The discussion will then consider insights developed from the review, regarding potential barriers to change. The limitations and clinical implications of the research and the review will be highlighted, and future research will be considered.

#### ***5.1.1 Psychosocial services for inpatients.***

Many therapeutic interventions were reviewed, ranging from structured cognitive (Drury et al., 1996) and CBT frameworks (Kuipers et al., 1997) to interventions of a more experiential nature (York, 2007). All studies demonstrated psychosocial services to benefit those in inpatient environments. Some studies found improvements in both symptoms and functioning (Dodd & Wellman, 2000; Chiesa & Fonagy, 2000). Other studies only found a decrease in symptoms, but were working with patients described as some of the most difficult to treat and still produced treatment effects comparable to that achieved with medication (Kuipers et al., 1997).



There were also more qualitative benefits for patients, including feeling better about themselves as individuals (York, 2007). Staff also felt empowered as a result of increasing their knowledge and skills (Dodd & Wellman, 2000).

Research demonstrated that effective interventions do not need to be extensive (Dodd & Wellman, 2000). Patients benefit from relatively brief psychosocial services (York, 2007; Dodd & Wellman, 2000). Even patients in acute stages of distress were able to make use of therapeutic interventions. In fact, it may be those in short stay environments that are most likely to benefit, as a result of increased staff focus on meeting patient's needs and increased tolerance, having implications for the therapeutic rapport (Chiesa & Fonagy, 2000).

#### *5.1.2 Psychosocial services for staff.*

Staff training of both a short and longer nature resulted in increased knowledge and skills that were still being used at follow-up, impacting positively upon clinical practice (Ferraz & Wellman, 2009). Some studies appeared to demonstrate staff having difficulty implementing services of a more psychosocial nature, which may be contributed to by a lack of confidence engaging patients (Richards et al., 2005). Findings by Hosany et al. (2007) and Ferraz and Wellman (2009) indicated that staff and patients benefit from training that specifically targets staff-patient interactions, providing staff with techniques and therefore structure on which to base sessions (Hosany et al., 2007). Furthermore, just basic skills including a positive approach can be incorporated into general interactions with patients, helping them feel more accepted and positive about their future (Hosany et al., 2007; Ferraz & Wellman, 2009; Stevenson et al., 2003) and raising staff confidence (Hosany et al., 2007).

### *5.1.3 Psychosocial interventions with organisations.*

Staff reports included a lack of support, low job satisfaction and symptoms of burnout (Bowers et al., 2006). Bowers et al. (2006) and Bowers et al. (2008) demonstrated the importance of including stakeholders and creating supportive organisational structures in a process of change. Supervision and reflective practice were judged crucial to providing a confidential and containing environment for staff, allowing them to verbalise feelings of dissatisfaction and attend to difficulties within the team (Flood et al., 2006; Brennan et al., 2006).

Through joint problem solving, staff inclusion, and implementing a comprehensive support system, staff-patient contact increased and conflict reduced (Bowers et al., 2006), as did methods of containment (Bowers et al., 2008). Although the results of the latter study were affected by the inclusion of control groups, methodological constraints including a small experimental group may have affected results. The findings demonstrated that an approach that attends to the nature of the environment can produce fundamental and long-term improvements for staff and patients.

### *5.1.4 Barriers to change.*

Improvements can be made with little financial and time investment (Bowles, Mackintosh & Torn, 2001), however some reasons why these services are not as developed as top-down guidance recommends have been highlighted. Chiesa and Fonagy (2000) proposed that the level of attrition in their study was attributable to a lack of acceptance of the research by staff and patients, highlighting the damaging effect of stakeholders not believing in a project. There were also practical limitations including resources, time and staffing (Stevenson et al., 2003; Dodd & Wellman, 2000). The development and implementation of psychosocial services requires

adequate, stable staffing and effective leadership and management from above the ward manager level (McCann & Bowers, 2005). Yet staff found managers to be unavailable and felt unappreciated and in need of help to work through difficulties with patients (Flood et al., 2006).

The review highlighted that psychosocial services are a vital part of the care pathway for patients. Staff also benefit from increased knowledge and skills, by feeling empowered and better equipped to care for patients. Improvement may be limited however if the organisational context is not included in a process of change.

The current review has revealed a complicated picture. The long-standing concerns about inpatient mental health wards have led to an ongoing negative perception of services, supported by disappointing and critical reports and audits. This has created a culture of blame, which usually targets those on the ground, particularly nursing staff. This narrow focus has ultimately prevented effective change from taking place. This has been reinforced by the traditional service focus upon medical interventions, making integration of alternative interventions difficult to achieve.

As well as these wider organisational considerations, the current economic climate cannot be ignored. The current review has highlighted the need to increase the number of psychologists in order to effectively and safely develop and implement psychosocial services for both patients and staff. The position of psychologists within services however, is currently being challenged. Their numbers are being reduced and services increasingly want psychologists to focus on direct client work at the expense of other roles including consultation, systemic work and research. Considering the paucity of research in this area, there also needs to be more robust research being conducted in order to increase knowledge about what services are

effective within this environment, thereby improving clinical practice. Again, this would necessitate releasing psychologists from direct clinical work. This may not be desired by Trusts, but may also be difficult to achieve due to the current economic challenges.

## *5.2 Methodological Limitations*

There was an absence of controlled studies, however to undertake controlled studies within inpatient environments would be difficult to achieve, considering their unpredictable and complex nature. Despite the complexity of inpatient environments, there was a focus on quantitative methodology. When qualitative methodology was employed it was less robust than its quantitative counterpart. There was also an absence of robust client data, often appearing as an add-on to staff reports. Additionally, it was often collected by professionals or those connected to the research. As a result, patients may have been reluctant to criticise services and professionals. This introduces concerns about response bias and limits the reliability of claims that knowledge and skills were transferred to clinical practice.

There tended to be reliance upon self-reports. These sometimes suffered from low response rates affecting the reliability of results and ability to generalise findings. Lucock, Leach, Iveson, Lynch, Horsefield and Hall (2003) highlighted that questionnaires may miss important data and emphasised the limitations of relating statistical improvements to clinical outcomes. Self-reports can also lead to biased responding and therefore lack objectivity (Robson, 2002). This was compounded by the absence of patient data. Finally, it is possible that some outcomes were affected by extraneous variables; the inclusion of control groups would have strengthened the reliability and validity of some research.

### *5.3 Clinical Implications*

Research has demonstrated that services of a more psychosocial nature have the potential to positively impact upon functioning and therefore relapse. In line with current political thinking, the review highlighted the idea of the nurse as therapist. Both staff and patients have been demonstrated as benefiting from staff increasing their therapeutic knowledge and skills. Services may therefore, have a duty to increase these skills. It is important however, that services increase their provision of staff training to enable nurses to perform therapeutic roles.

This would represent a major shift from the traditional nurse's role and would potentially require such training to be integrated into nurse training. For some already working as nurses, the change in role could be too great and could potentially result in experienced nurses either underperforming or leaving the profession. Implications of nurses undertaking therapeutic roles may go wider than the nursing profession, if services feel they can 'get by' with staff who have had minimal psychological training. This could potentially affect the future of those who undertake extensive psychological training.

The review however, discovered difficulties faced by inpatient staff which impacted upon their ability to implement services. Aside from resource constraints, staff were found to be unsupported and experiencing psychological distress. If services are now expecting staff to undertake therapeutic roles, they need to be held accountable for helping to protect staff from burnout, which would reduce staff sickness and turnover, having further ramifications for improved patient care. Services including supervision and reflective practice will be crucial.

#### *5.4 Future Research*

Considering the evidence-base for the effectiveness of psychosocial services within inpatient environments, it would be useful to further explore obstructions to change and improvement. The aim would be to develop suggestions regarding how the implementation of top-down guidance and empirical recommendations can be facilitated within inpatient services. Top-down guidance is aimed at the staff level who are then required to drive initiatives. In addition, the acute inpatient environment is complex and multifaceted. A qualitative design exploring the fundamental nature of the environment and staffs experiences and priorities would be appropriate.

Considering findings related to organisational barriers to the development of psychosocial services, it is appropriate for research to include samples from staff groups other than nurses. To include multi-disciplinary colleagues and management personnel, particularly those at the service level, would serve to build on the research of Bowers et al., (2006; 2008). This would also place the focus where it seems most appropriate - at the organisational level - rather than at individual staff on the ground. Action research in particular, appears to be a useful tool in helping staff and organisations to develop services, as opposed to merely highlighting the changes needed.

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## **Section B**

### **Research Report**

A qualitative study of staff experiences on an adult acute mental health inpatient unit:

Implications for the development of psychosocial aspects of the service.

Shelley Parkin

## 1.0 Research Report Abstract

**Purpose:** The research explored the experiences and priorities of staff working in adult acute mental health inpatient units, regarding the role of psychosocial services. The aim was to consider how this differs to and affects the implementation of national guidelines and scientific recommendations regarding these services, with a view to making suggestions regarding more effective implementation. **Method:** Eight staff members participated in a semi-structured interview. Data was analysed using grounded theory. Categories were developed from data that emerged from interviews. **Results:** The ward environment appeared to be an isolated place, functioning in a reactive way to daily challenges. There was a lack of team work and effective leadership and staff expressed feelings of being powerless, unsupported and undervalued. Under the reign of the medical model, there was a sense of hopelessness about patient progress and a lack of understanding about patients and their own feelings towards them. Staff were experiencing a lack of professional confidence, performance anxiety and fear of change. Although there was a sense that radical organisational change was needed, staff did not feel equipped to cope with even small scale changes, resulting in an overall ambivalence towards change and improvement. **Conclusions:** There is a clear role for psychologists in the training and modelling of psychosocial services and in providing therapeutic services for staff including, clinical supervision and reflective practice. Organisational consultancy is also needed to increase effective teamwork, leadership and staff input into service development.

## **2.0 Introduction**

### ***2.1 Background***

Despite research demonstrating their effectiveness and recommendations of top-down guidance, little in the way of psychosocial services is being delivered within acute inpatient facilities in the UK. A focus on medication (Sainsbury Centre for Mental Health; SCMH, 1998) and a lack of multi-disciplinary team working (SCMH, 1998; Healthcare Commission; HCC, 2008), limits the provision of services including psychology, occupational therapy and psychosocial services generally. Staff have also been found to have a “hard” attitude towards patients (SCMH, 2006) and there is a notable absence of staff-patient contact (SCMH, 1998; HCC, 2008).

Brief psychosocial services improve symptoms and functioning (Dodd & Wellman, 2000; Chiesa & Fonagy, 2000). Just talking to patients about their future and hopes can encourage a positive outlook and increase feelings of acceptance (Ferraz & Wellman, 2009; Pitkanen, Hatonen, Kuosmanen & Valimaki, 2008). Therapeutic groups increase skills, reduce distress and promote inclusion through normalising experiences and empowering patients (Romme, Honig, Noorthoorn & Escher, 1992). This leads to reduced reliance upon medication (Grandison, Pharwaha, Jefford & Dratcu, 2009) and positive effects upon mood, recovery, confidence, social interaction (Iqbal & Bassett, 2008) and relapse (Kern, Glynn, Horan & Marder, 2009). Staff benefit from working in a more therapeutic environment (Grandison et al., 2009) and are empowered through increasing their knowledge and skills (Dodd & Wellman, 2000; Hosany, Wellman & Lowe, 2007).

### ***2.2 Research in Context: Obstructions to Psychosocial Services***

Although research has focussed predominantly on nursing staff, it has developed insight into difficulties faced by acute inpatient services, which may

provide some explanation of what hinders the development and implementation of psychosocial services.

### *2.2.1 Difficulty coping with exposure to trauma.*

Some staff believe colleagues to be unmotivated to deliver therapeutic interventions (Grandison et al., 2009). Westhead, Cobb, Boath and Bradley (2003) however, discovered that nurses are anxious about how to deal with issues including abuse and trauma, rather than unmotivated. Inpatient staff are often exposed to distressing patient material (Wurr & Partridge, 1996) and experience being both idealised and disliked by patients (Fagin, 2001). The ward atmosphere can become characterised by dynamics such as, splitting, re-victimisation and detachment (Davenport, 2002) as staff attempt to deal with their emotions.

Defences include emotional withdrawal (Megens & Van Meijel, 2006) and the struggle to understand patient's difficulties and how they developed (Fagin, 2001). Staff difficulties dealing with their and their patient's emotions contributes to treatment drop-out, acting-out, a lack of therapeutic interactions (Davenport, 2002) and reduced empathy for patients (Jones, 2008), culminating in a less than therapeutic environment. The outcome can also be poor for staff, with increased sickness, low job satisfaction, high turnover (Davenport, 2002) and dissatisfaction associated with spending the working day in the nurse's office (Fagin, 2001). This affects the development of the secure base needed to develop and maintain a positive therapeutic alliance (Thurston, 2003), reinforcing patient's insecure patterns of attachment and failing to ameliorate staff feelings of stress.

### *2.2.2 Lack of support.*

A lack of opportunity to discuss patients leaves staff with limited understanding of their feelings and their patients (Fagin, 2001). Fagin (2001)

proposed that supervision alongside training in psychodynamic concepts would enable nurses to interpret patient's behaviour and provide therapeutic services. He believed it would be beneficial to allocate time within team meetings to discuss feelings and behaviours towards patients within a supportive environment.

Teams often contain conflicts which can be identified and accentuated by patients (Fagin, 2001). Conflicts between different disciplines can make some staff groups feel relegated and demoralised. Thurston (2003) linked conflict to feelings of failure and proposed that when individuals experience feelings of failure, they become self-absorbed and use defences including projection and splitting to reduce internal distress. This further reduces team cohesion and effective patient care. Increased opportunity to discuss group processes and patients responses to them could reduce difficulties (Flood et al., 2006) and increase staff morale, which is crucial for effective practice (Jones, 2008).

### *2.2.3 Difficulty adapting to change.*

Staff difficulty engaging with new ways of working has been noted, making it difficult to promote change. When undertaking a project to reduce conflict and containment on acute psychiatric wards, Flood et al. (2006) experienced direct challenges from staff. These took many forms including suspicion and lack of acceptance due to conflict with the conventional nurse's role. Those who had been in the service for many years were particularly likely to challenge projects through non-compliance (Brennan, Flood & Bowers, 2006).

### *2.2.4 Resource constraints.*

Often staff lack the supervised support needed to implement new skills (Tarrier, Barrowclough, Haddock & McGovern, 1999). There are also practical constraints on the implementation of psychosocial services, including limited

appropriate space for groups (Brennan et al., 2006), time and staffing (Stevenson, Jackson & Barker, 2003; Dodd & Wellman, 2000). Wards are often reliant upon agency and bank staff who are less familiar with the ward and viewed as less committed. As a result, staff remain over-stretched despite having a full ward team (Brennan et al., 2006).

#### ***2.2.5 Service configuration.***

Systems make the development and implementation of skills and services difficult (Corrigan, 1998). According to Lelliott, Bennett, McGeorge and Turner (2006), the amount of top-down guidance and management relating to performance and targets are themselves barriers to change within acute inpatient environments. This is further affected by repeated reconfigurations of NHS services (Smith, Walshe & Hunter, 2001). Provision of psychosocial services requires adequate and stable staffing as well as effective leadership and management (McCann & Bowers, 2005). Lelliott and Quirk (2004) found that clinical staff felt service managers were more concerned with safety, cost and turnover rather than care and that there was no time for therapy as a result. This leaves nurses with the challenge to deliver care whilst trying to move patients on quickly (Lelliott & Quirk, 2004). This inevitably leads to a focus on “nursing duties”, limiting the ability to meet service users needs (Richards, Bee, Loftus, Baker, Bailey & Lovell, 2005).

#### ***2.2.6 Summary.***

To provide a therapeutic service, staff need to try to understand patients and their feelings towards them (Fagin, 2001), however the reality is that they often have neither the physical time and space or the emotional and intellectual support to do so (Fagin, 2001; Westhead et al., 2003). In the absence of support, staff can resort to maladaptive coping strategies including emotional withdrawal (Megens & Van



Meijel, 2006) and absenteeism (Fagin, 2001; Davenport, 2002). As a result, the therapeutic relationship is affected; reducing patient outcomes (Richmond & Roberson, 1995) and the provision of psychosocial services.

Top-down guidance seems insufficient to produce change and improvement and instead may contribute to staff feeling deskilled and burnt-out, further reducing patient outcome. Development of psychosocial services including the therapeutic relationship is affected by organisational factors including structure, ward culture and stress (Porter, 1993). As a result, the service as a whole is responsible for service provision, not just the nursing staff.

### *2.3 Rationale for Research*

In 2002 the SCMH (2006) began the Search for Acute Solutions project in response to findings from their original 1998 study. Many wards improved access to activities of both a therapeutic and social nature. It was acknowledged however that further improvement was needed. Concerns about acute inpatient facilities are long-standing and although audits and reports repeatedly find the same difficulties, there is a lack of consideration of *why* services are under-performing. According to Brennan et al. (2006) consequences of the system for acute ward staff has not been adequately considered. In addition, research is lacking that specifically addresses difficulties associated with the development and implementation of psychosocial services. Research is needed that describes the psychosocial qualities of the environment as a whole and processes underlying the development of ward atmosphere (Thomas, Shattell & Martin, 2002).

#### *2.3.1 Research site.*

Upon the report from the HCC (2008), concerns were raised within the Trust, which formed the site of the research, regarding the atmosphere of their inpatient

wards. Specifically, concerns have been raised regarding the provision of therapeutic services and promotion of recovery and social inclusion (Care Quality Commission, 2008). Improvement was also needed within workforce input into services, clinical supervision and leadership training for ward managers.

### *2.3.2 Clinical implications.*

Developing insight into difficulties faced by acute inpatient staff could identify the need for specific training and support services, as well as wider implications for organisational change. This may lead to the development of roles for other professionals including psychologists to promote rehabilitation and provide services including supervision and reflective practice.

## *2.4 Aims and Objectives*

The current research utilised the grounded theory approach (Charmaz, 2009) to explore the experiences of staff on adult acute mental health inpatient wards. The objective was to understand how staff experiences and priorities impact upon the development of psychosocial services. The research aimed to discover how the implementation of top-down guidance and empirical findings could be facilitated.

## *2.5 Research Questions*

The research questions, based on the literature, the top-down guidance and local service concerns, were as follows:

- How would staff like to develop the service within which they work?
- How do their ideas correspond with top-down guidance and empirical literature regarding the development of psychosocial services?
- What can be learned about obstructions to the development of psychosocial services in an acute inpatient service?

### **3.0 Methodology**

Chronology of the research process is available in Appendix D and ethical approval is presented in Appendix E.

#### ***3.1 Design***

The current study explored experiences and priorities of staff working in adult acute inpatient units. Considering the complex and unpredictable nature of the environment, experiences and priorities were likely to be influenced by multiple factors. Additionally, government reports detailing difficulties relating specifically to the participating Trust had not been widely disclosed. What may have arisen during interviews was therefore largely unknown and would need to be researched using an exploratory method. The data therefore was qualitative as the methodology is more suited to research where there is little existing theory and that is more exploratory in nature (Robson, 2002).

##### ***3.1.1 Choice of method.***

Data gathered via audio-taped semi-structured interviews was transcribed and qualitatively analysed utilising grounded theory approach (GT: Charmaz, 2009), deemed useful in research with unclear or little existing theory (Robson, 2002). In contrast to Interpretive Phenomenological Analysis, the current study was not looking at individual experience but at the social processes of the environment. The aim was to generalise findings to acute inpatient units nationwide. GT was appropriate owing to its ability to explore social context.

The methodological aim was to allow theory to develop from the data, relating to the context of acute inpatient units. To allow categories to emerge, analysis coincided with data collection constituting the Constant Comparative Method to achieve data saturation. Participants were interviewed according to whether they

could develop emerging theory. Conclusions and implications were drawn from categories which emerged within the data.

### ***3.2 The Service***

The acute inpatient service of the participating Trust was spread across two sites. The service had eight wards, the majority being mixed sex wards. Most patient's difficulties related to psychosis and the average length of stay was 20-30 days. The unit had no dedicated psychological service and attempts to develop such services had had limited success. Partly as a result of concerns regarding the functioning of the unit and the provision of therapeutic services, the organisation readily expressed interest in the current study.

### ***3.3 Interviews***

Interviews were semi-structured, allowing a focus whilst remaining flexible through open-ended questions to explore participant's responses, clarify misunderstandings, facilitate rapport and allow assessment of beliefs and knowledge (Robson, 2002). The open design and ability to explore heightens the possibility of uncovering interesting and unexpected responses. Semi-structured interviews enable modification of interview structure and inclusion and exclusion of items depending upon relevance, adding depth to interviews and results.

#### ***3.3.1 Rationale for interview design.***

According to Charmaz (2009), professionals tend to avoid disclosure of personal opinions and experiences by regurgitating "public relations rhetoric". Similarly, according to Hollway and Jefferson (2002) "defended subjects" often adopt discourses including generalisations, for the same purpose. The timing of the research, amidst national concern regarding acute inpatient care and the occupation of the principal investigator increased these threats to validity.

To avoid these potential methodological difficulties, anecdotal evidence and open-ended questions were more suitable than closed questions and answers. Charmaz (2009) advocates broad open-ended questions to allow participants the rare opportunity to reflect upon their thoughts and experiences. This was important for participants in the current study given literature highlighting staff feeling overwhelmed in their roles. It also encourages responses that are not the result of careful consideration (Charmaz, 2009). Similarly, according to Hollway and Jefferson (2002), story telling, relevant to anecdotal evidence, allows participants to engage in free association, providing insight into what they consider to be significant.

Although a narrative approach carries potential problems including inaccurate memories (Hollway & Jefferson, 2002), the principal investigator believed that participant's memories and what they chose to emphasise provides valuable insights into staff experiences. Anecdotal evidence also allows exploration of participant's actions as opposed to just words. Describing actions allows exploration of how social processes are constructed through behaviour (Charmaz, 2009). This suits the essence of GT and the epistemological stance of the principal investigator (Appendix F).

### ***3.4 Procedure***

This section is presented according to the stages that the principal investigator progressed through in order to conduct the research. The procedure regarding developing the interview schedule is detailed. This includes the framework adopted and the pilot process. Also detailed, are subsequent developments of the schedule based upon emerging categories, to aid theoretical sampling and theory development. The nature of the sample and the recruitment process, including the rationale underlying theoretical sampling, are also detailed. The forth section describes how the interviews were conducted, including gaining consent from participants. Lastly,

the rationale for the approach to transcription is presented, according to the epistemological position of the principal investigator and the intention of the research to explore the social nature of the inpatient environment.

### *3.4.1 Development of interview schedule.*

The interview schedule followed the pattern outlined by Robson (2002), summarised in Table 3.

**Table 3:** Interview framework

Procedure	Purpose
Introduction	Study purpose, confidentiality and right to withdraw. Permission to tape interview
Warm up	Non-threatening questions to settle participant and principal investigator into interview
Main body	Key headings and questions. Order can be altered depending on interview flow. More “risky” questions asked later to encourage cooperation and reduce information loss. Alternative questions and prompts devised for differing answers.
Cool off	Easy questions to help participants feel at ease again
Closing comments	Thanking participants. Ending interview. Reminder about research procedures including withdrawing consent.

Interviews aimed to explore the occupational experiences of staff to help understand the development of their beliefs and priorities regarding the role of psychosocial services. The interview schedule (Appendix G) was designed by the principal investigator and piloted on a Trainee Clinical Psychologist to ensure it was understood and gained relevant information. Some items were rephrased to make

them more focussed and the use of items encouraging anecdotal evidence increased, owing to the richness of resulting responses and their ability to capture experiences more vividly.

The flexible approach employed allowed further development of the schedule to aid theoretical sampling (see Appendix H). Changes were minor however, to preserve consistency and mainly concerned the topic “experiences with patients”. When interviewing Psychiatrists the topic was altered to include the team. This allowed exploration of emerging categories regarding feelings of powerlessness among nursing staff. When interviewing the Improvement Lead it was altered to allow exploration of emerging categories relating to staff difficulty embracing change. The last item on the schedule was also altered after the first three interviews as the original question restricted responses.

#### ***3.4.2 Participants.***

The service manager was keen to increase research within the service. As a result, all acute wards were given the opportunity to participate. National guidance is aimed at staff who are then required to drive initiatives. Therefore participants were staff and not patients. Eight people volunteered. Demographic information is presented in Table 4 on the following page.

**Table 4:** Participant Demographic Information

Participant Information	Total sample	Male	Female
Sample size	8	1	7
Age group in years			
18-30	3		3
31-40	3	1	2
41-50	1		1
51-60	1		1
Ethnicity			
White British	7	1	6
Asian	1		1
Role			
Nurse	2		2
Health Care Support Worker	2		2
Occupational Therapist	1		1
Psychiatrist	2	1	1
Improvement Lead	1		1
Time in role			
Up to 1 year	4		4
2-5 years	2	1	1
6-10 years	1		1
11-15 years	1		1
Time in Trust			
Up to 1 year	2		2
2-5 years	1	1	
5-10 years	3		3
11-20 years	1		1
21-30 years	1		1

The sample included two Nurses, two Health Care Support Workers, two Psychiatrists, one Improvement Lead and one Occupational Therapist. All participants but one were female and the majority were aged between 18-40 years. Most had been in their current role for up to one year and in the Trust for up to ten years.



### *3.4.3 Recruitment of participants.*

The principal investigator introduced the study at a departmental meeting, attended by the Clinical Nurse Manager and Ward Matrons. Participant Information Sheets (Appendix I) were distributed, detailing the nature and aims of the study. Matrons were asked to display these in staff ward areas, making it easier for staff to refuse to participate. All staff were made aware of the research by a member of their team rather than through direct contact initiated by the principal investigator. The aim was to reduce the possibility of forced participation and subsequent biased data as a result of responding in a socially desirable way. Interested participants were required to contact the principal investigator directly to ask questions and arrange a time for the interview.

Initially, recruitment focused on nursing staff as research relates to this group and they have the most direct experience of the ward. As the study proceeded however and theory emerged, it was necessary for information to be more specific to the research aim. The principal investigator judged that multi-disciplinary colleagues would develop new insights. As a result, theoretical sampling was employed. According to Robson (2002), using the constant comparative method of grounded theory, achieved by simultaneous data collection and analysis, reduces potential threats to validity in the form of researcher bias. The method ensures that data collection and theory development are driven by the emerging data rather than the preconceptions and preferences of the researcher.

Psychiatrists were recruited, as categories relating to power emerged and they appeared to be representing an important group in terms of possessing power. The experiences of occupational therapists, as the only staff group providing therapeutic provision, were important for developing theory relating to potential obstructions to

the process. Finally, the experiences of an individual whose role entailed implementing change, including an increase in therapeutic provision, were important for developing insight into obstructions to change. These participants were made aware of the research by a member of their team via email. The Participant Information Sheet was attached and if they wished to participate they contacted the principal investigator directly.

#### *3.4.4 Interviews/administration.*

Once contacted by a participant, the principal investigator visited the unit to conduct the interview. Interviews took place away from wards to minimise distractions and facilitate open discussion. The study purpose was reiterated, their questions answered, their interest confirmed and the consent form signed (Addenda A). It was made explicit that consent could be withdrawn at any time by contacting the principal investigator. Interviews were audio-taped and transcribed (Addenda B). Participants were referred to by numbers to preserve anonymity.

As recommended by Charmaz (2009), to enhance data richness, the principal investigator kept a research log documenting the context of interviews. This included consideration of the interview itself, participants affect, events preceding the interview and the interaction with participants. The principal investigator also documented preconceived ideas and conflicts of role to reduce potential bias (Rolls & Relf, 2006). An excerpt from the research log is available in Appendix J.

#### *3.4.5 Approach to interview transcription.*

The principal investigator chose the denaturalised approach to transcription (Oliver, Serovich & Mason, 2005) as the most suitable method. A full explanation of the approach is presented in Appendix K. Those who use this approach are interested in the individual's meanings and perceptions that construct reality (Cameron, 2001,

cited in Oliver, Serovich & Mason, 2005) and as such take account of the social nature of that under study. Oliver, Serovich and Mason (2005) suggest that the denaturalised approach suits GT methodology as such research is specifically interested in the meanings and perceptions about social phenomena that are shared during interviews, thereby suiting the principal investigators epistemological position.

### 3.5 Analysis

Interviews were analysed using GT (Charmaz, 2009). The aim is to generate theory from the data by developing initial categories, defining relationships between them and developing core categories. Table 5 describes data analysis according to Charmaz (2009).

**Table 5:** Process of GT analysis

Level of analysis	Procedure
Line coding	Coding of words, sentences or paragraphs. Derived from the data rather than pre-conceived.
Focused coding	Selective, specific, brief and conceptual. Broader significant or frequent codes to explain larger pieces more accurately.  Information becomes whole again. Consideration of categories, relationships between codes and gaps in the analysis.
Conceptual categories	Identifies ideas, events and processes. Codes which best capture what is happening in the data are raised to conceptual categories.  May identify themes and patterns in several codes. Consideration of main phenomenon, conditions under which it arises, consequences and interactions. Hypotheses are developed.

### ***3.5.1 Coding.***

Data analysis began after an initial three interviews. This allowed the principal investigator to further interview participants who were judged able to develop insights. The principal investigator interviewed eight participants and was satisfied that no new insights were being gained. Inter-rater checks were performed with colleagues to enhance the validity of the results. Although rater's used differing codes to represent data, they related to similar phenomena. The principal investigator therefore judged the analysis to be reliable. Table 6 provides an example of the coding process.

**Table 6:** Example of coding

Focused coding	Excerpt	Line coding
Feeling powerless	<p>... it's really <u>interesting</u> to see erm, how much influence they have over certain things./ Erm you know, you may have been <u>shouting</u> about something for months, <u>years</u> even wanting to get change,/ <u>they</u> come down and do a visit,/ within a month by the time the next person comes 7 times out of 10 something's happened regarding that issue that was brought up/ whereas <u>before</u>, you could be god <u>banging</u> somebody's door down to want to get something done and it's not/...</p>	<p>Power held by others</p> <p>Feeling</p> <p>ineffective. Executive visit</p> <p>Power held</p> <p>by others</p> <p>Feeling</p> <p>ineffective</p>

### 3.5.2 Category development.

Categories were developed as analysis progressed. As a result, categories altered as new information encouraged their reorganisation. The record of category development is available in Appendix L. Table 7 demonstrates how many categories originated from each interview.

**Table 7:** Origin of categories

Interviews	Number of categories
Interview 1	18
Interview 4	6
Interview 6	3
Interview 7	1

Interviews 2, 3, 5 and 8 supported data from the above interviews but did not generate new categories. As a result, the data was considered saturated. These twenty-eight categories were organised into ten main categories, based on overall meaning, to present a concise representation of the results. These ten categories are presented in the Results section along with a process model, demonstrating their circular nature. The principal investigator then developed the core category “needing change but unable to effect change”, which represented the overall finding from the research. Appendix M contains an early process model, allowing the reader to see how the principal investigators thinking changed to allow the development of the current model.

## 4.0 Results

The core category is defined first. The main categories are then described, as well as those categories which comprised them to allow the reader to understand how the principal investigator made sense of the material. Negative cases are also highlighted to ensure a reliable presentation of the results. For further quotations illustrating categories, see Addenda C.

### *4.1 Needing change but unable to effect change*

This represented the overall finding from the research. The main categories highlighted a need for radical organisational change as well as a difficulty embracing it. Some staff wanted change within how the system operated and findings of isolation, disempowerment and demoralisation supported this need. Staff expressed feelings of being overwhelmed by the demands of their role including coping with patient's emotions and behaviour, being under-resourced and receiving inadequate Trust support. There was a ward culture of 'getting on with it' in response to distressing patient experiences and the environment was one of containment as staff focussed on medication and activity. A diagrammatic presentation of the development and maintenance of the ward environment is presented in Figure 1, at the end of this section.

### *4.2 "The medical model seems to rule"*

Definition of category and distribution of material

All interviews highlighted that not only was medication prioritised above other forms of treatment but it was seen as the only truly essential treatment for patients. There were low expectations of patients regarding their ability to engage in other treatments and a belief that patients do not change in the long-term. There was also a strong sense of tradition in terms of the nurse's role revolving around dispensing

medication. This traditional way of working seemed to influence less favourable attitudes towards the value of other treatment modalities that were not medically led. Non-medical treatments were therefore conspicuous by their absence.

#### **4.2.1** *“The medical model will always come first”.*

Many factors contributed to the dominance of the medical model including the number of consultants and the time allocated to ward rounds and handovers which were seen as excessive by some. Participant four reported that “The medical model will always come first...” [pg 6, 141-2] because of “...old school attitudes of the nurses that have been taught the medical model is the only way” [pg 22, 541-2]. Some nurses believed that “...the main task is giving out medication” [Participant 4, pg 21, 503-4]. As a result, medication was relied upon to treat emotional expression by patients:

“It’s just a case of someone’s feeling down or...emotional...lorazepam or diazepam are thrown at them. There’s not any...do you want to have a chat about it...express your emotions or anything. It’s diazepam” [Participant 4, pg 5, 115-9].

This impacted on non-medical professionals. Participant eight, an Occupational Therapist felt that “...because it’s not a medical model...OT’s have to justify what they do...” [pg14, 328-9] and “...sometimes you can do a report and that might not be taken into account...” [pg 20, 476-7].

#### **4.2.2** *Psychology do we need it?*

Participants regarded psychological intervention for patients as a possible addition or luxury, being “...something to consider if we wanted to...” [Participant 6, pg 9, 219-20]. Participant one performed a cost benefit analysis of implementing



psychological input by considering "...what you would have to trade in..." [pg 13, 308-9]. Whilst these are justifiable concerns particularly in the current economic climate, the same participant also reported "...I'm not sure it would benefit [ward] an awful lot..." [pg11, 261,].

#### ***4.2.3 Patients do not change.***

There was pessimism about patient progress. References were made to the fact that "...my patients have...been in the service for a long time..." [Participant 1, pg 6, 130-1] and "...they are constantly in and out of hospital..." [Participant 1, pg 6, 132-3] suffering frequent relapses. Rehabilitating patients when "...they're not new...[and] they don't...present with new symptoms" [Participant 1, pg 6, 133-4] appeared a hopeless task. It was also reported that "...they aren't the most motivated of patients" [Participant 1, pg 12, 288] and they...have...engagement issues..." [Participant 1, pg 6, 131-2]. Beliefs about patients were used as justification for an absence of psychosocial services. This vindicated staff and the organisation for the lack of provision:

"...psychologically, I would say our patients don't engage in anything...because...one there's not an awful lot offered but secondly, I don't think they would engage in it" [Participant 1, pg7, 164-6].

This was made more explicit when discussing the minimal impact of a recent initiative to increase psychological input on the ward:

"...I haven't really seen any impact...I don't think that's from the services fault at all. I think that's...the patient group that we have" [Participant 1, g6, 131-2]

#### ***4.2.4 “Psychologically there’s not a lot on offer”.***

Within the inpatient unit “...the psychological model is secondary, if non-existent...” [Participant 4, pg 6, 142]. Participants reported that “...we don’t have any dedicated psychological work for anyone...” [Participant 5, pg 19, 452-3]. They made reference to the ward not being a quiet or nice place to be. Participant six stated “...I don’t see...the ward as...a place to have psychotherapy...” [pg, 11, 261]. These participants also recognised that patients may not be ready for therapy whilst an inpatient. Whilst participant’s had realistic concerns about the ward environment, their opinion was that medication should take priority and psychological treatment should be postponed.

#### ***4.2.5 Negative cases.***

Two participants did not view medication as the primary treatment priority and complained that “...as well as being drugged up all the time...they need...psychological input...” [Participant 4, pg 5, 113-4].

### ***4.3 Focus on activity***

#### **Definition of category and distribution of material**

A focus on activity relating to both staff and patients was found in five interviews. Despite patient activities referred to being of a physical nature, many participants felt that levels needed increasing to keep patients busy. Participants wanted practical support for themselves in the form of guidance to ensure they were ‘getting things right’. This focus on action was carried into supervision when participants spoke about it as an opportunity to monitor performance.

#### ***4.3.1 Focus on patient activity.***

Participants recognised the value of social activities for patients and regular reference was made to keeping patients busy, providing them with a “...sense of

purpose...” [Participant 1, pg 5, 115], “...structure...[and] meaningful activity...” [Participant 2, pg, 14]. Participants felt “...there’s never been enough activity...” for patients [Participant 5, pg 18, 424] and it was “...another area that’s lacking that could be improved” [Participant 2, 14, 339-40].

#### **4.3.2** *Focus on staff activity.*

Staff focussed on additional practical needs when discussing further support they required:

“...I would like someone to...guide me and...tell me when I’m doing things that perhaps I need a little help [with]” [Participant 1, pg 20, 494-6].

Participants used supervision in the same way, to “...brain storm...and pick out what we perhaps could have done and what we didn’t do...” [Participant 1, pg 8, 182-4].

#### **4.3.3** *Negative cases.*

Participant seven reported that they would “...like to see the development of...a more therapeutic environment on the wards...” [pg 39, 955-6]. In addition, two participants acknowledged having psychological needs that were not being met by the organisation. Participant six spoke about wanting formalised supervision:

“It’s about how...our patients make us feel and...the dynamics of the relationship...I think that’s what I miss...it is always useful...having some formal time to do that...and...debriefing over difficult situations...They can come along quite often” [pg 22-23, 541-551].

#### **4.4** *“Psychologically I just haven’t got a clue”*

##### Definition of category and distribution of material

This category evident in four interviews was promoted to a main category. Staff had little understanding of patient’s psychology. Even after assessing a patient, staff struggled to understand their thoughts, feelings and behaviour:

“I really don’t know how...his mind works...although we’ve had time to assess him...” [Participant 1, pg 23, 557-9].

The need for staff to increase their psychological knowledge was recognised by Participant six who acknowledged the role of psychology within this:

“...there certainly needs to be more psychological mindfulness within staff and...if there is a role for psychology...it is probably...within training staff” [pg 10, 225-7].

##### **4.4.1** *Negative cases.*

Three participants had some awareness of psychological phenomena. Participant five understood the role of historical context in an individual’s presentation:

“...he feels guilty about things in the past...” [pg 7, 154].

#### ***4.5 Putting a sticking plaster on the problem***

##### **Definition of category and distribution of material**

Occurring in three interviews, it was evident that "...what is currently provided is containment, medication and...minimal... support" [Participant 7, pg 39, 957-8]. Staff were described as "...bandaging people up all the time..." [Participant 4, pg 16, 388], portraying a reactive environment. Some participants recognised the need to be more proactive and felt that psychological interventions would:

"...reduce boredom...reduce symptomology...[and] give them time to express themselves...because there's a lot of tension between patients that isn't getting addressed which is causing problems in the long run" [Participant 4, pg 16, 375-80].

They also saw the advantages of low-level psychosocial interventions:

"...if we've had a relaxation group the whole atmosphere of the ward is completely different..." [Participant 4, pg 17, 415-6]

#### ***4.6 Isolated and unsupported***

##### **Definition of category and distribution of material**

In seven interviews it appeared that staff were working without adequate physical or emotional support. A sense of isolation ran through the system. Individuals worked independently, wards did not communicate with each other and services had difficulties co-working. Additionally, some staff felt unsafe in supervision and therefore chose not to utilise it. Staff felt they needed additional support to cope with the demands of the environment and developed what seemed to

be an exaggerated sense of team cohesion, using potentially unsuitable opportunities to share difficulties. Some staff expressed a desire to share their experiences with others in a structured group format.

#### ***4.6.1 Staff need “more robust support”.***

Staff expressed a need for more support. In contrast to the majority of participants who focussed on activity, some considered their emotional needs and felt that psychological services would be useful:

“...there really should be groups...where staff can go and talk about difficulties...and get some support from the other staff, from the facilitators actually” [Participant 6, pg, 29, 698-702].

Others recommended smaller changes to currently inadequate support systems:

“...a supervisor you could trust...somebody that’s neutral to the ward...so...you could talk about anything [and]...it wouldn’t get back” [Participant 4, pg 15, 350-5].

#### ***4.6.2 A sense of team support.***

The language some participants used to describe their team was perhaps somewhat idealistic. Many made reference to the team being “...all very supportive of each other...” [Participant 1, pg 3, 57-8]. Another participant stated:

“...we’ve got supervisors, we’ve got managers who are...brilliant...all of them, they are just lovely” [Participant 3, pg 9, 224-5]

One participant suggested that "...I don't think disagreements are helpful so I don't think we have them. I can't think of any at all" [Participant 5, pg 9, 210-2].

#### **4.6.3** *An intense need to share.*

Staff expressed a strong desire to share difficulties with colleagues including using "...handovers...[as] a form of...informal supervision..." [Participant 2, pg9, 208-9]. Sometimes the need appeared so strong that people felt a need to tell others about "...everything that I'm doing..." [Participant 1, pg 18, 436].

#### **4.6.4** *Needing to feel contained.*

Some staff felt a need for somebody to tutor them and reported wanting "...somebody...to meet you...and ...say right what have you been given this month..." [Participant 1, pg 21, 509-12]. There was a sense of anxiety in their need to check things with managers as they spoke about a "...need to speak to them urgently..." [Participant 1, pg 19, 448] and having "...phoned up and ...went down within ten minutes and...managed to get a lot of things off my chest..." [Participant 1, pg 19-20, 471-3]. Others reflected more upon the stressful nature of the environment and the personal impact:

"...just for somebody...to say...it's ok for you to feel like that and it's normal...because at the minute I feel like it's not normal for me to feel like this" [Participant 4, pg 19-20, 471-4].

The same individual reported:

"...I feel like...I'm failing at my job because I am...unable to cope with it mentally at the minute" [pg 19, 467-9].

#### ***4.6.5 Feeling unsafe in supervision.***

The process of supervision was presented as arbitrary and unregulated as some “...colleagues...ask for supervision and don’t get it and a lot...don’t want it and avoid it” [Participant 7, pg 37, 970-10]. Some had experienced a lack of confidentiality when speaking to their supervisor:

“I don’t feel...safe...I don’t trust her at all. I’ve said things in the past to her that I was...struggling with and...somebody else was asking me about it that I hadn’t told” [Participant 4, pg 5, 100-3].

As a consequence although “clinical supervision in theory is available...the uptake is very low...” [Participant 7, pg 37, 904-7].

#### ***4.6.6 Isolated as a service.***

The inpatient service appeared isolated. Staff commented that “...the main challenge is trying to engage the community team on the ward...” [Participant 6, pg 19, 463-4]. There was a sense that people deliberately avoided the unit, leaving those in it to cope alone. There was talk of having to “...crowbar...” [Participant 6, pg 8, 180] and “...hound...” people to come in [Participant 6, pg 19, 470]. The sense of isolation was seen to impact upon staff safety:

“...we may have a patient admitted at 4 o’clock in the morning and not have anything on them, I think that’s wrong...we need to know where they’ve come from...what background they have...” [Participant 1, pg 27, 666-9].



#### **4.6.7** *“There’s very little joined up working”.*

Isolated working existed within the inpatient service itself and the individual ward environment. Within the team, reference was made to the staff “...all doing our things in silos...” [Participant 6, pg 27, 660] and needing a “...more...cohesive team...” [Participant 2, pg 11, 259]. Participant two agreed:

“...it would be good to get together as a ward and have...a day out for...team building...because...you don’t...see everybody and it’s hard to have...continuity...” [pg 10, 231-5].

Communication between wards was also seen to be lacking. Participant one commented that because a patient had “...come from another ward...I don’t know how he...functions...” [pg 23, 561-2].

#### **4.6.8** *Negative cases.*

In contrast to the majority, Participant eight, an Occupational Therapist felt they had “...quite a good network with the OT’s in the Trust” [pg 14, 336], having numerous groups to offer support and development of knowledge and skills.

#### **4.7** *“The culture is that staff don’t get affected”*

Definition of category and distribution of material

From two interviews it seemed that staff needed to be seen to be coping. They portrayed the image of not being affected by experiences of patient distress, intimidation, violence and death. In an attempt to cope with their experiences, staff seemed to treat the ward as a virtual world. They separated work from life outside and were seen to carry on without reference to past events as if they had not happened, keeping the focus on the present. This need to cope and to be seen to be

copied made it difficult for others to express their emotions through fear of not 'fitting in' and being seen as weak by colleagues.

#### ***4.7.1 "Staff aren't affected by what happens on the ward".***

Participant four remarked that "staff aren't affected by what happens on the ward" [pg 18, 425] and "everybody...seems...to just get on with it" [pg 11, 265-6]. This was attributed to the fact that "...the nurses...[have] seen a hell of a lot...so...it's just their way of carrying on, like it's normal..." [Participant 4, pg 11, 269-71]. Indeed Participant two remarked that difficult experiences with patients are just "...part of the job and...you have to get on with it...and let it go over your head..." [pg 8, 181-2]. Staff focussed on the present in order to cope:

"Everything that happened...means nothing. They don't mention it. They carry on with today..." [Participant 4, pg 12, 279-82].

#### ***4.7.2 Feeling is a weakness.***

Emotional expression was not valued by the ward. Staff avoided emotional language when describing their needs. Participant two corrected herself when talking about asking for others for "...not reassurance but some clarification..." [pg 9, 224]. Staff wanted to fit in believing that "...if they're not bothered then maybe I shouldn't be" [Participant 4, pg 11, 272-3]. The possible implications of disclosure were clear:

"...I don't feel comfortable...expressing my anxieties...because I'm...worried that they'll see it as a weakness..." [Participant 4, pg 13, 308-11].

### **4.7.3 Negative cases.**

The Occupational Therapist did feel comfortable acknowledging their emotional needs and gained benefit from doing so:

“...in my supervision contract it does say...to talk about...wellbeing...and...I’m comfortable to know that I can talk about anything...and I won’t be judged”

[Participant 8, pg 11, 261-5].

## **4.8 Feeling overwhelmed**

Definition of category and distribution of material

In all interviews was some indication that staff were struggling to cope with the many demands of their environment, despite perceived level of support. There was mention of staving off burnout as they tried to manage their roles with limited resources. This contributed to a lack of staff-patient contact but staff were also struggling to manage the emotions brought about through interacting with patients. In response, staff often restricted patient contact to something structured and purposeful.

### **4.8.1 “Feeling really busy, feeling stressed”.**

In keeping with the general focus on activity, many participants felt that “...the main challenge...is...trying to...juggle everything...” [Participant 6, pg 19,]. They questioned how they were going to “...prevent burnout” [Participant 6, pg 23, 568]. Staff reported feeling pressure due to the fact that “...we have no money to do anything, no staff to do anything and yet they want us to do everything...” [Participant 1, pg 33, 789-9].

#### **4.8.2** *“Stuck in an office answering phone calls and doing paperwork”.*

Staff made repeated reference to the burden of non-nursing duties and its preventative effect upon staff-patient contact. They complained about being “...forever tied up on telephones...” [Participant 1, pg 2, 48-9]. Staff felt that “...there’s no common sense anymore...everyone...has to have every bit of paper filled in whether they need it or not” [Participant 6, pg 26-7, 643-6], leading to “...duplicating yourself all the time” [Participant 1, pg 27, 660-1].

#### **4.8.3** *Struggling to manage emotions.*

Staff felt confused by their emotions towards patients, noting that “...all you kind of feel inside is you’re a really horrible person for doing what you’ve done” [Participant 1, pg 16, 395-6]. These emotions towards patients sometimes led to staff behaving in a way that they did not like:

“...I have seen it; staff getting cross with patients and...then patients getting cross back...and actually staff don’t come to work to get angry with patients...but it can happen...because of things that go on and...behaviours that happen on the ward...” [Participant 6, pg 30-1, 739-47].

The impact of working in such an emotionally provocative environment was described as high. Participant four reported that they were “...going home in floods of tears...” [pg 13, 319-20] and “...didn’t want to come into work this morning. I was tempted to ring...and say I...couldn’t cope...” [pg 10, 239-41]. Experiences with patients also impacted upon the functioning of the team:

“It’s tiring and it’s tiring and it’s making people feel quite drained and that’s when you...need everybody to be supporting each other but it’s very very difficult...”

[Participant 1, pg 17, 403-5].

#### ***4.8.4 Keeping staff-patient contact to a minimum.***

Limited time was spent with patients. Reference was made to having “...superficial conversation...” with patients [Participant 2, pg 5, 103] and restricting contact to mainly “...purposeful assessments” [Participant 2, pg 5, 102]. Speaking about nursing colleagues, Participant four noted:

“...I’ve never seen them sitting...in the communal area...reading the newspaper with them or...asking them what they’re doing for the rest of the day” [pg 17, 400-3].

Some staff felt that “...sometimes we just don’t know how to talk [to patients]” [Participant 3, pg 12, 283-4]. Others spoke about needing “...patience and tolerance over the person’s behaviour” [Participant 1, pg 10, 230-1]. Time spent with patients therefore linked with the ability to be with patients, as noted by Participant six:

“...I think the nursing staff do spend more time with patients...some of them anyway...the one’s that are good at spending time with patients...” [pg 34, 828-30].

#### ***4.9 Disempowered and devalued***

Definition of category and distribution of material

In seven interviews was evidence of staff feeling powerless and demoralised. Nursing staff felt they had little influence over the ward environment. Consultants

held the power regarding patient care. This made it difficult for nurses to use their own professional judgement. Decisions regarding the running of the wards were made by management without consulting those on the ground. They felt not listened to as their requests were ignored, and unimportant compared to patients, who they felt were regularly consulted about their experiences. The role of the nursing team had become one of following orders. Staff wanted more control over their work environment.

**4.9.1** *“We should have a much stronger nurse led philosophy”.*

It was remarked that staff “...don’t feel like they have much power...” [Participant 5, pg 24, 577-8] because “there’s a lot of top-down stuff...” [Participant 5, 25, 596]. They had little influence over decisions affecting the ward and wanted management to “...listen to what people are saying” [Participant 5, 24, 589]. They also felt that “...the service is too medically...led...” [Participant 6, pg 24, 579-80] and that “...the nursing staff need to take back control of the wards” [Participant 6, pg 24, 585]. Nursing staff felt disempowered as medical colleagues took charge of patient care:

“...we have two extremely...opinionated and strong willed doctors...[if] you...question a persons diagnosis...care and treatment...it goes in one ear and out the other” [Participant 1, pg 19, 460-464].

As a result nursing staff were either unable or reluctant to use their own professional judgement, needing to have “...every decision...rubber stamped...” [Participant 6, pg 25, 618-9] by the consultant and even resorting to using medical consultants reports to “...cut and paste...into their own documents...” [Participant 6, pg 26, 627-8].

**4.9.2** *“This organisation hasn’t done a lot to make people feel valued”.*

Staff felt demoralised by their lack of power and support from management.

Participant one reported:

“...staff attitude suffers because you feel like you’re constantly asking and it’s like...why can’t I just ask and...feel like its being done...” [pg 30-1, 743-6].

Referring to management, staff felt that “when they make changes, staff feel like they are never asked...” [Participant 1, pg 32, 782-3]. Staff felt “...let down...” by management [Participant 7, pg 12, 292]. Participant seven commented that staff are:

“...feeling mistrustful of managers...feeling that managerial commitment is...around areas of risk and...policies and procedures and making sure...you work the hours you’re meant to...staff feeling... that managers weren’t aware of how bad things were or didn’t really care” [pg 12, 276-85].

Staff felt also unimportant compared to patients:

“...staff...feel that patients are...more valued than staff...you have all these patient surveys...yet...when it comes to staff all they get given are orders shoved in front of their face...” [Participant 1, pg 32, 783-787]

#### **4.10** *“Staff safety is compromised”*

##### Definition of category and distribution of material

Four participants made reference to feeling unsafe on the ward. Staff described an environment housing people in a “...paranoid psychotic state...” [Participant 5, pg 5, 112], with situations that are “...unpredictable...impulsive and just so dangerous” [Participant 1, pg 24, 588-9]. They described instances where patients are “...directing...threats...and verbal abuse at you...[and] they...gang up together which can...be quite intimidating...” [Participant 2, pg 8, 184-7]. This was made more difficult for staff to cope with by feeling that “...staff safety is sometimes compromised...just seemingly to save money...” [Participant 2, pg 12, 294-5].

#### **4.11** *Ambivalence towards change*

##### Definition of category and distribution of material

It was suggested that radical organisational change was needed in the way the service operates and approaches change. Trust commitment to initiatives was seen to be lacking. There was a history of fleeting initiatives rendering them meaningless to staff. As a result, those trying to implement them were given inadequate support from staff and the organisation. Although change was needed, it was difficult for staff to effect change partly as a result of reliance upon established ways of working but also due to having doubts about their capabilities.

##### **4.11.1** *“We probably need a big bang; a big change to what we’re doing”.*

There was a strong feeling that “...we need a whole systems change...rather than...these little projects” [Participant 6, pg 33, 804-6]. Staff felt that initiatives only make “ripples in a pond” [Participant 6, pg 32, 780] because “...the systems on the ward are exactly the same as they always were. So there’s no fundamental change in the way we all work...” [Participant 6, pg 33, 797-800]. Participant six felt that



change was needed that "...completely changes the way that we do things" [pg34, 820]. They felt this meant "...quite radically changing the way that we've been doing things in the health service for many, many years..." [pg 30, 724-5].

#### ***4.11.2 Initiatives: "They don't see the point in it".***

Nursing staff had difficulty embracing change because of "...rigid...old fashioned opinions..." [Participant 4, pg 20, 487-8]. They were described as "...not interested...because...that wasn't [around] when they were in their prime" [Participant 4, pg 21, 504-10]. It was also noted however that "there's so many initiatives...they're all a bit meaningless" [Participant 6, pg 33-4, 813-7]. Initiatives had a history of being "...big for a few months...[to] then...disappear and not deliver..." [Participant 7, pg 11, 251-4]. The resulting staff response to new ways of working was often a "...hostile reception...[and] cynicism..." [Participant 7, pg 25, 602].

#### ***4.11.3 Needing to work hard to engage staff in change.***

Those who tried to implement new initiatives found it "...difficult to persuade others to come along..." [Participant 7, pg 5, 108-9]. As a result they had to "...work...hands on and [be] heavily involved..." [Participant 7, pg 5, 104-5] to encourage and support staff. They would also need to be creative by considering "...what can you do to engage them and trying to have an ally on the ward..." [Participant 7, pg 15, 356-7].

#### ***4.11.4 "Fear of change".***

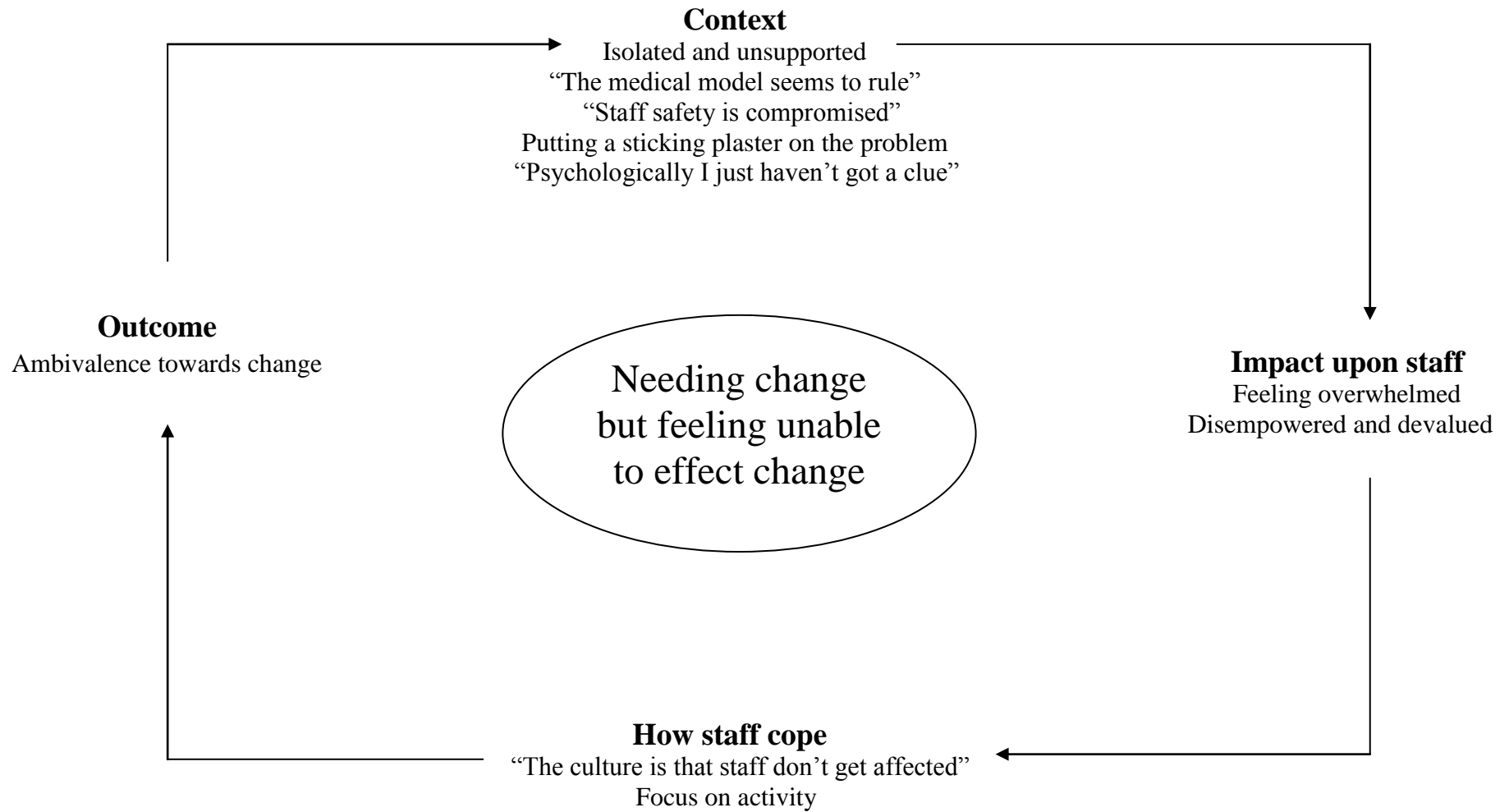
Change was viewed as difficult for staff who may not feel able to adapt. Staff were described as having "...a fear of change" [Participant 6, pg 30, 728] and "...worrying have I got the skills..." [Participant 6, pg 30, 730]. There is safety in the familiar as Participant six spoke about "...staff who have been in the health service

for thirty years...[having] a fear of the unknown...a fear of actually we'd all have to up what we're doing..." [pg 30, 726-9].

#### ***4.11.5 Negative cases.***

Not all staff had difficulty embracing change. Participant four referred to a younger nurse who was keen to implement different ways of working but was "...banging her head against a brick wall when it comes to the other nursing staff" [pg 21, 519-20].

**Figure 1:** Development and maintenance cycle: how the service functions



## 5.0 Discussion

A summary of the research and results will be presented first. The findings will then be discussed with relevance to the literature. This section will be structured according to the research questions posed and will focus on obstructions to service development. Lastly, there will be consideration of methodological issues, clinical implications and future research.

### *5.1 Summary of aim, method and results*

The current study explored experiences and priorities of staff working in adult acute mental health inpatient units, regarding the role of psychosocial services. The aim was to consider how this differs to and affects the implementation of national guidelines and scientific recommendations, with a view to making suggestions regarding more effective implementation. Eight staff members participated in a semi-structured interview. Data was analysed using grounded theory (Charmaz, 2009). Categories were developed from data that emerged from the interviews.

There was avoidance of the inpatient service by others, leaving staff feeling unsupported by managers and isolated from colleagues, other wards and services. Staff felt unsafe on the ward due to the unpredictable nature of patients and described feeling intimidated by them as a result. They felt undervalued as they perceived their safety to be at risk as a result of low staffing, dictated by a desire to save money. Decisions were made by consultants or by management without consulting those on the ground. Staff therefore felt disempowered and demoralised, as a result of feeling unable to use their professional judgement. To combat the isolation, some staff developed a strong bond with each other and resorted to using potentially unsuitable opportunities to share difficulties.

The ward functioned in a reactive way to daily challenges as staff struggled to cope with the demands of the environment. They wondered how they would prevent burnout as they tried to manage with limited resources. Staff also struggled to understand patient's difficulties and their uncontrollable and negative emotions towards patients. This contributed to a lack of staff-patient contact and activities with patients were usually left to occupational therapists as a result. Reliance on the medical model to explain patient's presentations contributed to this limited understanding of patient's thoughts, feelings and behaviour and possibly to the feelings of hopelessness about patient progress and lack of safety. There was a resulting over-use of medication and focus on activity, as staff tried to keep patients busy. Whilst some recognised the need to be more proactive and felt that psychological interventions could help patients in the long-term, there was a strong tradition around dispensing medication. This encouraged less favourable attitudes towards the value of treatment modalities not medically led.

Staff needed to be seen to be coping and so presented as if unaffected by their experiences. Staff were seen to carry on as if past events had not happened, focussing on the here and now. As a result, staff emphasised practical support for themselves, to the exclusion of their emotional needs. This made it difficult for others to express their emotions through fear of not 'fitting in' and being seen as weak by colleagues. It also impacted upon supervision, which was either not a priority or was used to monitor performance rather than used as a source of emotional support. This, along with breaches of confidentiality, led some staff to avoid it, reducing support further.

There was a sense that radical organisational change needed to occur. A history of fleeting initiatives, with little Trust commitment, rendered them

meaningless to staff. Consequently, those trying to implement change were given inadequate support from colleagues and the organisation. The main finding from the research was that although change was needed, staff felt unable to effect change. Staff wanted more control over the environment but struggled to cope with existing responsibilities. Nurses felt subordinate to consultants and were reported as relying on them unnecessarily to make decisions. Some consultants felt burdened as a result and wanted to return some control to nurses. Staff dependence upon the medical model therefore, although represented safety, further increased feelings of powerlessness and invalidation. There was also a fear of change, as staff worried they would be unable to adapt and would under-perform. Staffs doubts about their capabilities coupled with feeling overwhelmed, unsupported and demoralised, left them feeling ill-equipped to cope with even small changes. Consequently, they clung to traditional ways of working, further increasing these feelings.

## *5.2 Relationship of results to empirical literature*

### *5.2.1 How would staff like to develop the service within which they work?*

*and How do their ideas correspond with top-down guidance and empirical literature regarding the development of psychosocial services?*

Research has highlighted the psychosocial needs of staff, including an increase in clinical supervision and reflective practice (Fagin, 2001; Brennan, Flood & Bowers, 2006). For most participants however, clinical supervision was not a priority. Wards felt over-stretched and most staff concentrated on things that would make it more efficient and ease pressure on staff. They focussed on funding for staffing and beds and reducing paperwork viewed as unnecessary, but desired by management. Participants also wanted increased team work within the ward, unit and across services.

Staff appeared to be an invisible workforce and felt unimportant despite level of experience or seniority. Corresponding with findings from organisational research (Brennan et al., 2006), they wanted better communication with management and increased input into decisions which affected the ward. There was also a sense of anxiety about juggling their workload and getting things right. This felt akin to a fear of failure, resulting in a need for reassurance. As a result, staff felt they needed what appeared to be endless guidance.

The Sainsbury Centre for Mental Health (1998) and the Health Care Commission (2008) recommend increasing psychosocial services for patients, ranging from staff-patient contact to structured interventions. Most staff however, did not consider improvements relating to patients specifically, until prompted to do so. Participants valued the contribution of social input for patients, such as group activities, and wanted to develop this provision further. By way of contrast, most felt that psychological input was not appropriate within the ward environment or that it was unsuitable for their patient group. Some participants did want a more therapeutic ward environment but these participants were usually not based full-time on the ward. It may therefore have been easier for them to reflect on the needs of patients and embrace different ways of working that require additional commitment in terms of time and resources.

### *5.2.2 What can be learned about obstructions to the development of psychosocial services in an acute inpatient service?*

Fagin (2001) found that staff struggled to understand patient's difficulties, resulting in negative feelings towards them. According to Van Audenhove and Van Humbeeck (2003), high expressed emotion is particularly prevalent within nursing staff. The current research found staff to avoid patients and lose their temper with

them as a direct result of the ward environment. Some admitted to wanting a more managerial role and less patient contact. They wrestled with feelings that conflicted with the role of carer, including a lack of empathy, as also found by Jones (2008), resonating with reports of re-victimisation of inpatients (Fagin, 2001). This led to doubts about their ability and staff appeared plagued with feelings that they could be doing more. Staff were preoccupied with their own performance, consistent with findings of Thurston (2003), and were perceived as needing urgent containment. This left little room to consider needs of patients.

Staffs focus on activity was consistent with findings of Goodwin and Gore (2000). They reported this to represent a means of tolerating patient contact. Nurses in the current research however, were reported to not spend time with patients. Facilitating activity was left mainly to support workers and occupational therapists. Activity therefore, appeared related to a desire to keep patients busy in order to avoid contact rather than tolerate it. This seemed related to staff's sense of hopelessness about patients and possibly to their fears of under-performing. This reinforced feelings of impotence, failure and fear of patient contact. The traditional role of the nurse dispensing medication felt safe to participants owing to its familiarity and emotional distance from patients. Consequently, they clung to established ways of working at the expense of alternative and possibly better patient care. Over time this has created a reactive environment, perpetuating reliance on medication.

Patient improvement however is important for staff (Bray, 1999). They view more positively psychiatric wards in which they feel their role is significant as opposed to feeling inadequate (Hummelvoll & Severinsson, 2001, cited in Lelliott & Quirk, 2004) and report increased job satisfaction when they perceive patients as



progressing (Dorr, Honea & Pozner, 1980). Not equipping patients with the skills to prevent relapse meant that patients were frequent residents of the unit. Staff were therefore in a role that did not make patients better in the long-term. There was hopelessness about patient progress and low expectations regarding engagement in services, particularly of a psychological nature. This seemed to strengthen staffs resolve to resist psychological services.

There was the sense that the only way to cope with the emotional demands of the environment was to deny any emotional response to patients or the ward, as also described by Megens and Van Meijel, (2006). Consistent with findings of Davenport (2002), staff exercised detachment, and separated life from work. This culture led to considerable distress for some staff as they felt unable to seek emotional support. The lack of available organisational support possibly reinforced the perception that it was not needed.

There were implications for clinical supervision which is fundamental to a psychological service (Holmes, 2002). Reiterating findings of Inam (2001), supervision was not considered a priority, resulting in frequent cancellation. Its usefulness also seemed limited as nurses felt a need to present as coping, owing to a work history between supervisors and supervisees. Inam concluded that nurses were often in a position of having to sacrifice useful supervision to maintain positive working relationships. This was echoed in the current study. It also tended to be used as a tool for assessing performance and involved frequent breaches of confidentiality, resulting in avoidance. Nursing staff in particular felt overwhelmed and survived by developing a strong protective bond, the purpose of which, according to Brennan et al. (2006), is to defend themselves against the system and their managers. This would reinforce a 'them and us' mentality and further

entrench feelings of isolation and maladaptive coping strategies, leading to increased difficulty embracing change.

Parkes, Scully, West and Dawson (2006) conducted research into the role of managers in Primary Care Trusts. They concluded that top-down management is detrimental to job satisfaction, staff well-being and effective team working. Upon research with community and primary health care teams, West, Borrill, Dawson, Shapiro, Rees, Richards, Garrod, Carletta, and Carter (2002) proposed that effective leadership involves creating a team identity, flexibility, enthusiasm, optimism, confidence, acceptance of other professionals and learning from each other. None of these factors appeared present in the inpatient service. The attitude of staff was reported to 'suffer' as a result of being unable to influence their work environment, having their opinions and ideas ignored by management. Furthermore, staff were often unsure about who made decisions and policies and felt that no rationale for decisions was provided, as also found by Brennan, Flood and Bowers (2006). According to West et al. (2002) without a clear leader, there is a lack of clear objectives. Indeed, the roles of staff seemed confused, they felt over-stretched, being expected to do everything and yet found managers to be focussed on cost and turnover. According to Lelliott and Quirk (2004), this leaves nurses with the challenge to deliver care, whilst also trying to move patients on quickly. This would understandably reinforce the focus on medication.

West et al. (2002) found that a diverse range of professional expertise is linked to effective team work and better quality care, and that effective teams were more encouraging of innovation and accepting of change. Diversity was however, notably lacking, with for instance, no social workers or psychologists. According to Holmes (2002), as a result of staff feeling a need to protect themselves from

feelings aroused by patients, they can regard working with psychologists who advocate the owning of feelings, as scary. Indeed staff were actively resistant to new ways of working and to psychological input particularly. Echoing findings of Brennan et al., (2006), this appeared especially true of older more experienced staff whose working practices were perhaps more entrenched. This along with an absence of Trust commitment to initiatives, made it difficult for others to develop their therapeutic skills, impacting directly upon the psychosocial nature of the environment and making it difficult for others to implement any change. Commitment to current practices may therefore have an element of safety for staff, making it functional. It may protect them from exposure to distressing patient material, disclosure of personal feelings and further erosion of self-efficacy. Staff would therefore, have an interest in maintaining the status quo, making genuine integration of alternative interventions difficult.

All categories that emerged represented an obstruction in some form to the development of psychosocial services. Many related to organisational factors. The research developed new insights regarding a lack of professional confidence, performance anxiety and fear of change, resulting in overall ambivalence towards change and improvement. There was a sense of hopelessness, which although seemed the result of many factors including demoralisation, also felt directly related to dependence on the medical model. The research also added to the limited organisational literature concerning acute inpatient services, including limited Trust commitment to initiatives and lack of clear and effective leadership, resulting in reduced role clarity and joint vision.

According to systemic theory, problems are based on interactions and are circular in nature. This was found in the current research, as depicted by the process

model. Individuals gain self-esteem from feeling that they are performing a worthwhile role and that it is valued by others. Interactions between staff groups and between staff and management however, produced narratives and beliefs relating to feeling powerless, undervalued and burnt out. Self-esteem also develops through being part of a group. Nursing staff and psychiatrists have historically had a strong professional identity however systems do experience anxiety when change is needed. Staff had undergone transitions including being required to become more involved in delivering psychosocial interventions. This represents a significant and uncertain change in role and may threaten staffs professional identity.

Feeling powerless, undervalued and overwhelmed induces anxiety amongst staff, and in order to reduce these feelings, staff use defences including projection and cling to established ways of working which represent safety, reinforce group identity and in turn support self-esteem. The essence of systemic theory is that systems change because the people in it collectively create a difference. This emphasises the commitment needed from the organisation as a whole to produce change.

### *5.3 Methodological Considerations*

Qualitative research is often criticised for lacking objectivity. To help guard against affects of pre-existing assumptions, the principal investigator documented pre-conceived ideas and conflicts of role. This aided reflexivity and helped to reduce potential bias (Rolls & Relf, 2006). Negative cases were also reported to demonstrate the weight of information which may disconfirm theory (Robson, 2002). Triangulation and peer debriefing were utilised and an audit trail documenting data collection, analysis and write-up was conducted. Although this

helps to enhance the reliability of the research (Robson, 2002), the subjective nature of qualitative research, must be acknowledged.

Grounded theory (GT) assumes that researchers have no pre-existing agenda before data collection and analysis. The principal investigator acknowledges however, that her interest in ward functioning will have had some influence upon the research process, for instance in the development of the interview schedule. Additionally, those who volunteered may have had particularly strong feelings regarding psychosocial interventions, or felt in particular need of discussing their experiences. This leads to the possibility of a biased sample, as does the fact that some participants appeared to carefully consider their responses and so may have responded in a socially desirable way.

Approaches such as GT are said to have analytic/theoretical generalisation in that the theory developed helps in the understanding of other situations by virtue of these insights having a degree of universality that it can be related to others (Sim, 1998, cited in Robson, 2002). The ability to generalise the results to inpatient units nationwide however, would have been strengthened by the inclusion of more than one Trust.

#### ***5.4 Clinical Implications***

There is a need for ward-based psychologists within acute inpatient services. Psychiatric nurses are faced with the challenge of fulfilling the conflicting roles of both custodian and therapist, without appropriate support systems (Tarrier, Barrowclough, Haddock & McGovern, 1999) or training to enable them to negotiate these roles. Too much may be expected of staff, considering the complexity of inpatients psychological presentations. Staff are left feeling frustrated and stressed.

They also struggled to see how patients could benefit from psychology, emphasising the importance of psychologists assessing patient need, as opposed to staff.

Top-down guidance however now expects nurses to deliver psychosocial interventions. West and Borrill (2002) emphasised the importance of having a meaningful role and some staff were still enthusiastic about change and improvement. The concern is that these staff will be repressed, lose any sense of job satisfaction and leave services. To achieve an environment possible of developing and implementing psychosocial services, there needs to be a cultural shift from a custody environment to one of rehabilitation. Participants lacked basic understanding about patient's thoughts and behaviour and in turn about what psychology could offer, particularly for psychosis. There is a need for training facilitated by psychologists, about basic psychological models and services, helping staff to identify patient's needs. This should be coupled with teaching on structured, time-limited interventions that can be delivered by nursing staff. For staff to be able to develop psychosocial services competently and safely, they also require appropriate supervision from a psychologist, who could advise about assessment, intervention, process and outcomes.

There was the sense that staffs ability to cope was time limited and their psychological health is of concern. Another role for psychologists would be to provide reflective practice, for staff to share their experiences with colleagues. This would have the benefit of normalising their experiences and developing team cohesion. Also, the meaning of clinical supervision may need to be reframed for staff that use it and/or see it as performance monitoring (Thurston, 2003). This could help reduce burnout, sickness and turnover. It could be useful for

psychologists to model this process and have a protracted handing over period to staff.

Brennan, Flood and Bowers (2006) felt that there needs to be radical organisational change now or the acknowledgement that only limited change can be achieved within the current system. The many demands upon nurses including managing the environment, patients and other staff, place them in a position of keeping problems at bay (Hosany, Wellman & Lowe, 2007). This makes therapeutic provision difficult (Gijbels, 1995). Policies and structures need to be in place that supports the development of services (Doyle, Kelly, Clarke & Braynion, 2007; Thurston, 2003). A major obstacle to these suggestions relates to staffing and protected time to develop services, and use support, resources and training. This highlights the organisational commitment needed.

Before staff can engage in change, they need to feel valued by the organisation and secure and confident within their role. Effective teams are headed by effective leaders. According to West et al. (2002) without a clear leader, there is a lack of clear objectives, low staff involvement, low commitment, lack of support for innovation and high levels of workforce stress. He emphasised the importance of rewards, feedback and communication to develop objectives and clarify roles. There needs to be increased staff input into decisions that directly affect the ward. A psychologist with expertise in organisational psychology can provide leadership training and help services develop aims and strategies to achieve them.

### *5.5 Future Research*

There has been a relative lack of in-depth and robust research into the experiences of inpatient staff. Research should continue with qualitative methodology owing to its rich data and ability to explore complex phenomena.

NHS services are set to change again with commissioning powers being passed to doctors. It would be interesting to see how this further affects the implementation of NICE guidelines, specifically regarding the future development of psychosocial services. The implications for patient outcomes and non-medical staff groups, including psychologists and occupational therapists would also be interesting.

Many obstructions related to organisational factors including ineffective teamwork. There is a need for more research focussing on the role of the organisation within inpatient environments. The current research highlighted interesting findings regarding a lack of professional confidence, a fear of and ambivalence towards change and suggestions regarding a return of power to nursing staff. Action research may play an important role in future projects, in the piloting of training and supervision as suggested by the current study.



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## **Section C**

### **Critical Appraisal**



## **1.0 Critical Appraisal**

Undertaking qualitative research necessitates being reflexive, documenting thoughts, feelings and experiences in response to the process. This section makes available my personal reflections that were documented during the research.

### ***1.1 Research Topic***

Selection of a topic for the research felt quite pressured. The need to have a focus seemed to come along quickly and I was concerned about having to research a topic that did not interest me. This was partly influenced by my feelings of worry in anticipation of the research process. I was acutely aware that my whole training had culminated at this point.

I have a long-standing interest in staff groups, particularly those in inpatient environments owing to my previous experience within mental health inpatient facilities. I was keen to research something related to staff functioning. I was aware however that I had certain biases relating to inpatient ward staff. My experiences had led me to view them as territorial and somewhat hostile towards other staff groups, particularly those promoting psychology. These experiences, although at times anxiety provoking, made the psychology role all the more interesting and I have always felt drawn to these environments as a result. I feel that initially I wanted to prove my theories about staff; however, I came to realise that what was clinically interesting was not necessarily what staff did but why they did it.

Formulating a research topic coincided with a secondment within an adult acute inpatient mental health unit, which aimed to increase psychological provision. Involved in this secondment was the person who became my field supervisor. This provided a good starting point for the development of ideas. After much discussion

with my academic supervisor, it seemed that the obvious research topic revolved around why services had such difficulty implementing psychosocial services. This was not only topical but resonated with my own interests in staff teams.

## *1.2 Choice of Methodology*

The inpatient environment is emotionally and physically challenging and fraught with conflicting demands. Experiences and priorities of staff were therefore likely to be influenced by multiple factors. A lack of research considers the effects of staff experiences on the ability of services to implement initiatives. Additionally, government reports had not been widely disclosed. As a result, what may have arisen during interviews was largely unknown. It would be difficult to address such exploratory research quantitatively; the data was therefore qualitative, as the methodology is more suited to exploratory research (Robson, 2002).

In contrast to Interpretive Phenomenological Analysis, the current study was not looking at individual experience but at the social processes of the environment. The aim was to generalise findings to acute inpatient units nationwide. Grounded theory was therefore suited to my research owing to its capacity to explore the social context of an environment.

I tend to be drawn to qualitative research rather than quantitative. It suits my world view and I believe it more closely fits with the practice of psychology in that it is exploratory and focuses on people's meaning frames. It is also my personal opinion that the data has the capacity to say so much more.

### *1.2.1 Limitations of qualitative research.*

Qualitative designs, are criticised for lacking rigour, thereby limiting how representative the findings are and whether they can be generalised. Qualitative research can however be robust methodologically by documenting the process,

allowing transparency (Attride-Stirling, 2001). It is also important for the researcher to make their epistemological position known, to be aware of fit between data and claims made and to consider negative cases (Braun & Clarke, 2006).

Although I believe that achieving truly objective research is questionable and denies the role of context, I acknowledge the subjective element of the research.

### *1.2.2 Limitations of grounded theory.*

Using flexible research designs such as grounded theory raises concerns about the ability to provide an accurate account of the data. In response, all interviews were audio-taped and transcribed. This made sure I accurately represented participants and stuck closely to their meanings, enhancing the research's reliability (Robson, 2002). Grounded theory assumes that researchers have no pre-existing agenda before data collection and analysis. There is therefore a danger of imposing a framework on the data rather than letting the theory emerge. As I have already described, I was aware of my biases towards ward staff. To help guard against the affects of pre-existing assumptions, I documented pre-conceived ideas and conflicts of role. This aided reflexivity and reduced potential bias (Rolls & Relf, 2006). This was supported by considering negative cases and therefore information that may disconfirm my theory, enhancing the validity of the research.

### *1.3 Developing the Interview Schedule*

I had always considered myself to be too practical to be creative. I think as a result, I made this task harder for myself. My supervisor encouraged me to undertake much preparatory work prior to undertaking each part of the research and the same applied to developing the schedule. As a result, I had done quite a lot of reading around interviewing and schedules and gained a solid idea of the approach I wanted to take and why. From this point the process was much easier.

I spent much time developing the schedule. I focussed particularly on developing items that would elicit anecdotal evidence and I increased the use of these subsequent to piloting the schedule. In total there were three revisions. I also adapted the schedule slightly for the different staff groups in order to develop theory from data already emerging. I did not feel it necessary to pilot each adapted version as changes related to a couple of items only. This leads to the potential for interviewer bias in terms of what is given meaning and is further explored (Charmaz, 2009). As a result there is a need for transparency within the research which is represented by my research log, documenting my thoughts and actions relating to the interviews, analysis and write-up. This clearly demonstrates that all changes were made based on data already emerging from participants accounts.

#### *1.4 Recruitment of Participants*

Although gaining approval from the local Research and Development department was a quick and easy process, gaining ethical approval felt protracted and difficult. I was prevented from contacting staff directly which made the process of recruitment particularly difficult. I felt that to gain the participation of ward staff would be already be hard and I felt these extra restrictions just compounded this. As a result of being unable to promote the research, many staff may have been unaware of it, thereby affecting the ability of the results to represent the unit. At times, I felt slightly deflated by the lack of forthcoming participation and I was concerned that I would not have an appropriate sample size. I had to find more creative ways of contacting participants as a result. My field supervisor who was known to the service kindly offered to contact them to promote the research. This greatly helped the process.

I began with nursing staff and then progressed to theoretical sampling within other staff groups in order to develop emerging theory. I therefore became increasingly selective, exercising discrimination. This method although could be said to bias results, was necessary to stay specific to the research aim, gaining meaningful insights and aiding saturation. It was also the case that there were no further volunteers from nursing staff and therefore nobody who wanted to contribute were prevented from doing so.

Approaching just one Trust to participate could have limited the ability to generalise results. It was anticipated however that to gain consent from acute inpatient mental health services would be difficult. It was decided to approach a service known to be progressive in terms of its appreciation of research. The service was also known to my field supervisor, which was anticipated to make access easier.

### *1.5 Conducting Interviews*

I used semi-structured interviews, employing open questions. There is potential for a lack of interviewer control and subsequent difficulty in terms of the analysis (Robson, 2002), however possible richness of data gathered, potentially makes a more substantial contribution to the field of research. Additionally, the interview schedule helped to retain the focus of the interview. I felt this to be important as I anticipated difficulties with recruitment and therefore there was a need for each interview to be relatively focussed to make them meaningful to the research aim.

I felt nervous going into my first interview as it was a new experience. I also felt pressure to make each interview count. I learned a lot during the interviewing stage and it was at this point that feelings of pressure changed to

interest and enjoyment. I was finally feeling that I was getting somewhere and I started to grow in confidence. My perceptions of staff also began to alter as I gained insight into their experiences of feeling powerless and unsupported. I developed empathy for staff that I had not had before. This quite radically altered my focus from one of blame, for what I saw as an inadequate environment for patients, to one of wanting to help staff with their feelings of distress.

I felt very privileged that participants felt safe enough to discuss their personal feelings of distress. This had a huge impact on me. After a couple of interviews I felt quite preoccupied by what I had heard. I felt impotent to help despite desperately wanting to at times. My research log proved to be an invaluable resource. Of course there were elements of my own personality and experiences that came to bear upon my feelings, including a tendency towards wanting to protect others. Also, their distress made me feel distressed and so I knew that if I could ease theirs it would help me by proxy. I also felt some responsibility to help them in my capacity as a trainee clinical psychologist.

#### *1.5.1 Impact of the researcher.*

I was aware of the potential difficulties associated with my position as a trainee clinical psychologist, exploring the implementation of psychosocial services. I was as a result, concerned about participants feeling unable to respond honestly. Indeed some participants did appear a little guarded, however participation was entirely voluntary and I made it explicit that they could withdraw their consent at any time. Additionally, I stressed confidentiality and the need for honesty, as well as using strategies such as easy and non-threatening items. I hope that this helped participants to feel at ease and not see me as a threat.

Reminiscing about my previous work experiences also made me wonder about how participants would respond to me. This probably made me keener to develop a rapport to foster a sense of trust. I felt slightly anxious when approaching psychiatrists in particular. Again this was based on my previous work experiences of them as domineering and often dismissive of psychological approaches. During one interview, I felt I was dealt with in a rather brusque way. As a result I suffered a fleeting loss of confidence and wondered why they had volunteered. This was when my research log came in most handy. I found it very therapeutic to 'sound off'. Unfortunately, once I had done this I threw away my rant. I think this may have been the result of feeling a little shameful at the fact that I did not go home and describe my thoughts and feelings in a more professional manner. I now realise however that this rant is what provided me with my current understanding of the interaction and as a result I should have kept it.

My subsequent reflections upon the interview led me to realise that I had been keen to make a good impression encouraged by my feelings of anxiety, which I was aware of before I entered the interview. As a result I feel that I may have disempowered myself to an extent. When I reflected upon their comments, I realised that the difficulty had partly arisen as a result of what I felt to be the participants' lack of understanding of qualitative research and psychology generally. I realise that this could be my defence strategy, to project my own feelings of anxiety and incompetence onto them, however in order to enhance the reliability of my reflections, I discussed my experience with my field supervisor who confirmed that my experiences were often felt by others. It has to be said that I did have a very positive experience with one psychiatrist whose approach challenged my prejudices towards them.

### *1.5.2 Impact of the current economic climate.*

Conducting research during the current climate is interesting with regards to the changes and the effects of these upon staff and services. The Trust I undertook the research with had recently been involved in large-scale restructuring. This had resulted in many staff having to apply for their own jobs, being moved and new staff coming in. This had understandably unsettled staff and there is a possibility that findings regarding team working for instance could have been very different if staff felt generally less threatened. This process however had occurred some time prior to the research and so I hope that staff had settled slightly. It is the case however that this is the reality for services now; we are now expected to function with less stability and resources. It is therefore as valid to research now as at any other time.

I felt it may however have influenced participation. Staff may have felt obliged to participate in order to appear open to research and to new ways of working and therefore more desirable to the Trust. As volunteers were not very forthcoming however, this was unlikely. Equally, it could have made staff more inclined to report negative experiences owing to feeling less secure. As stated however, this is the reality for staff and so it would still reflect their experiences and in turn would represent valid findings. I think that in the end I managed to get a good mix of staff with a varied range of experiences, which would have increased the study's reliability.

### *1.6 Analysing Data*

I spent a large amount of time on the process of analysis. I transcribed the first interview myself and the remaining seven were transcribed by someone else. Undertaking qualitative research necessitates immersing oneself in the material. I



did not feel that I lost this as a result of someone else doing the transcribing. I made notes about interviews directly afterwards, transcriptions were always sent off immediately and they were transcribed very quickly. I also listened to the audio-tape of the interview whilst checking the transcript for accuracy. This re-familiarised me with the material but I have to say that I always felt immersed in the material owing to the time I spent working with it during the analysis. Grounded theory also entails using the Constant Comparison Method by analysing material alongside data collection, therefore I was always thinking about the interviews. Furthermore, I focussed on this stage exclusively; all other sections of the thesis went on hold during this process. As a result, there was nothing distracting me during this stage.

I realised how focussed I was on the analysis when themes of coding entered my thoughts during my sleep! Coding transcripts seemed to take forever and towards the end I was very much looking forward to finishing it. There was a danger of rushing the coding but I think feeling obligated to do participants justice and wanting a piece of research to be proud of prevented this. From this point onwards it would at times feel all consuming. Although sometimes this felt overwhelming, on the whole I felt that I had the process under control. Initially when coding, I found it difficult to stick to the data and not interpret participant's transcripts. This led to me to re-code some of the first interview. I felt however that I quickly got the hang of it. Furthermore, undertaking the process of triangulation with colleagues helped to combat threats to the validity of the results. Documenting the analysis also helped guard against bias.

Developing categories and seeing how they fit together was the part of the process I most enjoyed. At times it felt easy to focus on the negatives of the

environment, making it all the more important to report negative cases and document my own thoughts and feelings. As a result of developing categories as I collected the data, they changed over time. I refined the categories many times, paying particular attention to 'fit'. Grounded theory has an established framework which helps to overcome bias and aid saturation. New insights reduced as participants were interviewed and upon interview eight, no further categories were generated. It was therefore considered that categories were saturated. It felt very fulfilling to finally pull the findings together. It was at this point that I really felt like I had a project. The process model developed over time and my understanding of the ward environment altered from a causal process to one of a circular nature.

### *1.7 Writing up*

I soon realised this was the first time I had undertaken a proper piece of research. I felt that I had been on a steep learning curve throughout the process but it felt very fulfilling as I saw my hard work transform into a project. There were aspects however that I found less absorbing. I found myself increasingly focused on and interested in the empirical element of the thesis. This affected my interest in the literature review and I found it difficult to go back to it after undertaking the empirical piece. This contributed to an initial lack of focus and I was concerned that this came through to the reader.

I was worried about capturing the complexity of the environment and presenting it in a coherent way. The chaos of the environment was in my writing. There seemed to be so much happening that when I began the Discussion, it took a long time to develop a much needed structure. I felt a responsibility towards participants but I also knew I had some interesting and important findings and I worried about not explaining them adequately. I would have liked more time to

develop the Discussion further, as currently I do not think I have quite done it justice.

There were many opportunities for my perspective to influence the research, not least during the write-up. Mental health services are under pressure to meet government targets regarding treatment and discharge. As a result, the mode of treatment within inpatient environments is contrary to the practice of therapeutic professionals whose training advocates a person-centred approach to assessment, formulation, intervention and evaluation. Throughout the write-up I was careful about not letting my background influence my writing and there were times when I had to stand back and look at my work in a more dispassionate way in order to retain objectivity. This was further compounded by the fact that in the current climate, many professional groups are feeling a need to prove their utility. This may be especially the case for therapeutic staff including psychologists. Firstly, there is a focus on cost. Psychologists are not only more expensive than some other staff groups but therapy seems to be regarded as less essential than medical treatments. In addition to this, there is an expectation to increase the provision of cognitive-behavioural therapy (CBT), achieved partly through increased employment of CBT therapists and therapy delivered by other staff groups including nurses. I had to be mindful to not impose my views of the service and my concerns regarding the future of psychologists onto the analysis. However, its influence upon choice of topic is acknowledged.

## *1.8 Personal and Professional Development*

### *1.8.1 Personal development.*

There never seemed to be enough time to produce a piece of research to the required standard. This feeling was compounded by my tendency to put myself

under a lot of pressure and to doubt my abilities. I managed this through thorough planning and devising manageable time-scales for the various elements of the research. This was helped greatly by my academic supervisor's practical approach. Over time, I found it a little easier to take a break, as opposed to my tendency to plough on regardless. In addition to this, maintaining a work-life balance has always been extremely important to me. Although at times this had to be compromised for the sake of the research, it was never abandoned completely.

### *1.8.2 Professional development.*

Undertaking the research has opened my eyes to the challenges faced by inpatient ward staff and has served to reignite my passion for working in inpatient environments. I am not aware of any research that highlights so profoundly the difficulties faced by this staff group. In addition, no research has specifically set out to explore obstructions to the development and implementation of psychosocial services. Although some findings would be unsurprising to those with experience in this environment, to have them acknowledged is a positive step forward.

I would say that my confidence to undertake qualitative research has grown dramatically. It has dispelled many myths for me about the research process including reducing my fear. I acknowledge that this initial lack of confidence may have inhibited my work and I believe that I would now approach a project with more confidence, taking real ownership of it much sooner. What has surprised me the most however is my increased appreciation of research and the desire to integrate it into my future practice. At times the research was very enjoyable and it is satisfying to know that I have worked very hard to produce something that I am passionate about. This makes me feel very proud.

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## Appendix A

## Appendix B

## Search Results

### PsycINFO

Inclusion/exclusion criteria: English language, Fully published, Full articles, Peer reviewed journals, Human, Adults (18+), Year 2000-2011

Search terms	Outcome	Articles used
Specific reference	864. Searched first 400 until relevancy reduced. 30 relevant	6 2 used for references
Acute mental health wards Psychological therapy	219 17 relevant	1
Mentalisation Inpatient staff	0	
Mentalisation Inpatient Staff	0	
Mentalisation	51 1 relevant	0
Mentalisation Inpatient	4	0
Author		1
Psychological Mindedness Inpatient Staff	0	
Psychological Mindedness Inpatient staff	0	
Psychological Mindedness Staff	1-relevant	1 used for references
Psychological Mindedness	28 1 relevant	0
Psychological Mindedness Nursing staff Inpatient	0	
Psychological Mindedness Nursing staff	0	
Psychological Mindedness Nurses	0	
Psychological Mindedness Psychiatric nurses	0	
Psychological Mindedness Psychiatric staff	0	
Psychological services Psychiatric staff	2 1 relevant	0
27 titles from references	16	3



Specific article		1
Cognitive Behavioural Therapy Inpatient	28	0
CBT Inpatient Psychosis	2	0
Cognitive Behavioural Therapy Inpatient Psychosis	4	0
Dialectical Behaviour Therapy Inpatient	11	0
DBT Inpatient	13	0
DBT Inpatient wards	0	
DBT Mental health wards	0	
DBT Inpatient Personality disorder	7	0
Inpatient staff Therapy	5	0
Inpatient staff Psychological therapy	0	
Inpatient mental health staff Psychological therapy	0	
Inpatient mental health staff Therapy	1	0
Nursing staff Therapeutic alliance	1	0

### Medline

Inclusion/exclusion criteria: Full articles, English language, Journals@Ovid full text, Your journals@Ovid, Embase 1996-2011

Search terms	Outcome	Articles used
Psychological therapies Acute mental health wards	0	
Psychological therapies	98 1 relevant	0
Acute mental health wards Psychosocial interventions	3 3 relevant	1
Inpatient Therapy	279 9 relevant	0

Inpatient Psychosocial interventions	1421	
Narrowed search: Inpatient Psychosocial interventions Adult	693 14 relevant	0
Cognitive Behavioural Therapy Inpatient	408	
Refined search: Cognitive Behavioural Therapy Inpatient Psychosis	116	0
Dialectical Behaviour Therapy Inpatient	76	0
Inpatient mental health staff Therapy	3	0
Psychiatric staff Therapy	148	0
Psychiatric staff Psychological therapy	2	
Nursing staff Psychological therapy	43	
Psychiatric staff Therapeutic alliance	14	
Acute inpatient Therapy	0	

### Web of Science

Inclusion/exclusion criteria: Latest 5 years, Social Sciences, Full articles, English language

Search terms	Outcome	Articles used
Inpatient* Psychosocial* interventions* Adult*	14 2 relevant	0
Acute* mental* health* wards* Psychosocial* interventions* Adult*	0	
Acute* mental* health* wards* Psychosocial* therap* Adult*	0	
Inpatient* Psychosocial* therap* Adult*	12 1 relevant	0
Therap* alliance*	0	

Inpatient* Staff*		
Views* of Therap* Inpatient* Staff*	11	0
Inpatient* Staff* Therap*	135	0

### Google

Search terms	Outcome	Articles used
Mentalising in inpatients	2 relevant	0
Author search	1	1

## Appendix C

### Data Extraction

<b>Title:</b> London-East Anglia randomised control trial of cognitive behavioural therapy for psychosis. I: effects of the treatment phase. <b>Author/s:</b> Kuipers, Garety, Fowler, Dunn, Bebbington, Freeman and Hadley <b>Date:</b> 1997				
Aims	Method	Sampling	Analysis	Results
Research the efficacy of CBT with medication resistant psychosis.	RCT. Quantitative measures-baseline, 3, 6 and 9 months.	60 inpatient and community patients. 3 hospital sites.	Two-way ANOVA–symptom differences between setting and condition.	CBT reduced psychosis symptoms. No statistically significant effects for depression, functioning and degree of belief in delusions.
<b>Title:</b> Staff development, anxiety and relaxation techniques: a pilot study in an acute psychiatric inpatient setting. <b>Author/s:</b> Dodd and Wellman <b>Date:</b> 2000				
Aims	Method	Sampling	Analysis	Results
Efficacy of CBT with inpatients with a diagnosis of schizophrenia.	Quantitative measures. Pre and post-intervention. No control group.	Convenience sample. 23 Inpatients. Self-reported Anxiety.	Wilcoxon-pre and post-effects on symptoms.	CBT reduced anxiety and functional impairment
<b>Title:</b> Cognitive therapy and recovery from acute psychosis: a controlled trial. I. Impact on psychotic symptoms. <b>Author/s:</b> Drury, Birchwood, Cochrane and Macmillan <b>Date:</b> 1996				
Aims	Method	Sampling	Analysis	Results
Efficacy of CT upon positive and residual symptoms of psychosis.	RCT. Quantitative measures-baseline, 6 and 9 months.	40 inpatients. Randomly allocated to conditions.	Wald test–effects of time. T-tests for between-group differences.	CT reduced psychosis symptoms and conviction in delusions. No statistically significant effects between groups regarding disorganisation symptoms and negative symptoms.

<b>Title:</b> Cassel Personality Disorder Study: Methodology and treatment effects. <b>Author/s:</b> Chiesa and Fonagy <b>Date:</b> 2000				
Aims	Method	Sampling	Analysis	Results
Effectiveness of psychosocial services for patients with diagnosis of personality disorder.	Quantitative measures- baseline, 6 and 12 months. Control group.	90-inpatients and outpatients. Non-randomisation to two conditions.	MANOVA's-differences in mean scores between measures and conditions.	Psychodynamic therapy led to improvements in psychological health and functioning, greater in out-patients.
<b>Title:</b> A qualitative study into the experience of individuals involved in a mindfulness group within an acute inpatient mental health unit. <b>Author/s:</b> York <b>Date:</b> 2007				
Aims	Method	Sampling	Analysis	Results
Efficacy of mindfulness within acute inpatient mental health services.	Qualitative. Semi-structured interviews.	Eight inpatients. No explanation of sampling technique.	Thematic analysis.	Mindfulness associated with increased feelings of acceptance, relaxation and understanding.
<b>Title:</b> Specialist educational intervention for acute inpatient mental health nursing staff: service user views and effects on nursing quality. <b>Author/s:</b> Richards, Bee, Loftus, Baker, Bailey and Lovell. <b>Date:</b> 2005				
Aims	Method	Sampling	Analysis	Results
Efficacy of staff training on nursing practice.	Uncontrolled. Qualitative-patient semi-structured interviews. Quantitative-pre/post design, using nursing records.	Patients. 25 at baseline, 26 at follow-up. Purposive sampling. 96 patient records at baseline and 142 at follow-up.	Thematic analysis. Differences pre/post measured using chi-square tests, independent t-tests and Mann-Whitney U.	Staff training led to improvements in nursing practices and patient engagement in therapy. No reduction in illness severity or length. Difficulty implementing psychological services.

<b>Title:</b> Fostering a culture of engagement: a pilot study of the outcomes of training mental health nurses working in two UK acute admission units in brief solution-focused therapy techniques. <b>Author/s:</b> Hosany, Wellman and Lowe. <b>Date:</b> 2007				
Aims	Method	Sampling	Analysis	Results
Effects of nurse training in SFBT upon staff-patient interactions.	Uncontrolled. Quantitative measures-baseline, 2 weeks, 3 months.	Convenience sample. 36 nurses.	Wilcoxon signed ranks test-differences pre/post.	Training in SFBT led to improvements in some areas of clinical practice. Increased staff confidence, patients judged as more engaged.
<b>Title:</b> Fostering a culture of engagement: an evaluation of a 2-day training in solution-focused brief therapy for mental health workers. <b>Author/s:</b> Ferraz and Wellman <b>Date:</b> 2009				
Aims	Method	Sampling	Analysis	Results
Effects of nurse training in SFBT upon staffs knowledge, skills and clinical practice.	Uncontrolled. Quantitative measures-baseline, 3 and 6 months.	Convenience sample of 66. Nurses and voluntary sector staff.	Friedman's test-within group findings. Wilcoxon matched-pairs signed ranks-differences across time points.	Training in SFBT led to improvements in some areas of clinical practice.
<b>Title:</b> Finding solutions through empowerment: a preliminary study of a solution-oriented approach to nursing in acute psychiatric settings. <b>Author/s:</b> Stevenson, Jackson and Barker <b>Date:</b> 2003				
Aims	Method	Sampling	Analysis	Results
Effects upon practice of 2.5 days' staff training in solution-focused practice	Uncontrolled. Quantitative-patient reports, staff knowledge tests, case reports, audits of clinical notes, staff questionnaire evaluating practice.	23 staff-convenience sample. 15 patients.	Patient data-descriptive statistics, brief thematic analysis. Staff data-descriptive statistics, Wilcoxon test-pre/post knowledge.	Training in SFBT led to improvements in some areas of clinical practice, supported by patient reports

<b>Title:</b> Preliminary outcomes of a trial to reduce conflict and containment on acute psychiatric wards: City Nurses. <b>Author/s:</b> Bowers, Brennan, Flood, Lipang and Oladapo <b>Date:</b> 2006				
Aims	Method	Sampling	Analysis	Results
Project to reduce conflict and containment and increase therapeutic services.	Patient reviews, supervision, reflective practice, staff training. Uncontrolled. Quantitative measures of conflict and containment-each shift for 3 months, one year post-intervention. Official incident reports. Other measures pre/post-ward atmosphere, attitudes towards patients, burnout, ward structure, job satisfaction, staff-patient interactions.	Two wards-self-selecting.	Mann-Whitney U-differences pre/post for conflict and containment. Independent samples t-test-differences pre/post for other measures. Spearman correlations between official incident reports and staff reports of conflict.	Organisational approach to change reduced levels of conflict but not containment. No statistically significant changes regarding other measures.
<b>Title:</b> A replication study of the City nurse intervention: reducing conflict and containment on three acute psychiatric wards. <b>Author/s:</b> Bowers, Flood, Brennan and Allan <b>Date:</b> 2008				
Aims	Method	Sampling	Analysis	Results
Project to reduce containment.	Control group. Otherwise, as above.	5 control wards, 2 experimental. Self-selecting.	Mann-Whitney U-differences pre/post for conflict and containment.	Organisational approach to change reduced levels of conflict and containment. Differences not statistically significant when analyses included control groups.



## Appendix D

### Chronology of Research Process

Jan 2010	Submit proposal to peer review
Jan-May 2010	Develop draft interview schedule, PIS, consent form
Jan 2010	Discussion with service regarding research
March 2010	Submit proposal to service for approval
April 2010	Service approval
March 2010	Submit ethics form to IRAS
July 2010	R&D approval
May-June 2010	Amendments required by ethics committee
Aug 2010	Ethical approval
September 2010	Introduce research to Ward Matrons. Start recruitment process
May 2010	Pilot interview. Amend schedule
Oct 2010-Jan 2011	Data collection
Nov 2010-Jan 2011	Transcribe interviews
Dec 2010-Jan 2011	Conduct analysis
Feb-March 2011	Triangulation with colleagues
April 2011	Draft thesis write-up
May 2011	Submission

## Appendix E

## Appendix F

## Epistemological Position

The principal investigator works from a critical realist viewpoint with a tendency towards social constructivist thinking. She acknowledges that the interviews will not reveal an existing “reality” (Murphy & Dingwall, 2003, cited in Charmaz, 2009) but a version of reality that is part-constructed through interactions between participant and principal investigator. She believes that much of what is considered reality, in terms of meanings and importance is co-constructed between people. Therefore, seeking participants meaning frames, assumptions and implicit rules suits the principal investigators world view (Charmaz).

## Appendix G

## Interview Schedule

### Warm-up questions (Prior to audio-taping)

- Code:
- Age:
- Gender:
- Ethnicity:
- Job title:
- Banding:
- How long worked in that capacity:
- How long worked on the unit:

### Perception of roles

- What initially attracted you to your role?
- Can you give me a recent example of when you have been able to do this?

Follow-up: What do you feel hinders you from practising as you would like?

Example.

- What do you feel the service is here to do? Example.

### Experiences with patients

- Tell me about a recent interaction with a patient that is on your mind.
- What is your understanding of what was going on?

### Resources/support

- Tell me about a challenge that you have faced in your role recently.
- How do you cope at work with the demands of your role?
- Is there anything at work that would help you to cope but is currently unavailable?

### Values and priorities

- If you were chief executive, how would you develop the service?
- What does the service have in terms of psychological and social interventions for patients?
- What does the service have in terms of psychological and social input for staff?
- What would a service look like if it was fully developed in terms of its psychological and social input for both staff and patients? Example.
- What difference would such a service make?

Follow-up: Tell me more/example.



- What would be the barriers to the development of such a service?
- There have been many initiatives implemented by the service aimed at improving patient care. Regarding the Consultant for Inpatient Psychological Therapies role, what impact would you say these have had on the service?

Closing questions (subsequent to audio-taping)

- How have you found talking to me today?
- Are there any questions you would like to ask me?

## Appendix H

## Interview Schedule (Improvement Team)

### Perception of roles

- Tell me about your role in the implementation of the RTTC initiative.
- What initially attracted you to your role?
- Can you give me a recent example of when you have been able to do this?

Follow-up: What do you feel hinders you from practising as you would like?

Example.

- What do you feel the service is here to do? Example.

### Experiences implementing new initiatives

- Tell me about a challenge that you have faced in your role recently.
- Follow-up: What is your understanding of what was going on?
- What impact would you say the initiative is having on the service?

### Resources/support

- How do you cope at work with the demands of your role?
- Is there anything at work that would help you to cope but is currently unavailable?

### Values and priorities

- If you were chief executive, how would you develop the service?
- What does the service have in terms of psychological and social interventions for patients?
- What does the service have in terms of psychological and social input for staff?
- What would a service look like if it was fully developed in terms of its psychological and social input for both staff and patients?

Follow-up: example.

- What difference would such a service make?

Follow-up: Tell me more/example.

- What would be the barriers to the development of such a service?

## Interview Schedule (Psychiatrists)

### Perception of roles

- What initially attracted you to your role?
- Can you give me a recent example of when you have been able to do this?

Follow-up: What do you feel hinders you from practising as you would like?

Example.

- What do you feel the service is here to do? Example.

### Experiences with patients and team

- Tell me about a recent interaction with a patient that is on your mind.
- What is your understanding of what was going on?
- How would you describe your approach as a clinician? Example.
- Tell me about a time when you have had a difference of opinion with other members of the team regarding a patient's treatment.

Follow-up: Tell me about how it was resolved.

### Resources/support

- Tell me about a challenge that you have faced in your role recently.
- How do you cope at work with the demands of your role?
- Is there anything at work that would help you to cope but is currently unavailable?

### Values and priorities

- If you were chief executive, how would you develop the service?
- What does the service have in terms of psychological and social interventions for patients?

- What does the service have in terms of psychological and social input for staff?
- What would a service look like if it was fully developed in terms of its psychological and social input for both staff and patients? Example.
- What difference would such a service make?

Follow-up: Tell me more/example.

- What would be the barriers to the development of such a service?
- There have been many initiatives implemented by the service aimed at improving patient care-Consultant for Inpatient Psychological Therapies, RTTC, TLW. What impact would you say these initiatives and any others you can think of have had on the service?

## Appendix I

## **Participant Information Sheet**

### **Title of the research**

**A qualitative study of staff experiences on an adult acute mental health inpatient unit: Implications for the development of psychosocial aspects of the service.**

### **Researcher**

Shelley Parkin, Trainee Clinical Psychologist, University of Leicester.

I am requesting your participation in a research study. The research is to be completed as part fulfilment of the Doctorate in Clinical Psychology. To help you to consider whether you would like to participate, please read the information below carefully so that you are aware of the purpose of the research and what it involves. If you do decide to participate, you may change your mind at any point either before, during or after your participation. If there is anything that you feel needs clarifying and you have any queries, please do not hesitate to contact me on the details provided by leaving your name, telephone number and a convenient time for me to ring you the following week.

This research has been reviewed by the Nottingham 1 Research Ethics Committee.

### **Background to the research**

There has been much recent interest and subsequent guidance relating to the quality of care that is delivered in inpatient facilities. However there appears to be no research that considers how staff experiences affect the ability of services to implement initiatives. This research intends to explore the experiences of ward staff to understand how useful this guidance alone is to them and to the improvement of services. Ultimately the research will make recommendations as to how staff can be supported to implement the guidance more fully.

### **Benefits arising from the research**

By taking part in this research you will have an opportunity to discuss and explore the daily challenges that you face at work and how this affects your ability to cope with the many demands placed upon you. It is also an opportunity for you to be part of a piece of research that is intended to improve the ward environment. This will hopefully benefit both you and your patients.

### **What will happen next if you agree to take part?**

If you do decide to volunteer, you can contact me on the details provided and I will place your name and the names of other volunteers into a box. I will then randomly



select participants by drawing names from it. If your name is drawn out, I will visit the unit at a convenient time for you, to further discuss the research with you and to answer any questions you may have. If you are still happy to participate, you will be asked to sign a consent form which demonstrates that I have acted properly. Please note that this is not a contract and you are entitled to change your mind at any point before the results are written up (scheduled for January 2011).

After you have signed the consent form we will be able to have an informal interview where we will discuss your daily experiences on the ward. Your interview will take place on the unit but away from the ward to minimise distractions. Management permission has been granted for you to take part in the interviews during work time. Therefore, there is no additional time commitment for you, unless you would prefer to take part after your working day. The length of your interview will depend on how much you want to discuss. However it should last no longer than one hour and as stated you may stop at any time. Your interview will be taped and typed up to ensure that your views and experiences are accurately represented. You may have a copy of this transcript should you wish. There are no right or a wrong answers, the research is very much interested in your views and experiences.

#### **Do you have to take part?**

Your participation is entirely voluntary and as such, even if you do decide to take part, you can change your mind at any point before the results are due to be written up. You may withdraw from the study by contacting me directly. There would be no adverse consequences if you decided you did not want to take part or if you changed your mind at a later date.

#### **Will your information be kept confidential?**

Your individual interview will not be discussed with anyone from your service. Additionally, if you feel you have said anything particularly sensitive during the interview, you have the option of this information being omitted from the analysis. Your interview will be typed by someone other than me who is entirely unconnected to the service. Only myself and my academic supervisor for the research will have access to information arising from your interview as I conduct the analysis. Your individual name will not be used; instead a code will be used to represent you. To increase the level of anonymity, it is necessary for you to avoid the use of names of colleagues and patients. Consent forms, interview tapes and transcripts will be kept in a locked cupboard in my academic supervisors' office at the University of Leicester. These materials will be destroyed five years after completion of the study (scheduled for May 2011). All paper material will be destroyed by shredding and audio tapes will be wiped or cut. Any information used on a computer will be held on an encrypted memory stick. This will be accessed only by me. Results will be presented in general form only, highlighting trends.

The only time I would have to inform someone else about the content of your interview would be if you said something which led me to believe either you or someone else was in danger or, if you disclosed something that would constitute 'bad practice'. In such circumstances the General Manager of the Acute Inpatient Services would be informed and he would action any necessary procedure as dictated by [name] NHS Trust.

**Are there any risks associated with the research?**

Due to the potential small sample size, it is possible that colleagues may be able to identify you from quotations reported in the results. Therefore, your complete anonymity cannot be guaranteed. However, your responses can be further disguised by not reporting certain information such as your job title. Additionally, you are entitled to request that information is omitted from the analysis.

There are no other risks known to be associated with the proposed research. We will be exploring your perceptions and experiences on the ward and therefore there are no additional risks of physical or emotional harm than is already present in your daily life. However it is acknowledged that taking part in informal interviews may feel anxiety provoking. If you do become uncomfortable you may withdraw from the research at any time. To re-iterate, anonymity and confidentiality are of the upmost importance throughout the research. If you wished to further discuss your participation after the interview, you may do so by contacting me directly.

**What will happen to the research overall?**

The research, including the results, will be written up as a thesis in part fulfilment of the Doctorate in Clinical Psychology. It is also intended to result in a published article within a relevant journal. You may have a summary of the results if you wish once the study has been completed. When the study is complete, all participants will be invited to attend a presentation of the results. The findings will be fed back to participants and you will be offered the chance to discuss how you found the process. Again, attendance at this presentation will be voluntary.

**Concluding comments**

If you decide that you would like to take part, you can contact me via the details provided. I will subsequently make a time to visit you to clarify any queries you may have. Once we have done this, if you are still happy to participate you will be asked to sign two copies of the consent form, one for you and one for me. Again, the purpose of this is purely to make sure that I have acted properly in asking you to participate. Once this is done we can begin the interview. Please remember, you may withdraw from the study at any time by contacting me directly.

Thank you for your time and consideration.

Shelley Parkin  
Trainee Clinical Psychologist  
University of Leicester  
104 Regent Road  
Leicester  
LE1 7LT

Tel: 0116 223 1639  
Email: smp25@le.ac.uk

Please note: If you do volunteer to participate in the research and your name is not selected and you are experiencing difficulties that you would like to discuss further, the Occupational Health service [number] offers a free and confidential support and advisory service to all staff where you will be able to discuss work or personal difficulties with a counsellor.

## Appendix J

## Research Log Excerpt

Tuesday 9<sup>th</sup> November 2010

I have an overwhelming feeling of sympathy for the girl I saw today. She arrived 10-15 mins early and spoke about experiences that were considerably distressing which she'd received very little support for. She was struggling to cope. She said she wanted to phone in sick today because she felt so bad. She's having other problems with colleagues which are making it difficult for her to gain psychological experience. Although her managers are aware, they aren't doing anything about it.

I think she arrived early to escape the ward. Post-interview she stayed for 20 mins talking about her experiences and helping me to understand a service initiative. It was obvious she wasn't in a rush to return to the ward. After the interview I tried to contain her feelings but felt quite helpless. I left feeling very sorry for her and I feel preoccupied by the experience. She still managed to be enthusiastic about the patients. She wants to increase psychosocial interventions and seemed different to other participant's which made me feel for her more. It was also a good interview and I'm grateful to her for that. The fact that she wants to train on the Clinical course has undoubtedly increased my empathy for her. I know she needs better experiences than she's getting now which makes me want to help her to find another job. I feel frustrated with the ward for not helping her. She needs confidential and supportive supervision. She's very young and I feel a degree of protection towards her. This is probably influenced by my own experiences of the inpatient environment.

She said it had been useful to talk to somebody. I think she felt ok talking to me because we're the same gender and I'm only a few years older than her. I also think she assumed I'd be discrete and would understand because I'm a trainee.

## Appendix K

## Approach to Transcription

### Individuals transcribing

The trainee transcribed the first interview to familiarise herself with the process and to ensure she had chosen an appropriate approach. Subsequent to this, someone other than the trainee transcribed interviews. This individual was provided with the interview schedule to increase their understanding of the research, as deemed useful by Bailey (2008). Upon receipt of transcriptions, the trainee compared them to the taped interviews, enhancing accuracy and immersion in the data.

### Transcription technique and rationale

Oliver, Serovich and Mason (2005) describe two approaches to transcribing interviews—naturalised and denaturalised. The former approach tends to be employed in conversation analysis and is therefore concerned with how conversation is organised and constructed. As such, it details all utterances made during the interview. Furthermore, being more akin to a realist perspective (Guba & Lincoln, 1994, cited in Oliver et al., 2005), it ignores the influence of society (Billig, 1999a, 1999b, cited in Oliver, et al., 2005) and therefore takes no account of the social nature of that under study. In contrast, those who use the denaturalised approach are interested in the individual's meanings and perceptions that construct reality (Cameron, 2001, cited in Oliver, et al., 2005). This not only allows the researcher to omit information such as non-verbal behaviour, if deemed unnecessary, but also fits with the trainee's epidemiological position of critical realism/social constructivism.

Those who advocate a naturalised approach believe they are presenting a more objective representation of the interview (Schegloff, 1997, cited in Oliver, et al., 2005). However, according to Bailey (2008) data reduction is an inevitable part of transcription. Judgement is still required for the interpretation of utterances including

sniffing, laughing, slang speech. Additionally, transcribing participant's spoken language exactly can expose them to prejudicial assumptions (Oliver, et al., 2005) from both researchers and transcribers. It is therefore not possible to produce a completely objective transcription (Roberts, 1997).

Oliver, et al. (2005) suggest that the denaturalised approach suits research using grounded theory methodology; as such research is interested in the meanings and perceptions about social phenomena that are shared during interviews for instance. The denaturalised approach was felt to be an appropriate method of transcription.

### Information transcribed

#### 1. Standard English

As the research was interested in meanings rather than how conversation is constructed, interviews were transcribed into standard English to make them more readable (Oliver, et al., 2005). Roberts (1997) discusses the possibility that this "denies the whole social person". However, participant's ethnicity etc. was not specifically of interest. The researcher therefore needed to clarify uncertainties, which allowed participants to clarify their own meanings, reducing possible misinterpretation (Oliver, et al., 2005).

#### 2. Response/non-response tokens

Although more characteristic of a naturalised approach, according to Oliver, et al. (2005) utterances including yeah and mm, are intentional forms of language and can influence the interaction and facilitate understanding of meaning and emotion. The researchers own noises of encouragement can also highlight areas of hesitancy and convey understanding/misunderstanding.



### 3. Involuntary vocalisations

Crying and laughter were to be transcribed. Involuntary vocalisations perceived as unrelated, including sniffing and coughing, and those requiring more interpretation as to their meaning, such as whether laughter is the result of feeling nervous, were not transcribed. This is because the individual transcribing would lack insight into context. Additionally, this fine detail felt unnecessary for the research. However, to enhance the context of interviews, the trainee made field notes immediately afterwards, documenting perceptions of participant's presentation and the interaction generally, including quality of rapport.

### 4. Non-verbal behaviour

The inclusion of non-verbal behaviour within transcriptions was considered unnecessary and impossible for the individual transcribing.

#### Transcription guidelines:

<u>Participants words underlined</u>	Denotes emphasis (Oliver et al.; Bailey)
(1)	Pause time (Oliver et al.) in seconds
( <i>laughter</i> )	Participant/researcher laughter (Oliver et al.)
( <i>crying</i> )	Crying (Oliver et al.)
-	Stop mid-sentence (Oliver et al.; Bailey)
(?)	Inaudible speech (Bailey)
[place/name]	Information omitted to preserve confidentiality (Bailey)
Speech such as "givin"	Transcribed into standard English (Oliver et al.)
All vocalisations e.g. "yeah", "mm", "erm"	Transcribed (Oliver et al.)

## References

- Bailey, J. (2008). First steps in qualitative analysis: transcribing. *Family Practice*, 25, 127-131.
- Roberts, C. (1997). Transcribing Talk: Issues of Representation. *TESOL Quarterly*, 31(1), 167-172.
- Oliver, D. G., Serovich, J. M., & Mason, T. L. (2005). Constraints and Opportunities with Interview Transcription: Towards Reflection in Qualitative Research. *Social Forces*, 84(2), 1273-1289.

## Appendix L

## Category Development

Category	Development
“This organisation hasn’t done much to make people feel valued”	Upon interview 1-felt to be about powerlessness.  Became apparent there were two processes–the objective: being powerless, and the subjective: implications. Includes demoralisation. Power element represented in another category.
“Staff safety is compromised”	Initially about difficulties understanding patients, lack of control over patients. Reworked after interview 2.  More about unpredictability and lack of control generally.
Struggling to manage emotions	Thought to be about difficulty keeping patients in mind, but didn’t explain why.
Patients do not change	Jumped out of interview 1. Initially two categories.  Other category: “Low expectations of patients”.  Related to same thing. Includes belief that patients cannot cope.
“Psychologically I just haven’t got a clue”	Jumped out of interview 1. Supported throughout interviews.
“Feeling really busy, feeling stressed”	Throughout interviews their job seemed too big.  Almost not coping. Element of feeling overwhelmed.
Psychology do we need it?	Interview 1-felt to be about the medical model vs. psychological model or nurse vs. psychologist. Didn’t fully capture data. Upon interview 6-apparent that it related to specific beliefs about psychology.

	<p>Participants reflected upon and weighed up need but didn't always dismiss its use other environments.</p> <p>Originally two categories, the other being: "I don't see the ward as a place for psychotherapy", but they related to the same phenomena.</p>
Focus on patient activity	Ran through many interviews.
Focus on staff activity	Absence of feelings stood out in many interviews.
Staff need "more robust support"	Ran throughout.
An intense need to share	Ran throughout.
"Stuck in an office answering phone calls and doing paperwork"	<p>Interview 1-focus on non-nursing duties, felt to be avoidance of attending to psychological phenomena.</p> <p>Interview 6 led to reorganisation of material-appeared a reality of the ward. Merged with another category regarding being under-resourced.</p>
<p>Isolated as a service</p> <p>"There's very little joined up working"</p>	Initially one category: Working In Isolation. Upon interviews 2 and 6-became apparent that it was more complicated-lack of team cohesion and service isolation.
A sense of team support	Interview 1-importance of perceived support. First felt to be wholly positive. Reworked after interview 6-felt exaggerated and deliberate-reaction to isolation.
"Psychologically there's not a lot on offer"	Ran throughout.
"The medical model will	Interview 1-felt to be about dominance of medical

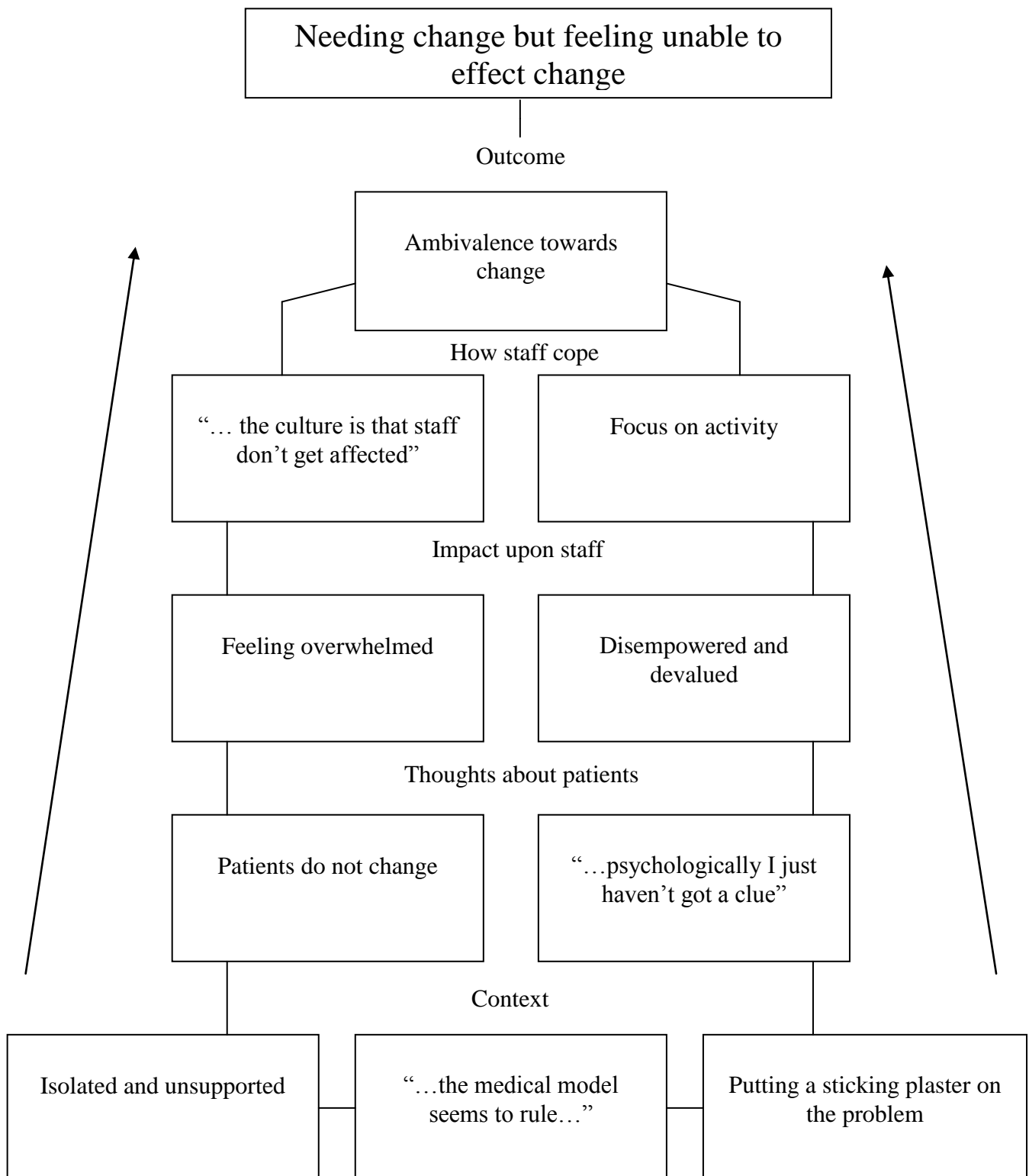
always come first”	consultants. Upon interview 2 and 4-seemed more about dominance of the medical model and medication generally. Dominance of doctors fitted better into category regarding needing a nurse led philosophy.
“Staff aren’t affected by what happens on the ward”	Interview 1-staff felt overly focussed on the present. After interview 2-included not acknowledging distress. Supported in interview 4. Presenting an image of not being affected had more explanatory power.
Needing to feel contained	From interview 1. Supported by interviews 2 and 4.
Feeling unsafe in supervision	Referred to in interview 1. Jumped out of interview 4. First felt to revolve around trust. Upon interview 7-included fears about performance management, having the skills. Represented a threat.
Feeling is a weakness	Jumped out of interview 4. Considered need to fit in but this didn’t explain perception of weakness.
Putting a sticking plaster on the problem	Interview 4-sense that ward was a reactive environment and needed to be more proactive. Supported by Interviews 7 and 8.
Keeping staff-patient contact to a minimum	Interview 2-sense that patient contact was difficult and as a result was kept purposeful. Felt like staff didn’t know how to interact with patients-confirmed in interview 2. Little time spent with patients-reiterated in interviews 4 and 6.
Initiatives: “They don’t see	Interview 4-felt that anything other than medication

the point in it”	<p>was considered pointless/attitudes towards usefulness.</p> <p>Supported by interviews 1,2,3,6,7,8-unaware of initiatives or whether they were implemented on their ward. Interview 7 highlighted difficulties engaging staff in new ways of working.</p>
Fear of change	<p>Interview 6-staff concern about having skills to change practice. Supported by interview 7.</p>
“We probably need a big bang; a big change to what we’re doing”	<p>Jumped out of interview 6.</p>
“We should have a much stronger nurse led philosophy”	<p>Interview 6. Related to powerlessness (includes previous category relating to power). Concerns a shift of power over time, daily running of wards, inability to use professional judgement.</p>
Needing to work hard to engage staff in change	<p>Jumped out of interview 7. Need for persistence.</p> <p>Merged with another category-Needing to prove that something is worth participating in.</p>

## Appendix M



### Previous Process Model



This model was too causal; many influences were bi-directional and more circular. It needed to be more narrative in form, to capture the complicated functioning of the environment.