Canterbury
Christ Church
University

Eloise G. DONAGHAY-SPIRE BSc (Hons) MSc

AN EXPLORATION OF PSYCHOLOGICAL INTERVENTIONS IN THE ACUTE INPATIENT MENTAL HEALTH SETTING

Section A: A review of psychological interventions in the acute inpatient mental health setting

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Section B: An exploration of service-user and staff member narratives of psychological input in acute inpatient mental health settings

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Summary of the MRP Portfolio

Section A: A review of psychological interventions in the acute inpatient mental health setting

Section A is a paper outlining a systematic search and review of the literature that explores the value of psychological input in acute mental health inpatient settings in the United Kingdom (UK). Relevant papers are reviewed in terms of their strengths, limitations and implications for clinical practice and future research.

Section B: An exploration of service-user and staff member narratives of psychological input in acute inpatient mental health settings

Section B presents a qualitative interview study, focused on a narrative analysis of service-user and staff member experiences of psychological input in the acute mental health inpatient setting. Results indicated that psychological input in this setting is valued, can help people make sense of a crisis, and can lead to improvements in relationships and meaningful recovery. These findings are discussed in the context of the study's strengths and limitations, focusing on the specific implications for research and clinical practice.

Section C: Supporting information

Section C is an appendix of supporting material, which includes: the search strategy methodology for Section A; submission guidelines of the journal for which Section B is intended; a research diary excerpt; a sample interview transcript, and relevant information to the research process.

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Section B

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Eloise G. DONAGHAY-SPIRE BSc (Hons) MSc

INPATIENT PSYCHOLOGICAL INTERVENTIONS

MAJOR RESEARCH PROJECT

SECTION A: LITERATURE REVIEW

A REVIEW OF PSYCHOLOGICAL INTERVENTIONS IN NHS

MENTAL HEALTH INPATIENT SETTINGS

ACCURATE WORD COUNT: 7,889 (169)

Abstract

Background

There is evidence to support the application of psychology in community-based mental health services; however, there is limited access to psychologists in National Health Service (NHS) inpatient mental health settings in the United Kingdom (UK). Calls to increase access to such provision exist without consensus as to whether this is cost and clinically effective.

Methods

This paper presents a discussion of the theoretical background, a systematic literature search and review of the available evidence to support psychological interventions in the inpatient mental health setting.

Results

A review of sixteen papers concluded that UK psychologists offer direct, indirect and strategic interventions. There are significant challenges in the provision and research of psychological input in this setting, and limited evidence to support the benefits of inpatient psychology. Tentative and optimistic findings suggest that interventions can reduce distress and lead to a more rapid recovery.

Conclusions

Psychological interventions such as individual and group Cognitive Behavioural Therapy (CBT), Compassion-Focused Therapy (CFT), reflective practice for staff, and mixed therapeutic approaches, are feasible and valued in the inpatient mental health setting. Further research is needed and should be focused on exploring the ways in which psychology in this environment can lead to clinically meaningful change.

Key words: Inpatient, psychology, interventions, NHS, Mental health

A review of psychological interventions in the mental health inpatient setting

Acute inpatient environments

In the UK, acute psychiatric hospitals form part of tertiary mental health services in a 'stepped care' service model. Individuals may be admitted to an acute mental health hospital voluntarily, or detained under a section of the Mental Health Act (MHA; DoH, 1983), either: in the interests of their own health; in the interests of their own safety; and/or for the protection of other people (Campbell, 1991).

The NHS and Community Care Act (Department of Health; DoH, 1990) aimed to reduce the reliance on hospital care for individuals with mental health problems, plus inpatient beds (Korman & Glennerster, 1985). Acute mental health hospitals have become institutions for crisis stabilisation, admissions are largely unplanned emergencies, and there is a reported increase in detention using the MHA (Audini et al., 1995; Ford, Durcan, Warner, Hardy & Muijen, 1998; Fulop et al., 1994; Quirk & Lelliott, 2001; Ward, Gournay, & Thornicroft, 1998). Arguably the quality of inpatient care has consequently suffered (Ford et al., 1998). There are claims of increased bed occupancy rates and intense pressure on bed space, leading to shorter admissions (Shepherd et al., 1997; Lelliott, Audini, Johnson & Guite, 1997), alongside a rise in the threshold for an inpatient admission (Brooker, Ricketts, Bennet & Lemme (2007).

Inpatient psychological provision

A growing body of literature considers the application of psychology in the acute inpatient mental health setting, with psychologists acting as therapists, consultants and strategic change agents (Hall & Parry, 1988; Manpower Planning Advisory Group, MPAG, 1990). Recent guidance from the Division of Clinical Psychology (DCP) of the British Psychological Society (BPS) highlighted the importance of psychological formulation in the acute inpatient setting, and suggested that development of collaborative understanding of mental health

experiences can inform treatment, and support staff to create a safe and therapeutic environment (DCP, 2011). Inpatient psychologist roles can be further defined as providing three levels of intervention: firstly, direct client work; secondly, indirect client work aimed at enhancing multidisciplinary thinking and action; and thirdly, strategic work towards team, policy and service development (Nicholson & Carradice, 2002).

Applied psychologists in the acute setting have argued that interventions can inform and enhance inpatient care (Clarke & Wilson, 2009), and this has been supported by calls for an increase in the availability of psychologists in NHS mental health hospitals in the UK (BPS, 2002; National Institute for Mental Health in England [NIMHE], 2004; DoH, 2002; Royal College of Psychiatrists [RCP], 2011; Sainsburys Centre for Mental Health, 1998). There are, however, also claims of a lack of evidence to support this (McGowan & Hall, 2009) and that the available evidence is far from robust (Holmes, 2002). In 2006, only 13% of NHS mental health wards were reported to have access to a psychologist (Hanna, 2006); it would therefore appear that those responsible for commissioning acute mental health services are yet to be convinced of the value of providing increased psychological input in this setting.

Theoretical background

Challenges. Generalising outcomes derived from community-based empirical research to inpatient populations is problematic, as community services are fundamentally different from acute inpatient services in terms of patient distress, prescribed medication, and therapeutic input received (McGowan and Hall, 2009). Mental health service-users in acute inpatient NHS settings face unpredictable lengths of stay (Kennedy-Williams, 2013); there is a complex mixture of diagnostic groups, and a constant pressure for new admissions (Clarke, 2009), impacting on the application of methodologically rigorous studies in this setting.

Meta-analyses has revealed that between 57.6% and 67.2% of community-based patients showed a clinically significant improvement in psychiatric symptoms within an

average of 12.7 psychotherapy sessions in clinical trials (Hansen, Lambert & Forman, 2002). However, naturalistic data from the same study showed that the average patient received fewer than five psychotherapy sessions and that the rate of improvement in this sample, indicated by clinically significant changes in psychiatric symptoms, was about 20% (Hansen, Lambert & Forman, 2002). This suggests that therapies delivered in a brief format may not be clinically or cost effective.

Psychological therapy. There are a number of UK-based publications that describe the application of psychological models, such as CBT in the acute mental health inpatient setting (Clarke & Wilson, 2009; Durrant & Tolland, 2009; Hanna, 2006; Kinderman, 2005; Rendle & Wilson, 2009; Rosebert & Hall, 2009). Clarke argued that the Interacting Cognitive Subsystems model (ICS; Teasdale & Barnard, 1993) presents an ideal "theoretical foundation to provide coherence between mindfulness-based treatments, attachment and transference theories, and direct work with emotion in the inpatient setting" (Clarke, 2009, p.67). It is suggested that there are several attributes of CBT that make it ideal for inpatient treatment, namely: the time-limited and relatively short-term course; manualisation of several versions; empirical evidence in support of the approach alongside psychopharmacology; and the ability to include a multidisciplinary team in the implementation and promotion of a cognitive milieu (Stuart & Bowers, 1995; Stuart, Wright, Thase & Beck, 1997).

Dialectic Behaviour Therapy (DBT), an approach developed for people with self-harming behaviour and a diagnosis of Emotional Intensity Disorder (EID; Linehan, 1993), has been adapted for use in specialist inpatient units (Bohus et al., 2000; Kroger et al., 2006; Swenson, Sanderson, Dulit & Linehan, 2001). Emotional coping skills groups, based on DBT principles, are often used in UK inpatient settings and focus on: exploring mindfulness, emotional regulation, distress tolerance and interpersonal skills (Rendle & Wilson, 2009).

The inherent unpredictability of inpatient admissions is likely to be a barrier in developing and maintaining a therapeutic relationship (BPS, 2012; Kennedy-Williams, 2013). Despite this, Holmes (2002) argued that clinicians have the capacity to build a therapeutic alliance with patients and their relatives in this setting. The main contributing factor to the success of community-based psychotherapy is thought to be the extra-therapeutic effects, with relationship factors possibly contributing to 30% of the variance in outcomes (Lambert, 1992; Lantz, 2004). Hanna (2006) highlighted complex issues regarding individuals' ability to engage in therapy, which can often be painful and challenging when extremely distressed or seriously unwell.

Psychological input for staff teams.   The role of psychologists in the acute inpatient setting is often far broader than providing individual therapy. It combines direct client work alongside with indirect work in the wider team, and strategic work within the care environment (Hanna, 2006; Nicolson and Carradice, 2002). The influential paper, 'Social systems as a defence against anxiety' (Menzies-Lyth, 1961), outlined the emotional impact of working in mental health inpatient settings and highlighted the need for support for front-line staff so that anxiety can be tolerated.   Input to the psychological thinking of the team in the form of consultation, reflective practice and supervision may enhance staff members' ability to reflect, empathise, and demonstrate mentalisation in relation to others: this is considered essential for the therapeutic relationship (Steadman and Dallos, 2009). It has been argued that indirect work with teams can have greater beneficial outcomes compared to individual client work in this setting, by indirectly influencing quality of care and treatment (McGowan & Hall, 2009).

Literature search

Rationale

Numerous organisations have called for an increase in the provision of psychologists in acute inpatient mental health hospitals; however, there are inherent challenges in providing inpatient psychological therapy and conducting empirical research in this setting. Despite this, a number of publications have explored the value of inpatient psychological therapy; but there has been no comprehensive review of the UK literature to date.

Research in the UK. The UK NHS operates a unique model of healthcare, based on availability to all, regardless of wealth. Despite similarities to European models of healthcare, there are important differences (Gold, 2011). The UK NHS is a centrally funded health service, 'free at the point of delivery' (Delamothe, 2008). Due to international differences in healthcare spending, demographic trends, and funding models (Keith Harris, personal communication, March 19, 2014), this review focuses on NHS services so that findings are representative of psychological application in the UK.

NHS context. Within the NHS there is a drive for clinical and cost-effective care. The Health and Social Care Act (DoH, 2012) introduced greater competition: those tendering to provide health services must offer low-cost and effective treatments (DoH, 2011), leading to an increase in emphasis on empirical evidence and practice-based evidence.

Aims

The aims of the review were to address the following questions:

1. How does the evidence present the role of inpatient psychologists?
2. What evidence is there to support the value of this provision?
3. What are the implications for clinical practice and further research?

Method

This review followed the systematic search and review process outlined by Grant & Booth (2009), whereby UK-based literature was searched to explore the value of psychological interventions in acute mental health NHS hospitals.

Search strategy.

Due to the changes in 1990 in terms of the provision of inpatient and community mental health care (NHS and Community Care Act, DoH, 1990), an advanced search identified the relevant papers published from January 1990 to March 2014. This was carried out using: PsychINFO, Medline, CINAHL, Web of Science, and all the EBM databases including Cochrane.

Key search terms were chosen by reviewing medical subject headings, and through identifying key words from previous reviews and relevant papers. The Population Exposure Outcome criteria (PEO; Bettany-Saltikov, 2013) were used to include words relating to 'mental health hospital' (population), 'psychology' (exposure), and 'change' (outcome) (Appendix A). The search strategy for each database included the mapping and exploding of search terms. An additional search was conducted using the indexing website Zetoc, in order to search psychological publications not indexed elsewhere. The abstracts for all search results were read, followed by the full article if the title or abstract clearly focused on a psychological intervention based in the acute mental health setting. The references of the relevant studies were hand searched.

Inclusion and exclusion criteria.

Search results had to be written in English, with papers that focused on psychological interventions in adult acute mental health hospitals. Papers were only included if they were

published and specifically attempted to measure the value of inpatient provision; therefore, discussion papers and those outlining or commenting on an approach to this type of provision were excluded.

This review does not address the needs of children, or forensic client groups. This is due to the clinical distinction between these populations; children and individuals convicted of criminal offences are likely to access specialist child and adolescent or forensic/high secure services respectively. Adults over the age of 65 years were excluded due to age-related risks of health and physical co-morbidity (Drayer et al., 2005; RCP, 2013).

Search results.

A total number of 2,227 relevant papers met the PEO criteria. This was reduced to 1,074 when limited to papers focused on working age adults, were written in English, and published post-1990 (Appendix B). These papers were reviewed and duplicate studies were excluded, plus those that did not report studies exploring NHS mental health populations in the UK. Papers that reported interventions as part of a therapeutic community were excluded; these settings are very different, often operating partial hospitalisation and intense psychotherapeutic treatment programmes (Chiesa, 2000). Sixteen papers were reviewed in depth to explore the value of inpatient psychological interventions in NHS acute mental health hospitals in the UK (Appendix C).

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Review

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Review process

The first stage of the review process assessed how the evidence presents the role of inpatient psychologists in acute mental health NHS settings in the UK (Appendix D). This was followed by a critical review of the evidence to support this provision. As a framework for reviewing the methodological rigour and quality of reporting, a checklist was developed to

incorporate guidance provided by Consolidated Standards of Reporting Trials (CONSORT, 2010; Zwarenstein et al. 2009), and the Critical Appraisal Skills Programme (CASP, 2013a; 2013b) (Appendix E). Quality of evidence was categorised as either 'good': methodologically sound and high quality of reporting, with meaningful treatment effects (not necessarily significant); 'moderate': methodological or reporting issues but meaningful treatment effects; 'tentative': methodological and/or reporting issues leading to tentative conclusions about treatment effects; and 'inconclusive evidence': methodological and reporting issues, with a lack of clinically meaningful treatment effects reported.

Role of inpatient psychologists

Ten papers reported psychological interventions exclusively exploring direct client contact. Three papers reported indirect interventions with staff teams. Three papers reported interventions covering a mixture of direct, indirect and strategic interventions (Table 1).

Table 1

Relevant papers organised by type of inpatient psychological input

Level of input	Role of psychology	Author (year of publication)	Quality of evidence	Total
Direct intervention	Individual therapy	Durrant, Clarke, Tolland & Wilson (2007)	Tentative	4
		Haddock, Tarrier et al. (1999)	Tentative	
		Lewis et al. (2002)	Good	
		Tarrier et al. (2004)	Good	
Direct intervention	Group therapy	Heriot-Maitland, Vidal, Ball & Irons (2014)	Inconclusive	2
		Ruane & Daddi (2011)	Inconclusive	
Direct intervention	Individual/ group and family therapy	Drury, Birchwood, Cochrane & MacMillan (1996a, 1966b)	Moderate	4
		Drury, Birchwood & Cochrane (2000)	Moderate	
		Long, Fitzgerald & Hollin (2012)	Tentative	
Indirect intervention	Input with staff	Berry, Barrowclough & Wearden (2009)	Moderate	2
		Shepherd & Rosebert (2007)	Inconclusive	
Direct and indirect intervention	Individual therapy plus staff input	Kerr (2001)	Inconclusive	1
Direct, indirect and strategic intervention	Mixed therapeutic approach	Gibson et al. (2008)	Inconclusive	3
		Kennedy, Smalley & Harris (2003)	Inconclusive	
		Kerfoot, Bamford & Jones (2012)	Tentative	
Total relevant papers				16

Evidence for psychological interventions

Relevant papers focused on Cognitive Therapy (CT), individual and group CBT, Cognitive Analytic Therapy (CAT), Compassion Focused Therapy (CFT), reflective practice, formulation meetings and mixed therapeutic approaches. The following section provides a synthesis of available evidence, organised by type of intervention.

Direct interventions.

Individual therapy. Lewis et al. (2002) reported the acute phase outcomes for a Randomised Controlled Trial (RCT) of CBT compared to Supportive Counselling (SC) and Treatment As Usual (TAU) in early schizophrenia. Tarrier et al., (2004) reported 18-month follow-up data. Both papers demonstrated a high quality of methodological rigour and reporting in accordance with the CONSORT (2010) checklist. Independent clinicians offered CBT and SC sessions, delivered in 15 to 20 hours within five weeks, plus booster sessions at two weeks, and one, two, and three months. Two standardised measures, reported as reliable and valid, were used: the Positive and Negative Syndrome Scale (PANSS; Kay, Opler & Lindenmayer, 1989), and the Psychotic Symptom Rating Scale (PSYRATS; Haddock, McCarron, Tarrier & Faragher, 1999). There were six follow-up outcome intervals between baseline measures and 70 days post-treatment, plus an 18-month follow-up.

Lewis et al. (2001) presented intention-to-treat, linear regression analyses using the Stata xtreg procedure. The Stata xtreg procuedure is a computational algorithm, which allows for efficient regression analyses in models with multiple levels of fixed effects, and is especially useful in longitudinal studies (McCaffrey, Lockwood, Mihaly & Sass, 2012). The authors reported that by week four the CBT group had statistically significant improvements in their outcome scores, compared to the SC and TAU group. This effect increased and remained significant at week five. At week six, there were significant treatment effects for both the CBT and SC groups compared to the TAU group, but the significant difference

between the effect of CBT and SC found at weeks five and six was not maintained. However, the resolution of auditory hallucinations as measured by the PSYRATS was faster in the CBT group compared to the SC group, which makes it difficult to interpret the significant combined treatment effects compared to TAU. The authors give a tentative interpretation that these findings might mean that CBT can lead to remission of acute psychotic symptoms at four weeks, whereas SC can achieve this at six weeks. They add that these results are based on post hoc analysis and should be interpreted with caution. It is reported that the resolution of auditory hallucinations in the SC group actually slowed by week five, suggesting that some elements of SC may be detrimental with respect to auditory hallucinations.

Tarrier et al. (2004) reported data collected at 18-month follow-up, namely: total and positive symptom scales (PANSS, PSYRATS), rehospitalisation and time to relapse; defined as: "An exacerbation of psychotic symptoms lasting longer than one week and leading to a change in patient management" (p.232). Analysis of Covariance (ANCOVA) and survivor analysis revealed significantly improved outcomes in terms of PANSS total and subscale scores for the treatment groups (CBT and SC) compared to TAU, but no differences on follow-up PSYRATS scores. There were no significant differences between treatment groups, but a trend towards a superior effect on hallucinations for the CBT group. The authors acknowledged a significant amount of missing data (n=85 cases), plus significant treatment centre effects on the number of sessions of therapy; one centre showed strong effects for CBT and SC, although this was not replicated in the other two centres. The paper stated that results indicate the beneficial nature of psychological treatment in terms of symptom profile at follow-up, but no advantage in terms of rates of relapse or hospitalisation. No significant differences between the CBT and SC groups provide counter evidence for the authors' hypothesis that specific CBT techniques were the active agents of change. This

research found evidence that contradicted findings by Sensky et al. (2000), where the treatment effects of SC were not maintained at follow-up. Tarrier et al. (2004) stated; "since supportive counselling is unstructured, it is difficult to understand why it performs as well as it does" (p.235). However, it could be argued that the 'active agents' in the psychological treatment relate to the therapeutic relationship, a common feature of CBT and SC. This study reported less intensive psychological input than Drury et al. (1996a, 1996b). The authors also acknowledged that their hypothesis that eight hours of therapy would lead to significant long-term benefits was over-optimistic.

Haddock, Tarrier et al. (1999) reported a controlled, parallel group study that evaluated the effectiveness of individual inpatient CBT compared to SC for inpatients with a schizophrenia diagnosis. Twenty-one participants were randomly allocated to the CBT or SC group, and interventions were delivered over five weeks or until the patient was discharged. 'Booster' sessions were offered in the community at one, two, three and four months post discharge. Eighteen out of 21 participants completed the Brief Psychotic Rating Scale (BPRS; Overall & Gorham, 1962) and the PSYRATS at study entry and end of treatment. Two-year follow-up data was collected in terms of relapse information, time to readmission, and the number of days in hospital post-treatment. Analysis of variance (ANOVA) revealed significant main treatment effects in terms of BPRS and PSYRATS scores over time, but no significant differences for group or interaction. Whilst the authors provided data for the BPRS pre and post mean scores and standard deviations, they did not provide this information for the PSYRATS scores and did not report effect sizes. This review calculated the effect sizes for the BPRS scores and found larger treatment effects for the SC group (d=1.10, r=0.48) compared to the CBT group (d=0.78, r=0.36), suggesting that the SC intervention may be superior in terms of psychotic symptom reduction for acute inpatients with a psychosis diagnosis. This is in contrast to findings from the previous studies, which

employed much more rigorous methodological designs and demonstrated a higher quality of reporting. Methodological concerns and reporting issues in this paper mean that only tentative conclusions can be drawn.

Durrant et al. (2007) reported a quasi-experimental before and after study that explored a transdiagnostic CBT programme. The authors claim that the research provides practice-based evidence, although arguably due to the methodological approach and reporting style, the available conclusions are limited. Specifically, this paper presented an optimistic but tentative 'case' for CBT in the inpatient setting. The intervention was based on the cognitive science-based model (Teasdale & Barnard, 2003), and provided a simple formulation and skills-based treatment. The authors claimed that this approach allows brief input over one or two sessions and can help people understand how their breakdown occurred, and offers simple ways to increase autonomy. Significant increases in post-therapy Mental Health Confidence Scale (MHCS; Carpinello, Knight, Markowitz & Pease, 2000) scores were reported. Further exploration revealed that the significant difference was specific to the 'coping style' subscale. Mean pre-therapy scores for internal locus of control were significantly lower than post-therapy scores, although no significant differences were found between pre and post therapy scores for the measure of external locus of control. The authors stated that post-therapy, participants reported significant increases in their ability to express emotions and the use of strategies to cope with emotions. Approximately 57% of participants reported that they met at least one goal completely, whereas 42.85% felt that none of their goals were achieved post-therapy indicating a variation in experiences of the intervention.

Group therapy. Raune and Daddi (2011) reported an observational case series study, which presented a ward-based weekly CBT group, facilitated by a clinical psychologist. The group adopted a sole-stand-alone treatment format for a heterogeneous acute psychiatric sample recruited from two wards from the same unit. One hundred and thirty-seven patients

attended a total of 291 times across 31 groups: being female and having a diagnosis of

bipolar disorder predicted re-attendance. 43% patients attended more than once, with

relatively good attendance each week (M=9.4, range=1-20). 63% of attendees completed a

brief, non-standardised, questionnaire and correlational analyses were used to explore the

association between the questionnaire feedback and attendance. Finding the group enjoyable

was the strongest significant predictor of re-attendance, whereas learning something to

reduce distress was a low significant predictor of re-attendance. This finding is likely to be

important for this service in terms of group CBT engagement. Unfortunately there were no

follow-up measures or feedback from staff about the impact of the group. Whilst the authors

attempted to thoughtfully interpret the feedback from the group attendees, the lack of

methodological rigour means that clinically meaningful claims about the interventions cannot

be substantiated. The lack of standardised outcome measures, plus insufficient detail of

reporting, limits the findings from this research.

Heriot-Maitland et al. (2014) presented a quasi-experimental before and after study of

a weekly 50 minute, four-session transdiagnostic group approach informed by CFT in an

inpatient setting. The CFT sessions incorporated psychoeducation, mindfulness, compassion

and imagery respectively. The authors presented pre and post outcome data from a non-

standardised measure for calmness and distress for 57 group attendees and reported that non-

parametric analysis revealed a significant reduction in post-session distress overall,

particularly for the session focused on compassion. A significant increase was found for

overall and post-session calmness, especially after the session focused on imagery. Semi-

structured interviews with four participants by an independent researcher focused on

participants' motivations in attending the group, their experiences of the group, and

recommendations for improvement. Thematic analysis of the semi-structured interviews

tentatively concluded that inpatients' engaged well with the group, and that their experiences

were closely aligned to the key features of CFT. Difficulties in attending, as described by the patients, were: getting on with other group members, high distress or agitation, lack of engagement with the content, or needing to attend other appointments or meetings. The authors commented on how the group allowed people to share stories and their distress, leading to feelings of normalisation and validation, although it is not possible to generalise these findings due to methodological constraints. Similarly to previous studies, the lack of standardised outcome measures limits the reliability and validity of this study, in addition, the study is limited by the lack of sufficient detail in the reporting; for example, regarding recruitment and sample selection.

Individual, group and family therapy. Drury et al. (1996a, 1996b) and Drury et al. (2000) reported data from a RCT comparing an intensive treatment model of individual and group CT plus family work, to a control group that received recreational therapy and informal support. Participants presented with hallucinations, delusions and abnormal behaviour, such that functional psychosis was indicated as a primary diagnosis. Forty inpatients were recruited to the Drury et al. (1996a, 1996b) studies; 20 participants in the treatment and control groups, of which 25 (62.5%) were men. Thirty-four of these participants were available to follow-up in the Drury et al. (2000) study. Both the CT group and the control group received an average of eight hours of activity per week for a maximum of six months. Symptomology was measured using the Psychiatric Assessment Scale (PAS; Krawieca, Goldberg & Vaughn, 1977) and a self-report measure of delusional conviction (Brett-Jones, Garety & Hemsley, 1987).

In paper 1, Drury et al. (1996a) reported that both the CT and the control group showed a significant and marked reduction in positive symptoms in the 12-week period post admission. This decline in positive symptomology was greater for the CT group, significant after week seven, maintained at week 12 and in line with the authors' hypothesis. In terms of

core delusional beliefs, both groups demonstrated a reduction in 'belief conviction' and 'preoccupation' over the 12-week period. For 'belief conviction' this decline was significantly greater in the CT group.

In paper 2, Drury et al. (1996b) reported that based on three distinct recovery criteria, the CT intervention led to more rapid resolution of psychotic symptoms within the six-month follow-up period. In comparison to the control group, the CT group participants' recovery time was reduced by between 25-50%, which equated to between 42-84 fewer days than the control group. Gender, duration of untreated 'illness' prior to the first episode, and time elapsed since first episode were found to influence rates of recovery in both groups.

In paper 3, Drury et al. (2000) reported five-year follow-up data, which found no significant differences in relapse rates, positive symptoms or insight between CT and control groups. However, the CT group was reported to show greater perceived 'control over illness' than control group individuals. For those experiencing a relapse of psychotic symptoms in the five-year follow-up period, self-reported psychotic symptoms were significantly lower in the CT group. Due to some methodological issues and insufficient reporting, the moderate findings presented by these papers should be interpreted with caution.

Long et al. (2012) reported an observational case series study, which focuses on an 'eclectic' intervention for 34 inpatients with an Anorexia Nervosa (AN) diagnosis in a specialist eating disorders inpatient unit. The inpatient treatment formed four phases and included 15 different therapeutic interventions ranging from 'supportive psychotherapy' to 'dynamic group therapy', CBT, and art therapy. The psychological components of this eclectic approach were reported as typically delivered in the 'latter stages' of inpatient admissions. Seven outcome measures were completed pre-admission, post-discharge and 4 years after admission. Significant differences were found between admission and discharge for measures of outcome (Morgan-Russell Assessment Schedule; MRAS, Morgan &

Hayward, 1988), eating disorder symptomology (EDI; Garner, Olmstead & Polivy, 1983), psychological distress (Brief Symptom Inventory; BSI, Derogatis, 1993), and self-esteem (Culture-Free Self-Esteem Inventory; CFSEI, Battle, 1981). Forty-four percent of patients were classified as remitted four years after leaving inpatient treatment. Patients with post-discharge continuity of treatment, whereby inpatient treatment continued in the community had higher rates of improvement. Due to the eclectic mix of available interventions and lack of control group, the authors rightly state that it is not possible to attribute change to particular treatment elements. Lack of adequate controls mean that it is impossible to attribute change to the psychological intervention alone; therefore, this paper has been classified as offering tentative conclusions.

Indirect interventions.

Input with staff. Berry et al. (2009) reported a quasi-experimental before-and-after study, which explored the impact of a service-user formulation group for staff members. Ward-based formulation meetings were facilitated by a clinical psychologist and included a discussion about the possible factors that were involved in the development and maintenance of service-users' presenting problems. Each meeting focused on one case that staff members reported as struggling with, or wanting to understand better. Staff perceptions were measured immediately prior to the intervention and also six hours afterwards, using the Brief Illness Perception Questionnaire (IPQ: Broadbent, Petrie, Main & Weinman, 2006) and the IPQ for Schizophrenia (Lobban, Barrowclough & Jones, 2005). Repeated measures t-tests revealed significant differences in pre and post scores for all of the measures, indicating that post-intervention staff perceived service-users as exerting more effort into getting well, less likely to have caused their problems themselves, and less likely to blame for their problems. Interestingly, staff member optimism increased: beliefs about treatment efficacy increased, beliefs about the likely duration of problems decreased, and positive perceptions about

service-users' control over problems increased. However, there was no exploration of the impact of these changes. The authors' adhered to high standards for the reporting of results, although this was not a comparative study and lacked sufficient controls, blinding and follow-up.

Shepherd and Rosebert (2007) reported data from an evaluation of an inpatient-based reflective practice group for inpatient and community staff members working with inpatient service-users. Methodological constraints and a significant lack of reported information limit the findings, although they give an indication of the type of provision that is feasible in this setting. The weekly group included a brief presentation by a staff member of a particular service-user, an outline of the help or advice needed, followed by a 35 minute group discussion drawing on theory-practice links and reflective practice. A non-standardised questionnaire was given to 12 staff members, the 'majority' of whom felt that group discussion was useful, they felt comfortable presenting to the group, they were interested in the presentations, and communication between teams in the group had been good. Qualitative feedback indicated that the group had been useful in helping manage and work with service-users on the ward and that more time for the group was needed to enhance attendance. The lack of standardised outcome measures limits the findings in terms of reliability and validity, which means that they cannot be generalised and are limited in terms of informing service development.

Direct and indirect interventions.

Individual therapy plus work with staff. Kerr (2001) reported an observational case study focused on brief CAT with four Psychiatric Intensive Care Unit (PICU) patients that presented with treatment-resistant psychosis. The intervention, delivered over one to six sessions, aimed to establish a therapeutic alliance, improve treatment compliance and reduce levels of disturbed behaviour. The CAT reformulations were discussed in staff team

meetings to consider the role of staff members in the maintenance of patients' presenting problems. Treatment proved 'redundant' for two patients: one had an improved medication regime, and the CAT treatment was impossible for the other due to fixed grandiose and paranoid delusions. Kerr (2001) reported that for the two remaining participants the approach appeared 'containing' and effective, evidenced by subsidence of disturbed and non-compliant behaviour. The author valued the relational nature of CAT interventions, stating that this can be a useful approach to address difficult staff member dynamics often experienced in the acute inpatient setting, although this research does not explore this hypothesis. The paper stated that a collaborative and therapeutic working relationship was possible and productive. However, due to the case study nature of the report, it is not possible to establish the causal relationship between the CAT intervention and 'productivity'. Kerr (2001) suggested that the CAT approach appeared helpful for the staff team, acting as a 'containing' and 'defusing' process for the stress and anxiety felt when working with distress. The author claims that the research constitutes study of the efficacy of CAT-based reformulations, although he acknowledges that in order for these findings to be substantiated, further evaluation using a controlled study design is needed.

   Direct, indirect and strategic interventions.

   Mixed therapeutic approach. Kennedy et al. (2003) presented a service evaluation of psychological provision to an acute inpatient ward over the course of a year. One of the important findings in this audit was that it provided evidence of all three levels of working as set out by the MPAG (1990). This provides tentative indications about the broad scope for psychology in this setting. Service-user and staff member feedback was sought based on a non-standardised questionnaire that focused on treatment, access, communication, usefulness, education and change influence. The authors reported positive outcomes for all feedback items, although the lack of independent data collection may have led to response bias.

Service-user feedback included feeling 'normal' and gaining a new understanding of their problems following psychological input. Given the non-experimental design of this study, these findings cannot be substantiated or generalised. Responses also indicated that all groups would like increased access to psychological treatment in the inpatient setting, although this paper does not provide conclusive evidence to demonstrate that an increase in such provision would be clinically worthwhile. Service evaluation can be incredibly useful in terms of the development of unique services; however, given the non-experimental design, findings cannot be generalised to other inpatient populations. Additionally, insufficient detail about the sample, measures and response rates is concerning.

Kerfoot et al. (2012) reported a quasi-experimental before and after study of an inpatient psychological service which was formed in 2009 and provided input across three mental health wards and a PICU. The authors acknowledged that, at best, this service was viewed as beneficial by staff members and service-users. They also acknowledged that there is a greater need for further and more methodologically rigorous research. The team were reported to operate a 'stepped care' model of psychological input, which ranged from ward-based groups using CBT, DBT, motivational interviewing and mindfulness techniques, to individual assessment and treatment with inpatients. Consultation and formulation were offered, to inform care plans, discharge and risk planning for the inpatient teams. Staff member feedback was collected using the Recovery Self-Assessment: Provider Version (O'Connell et al., 2005), a 32-item measure of staff-knowledge and use of recovery principles. Sixty-five responses across four wards were received and indicated that the psychology service is highly valued by staff members in terms of patient care, plus personal and professional support.

Patient feedback was elicited through the use of the Essen Climate Evaluation Schema questionnaire (EssenCES; Schalast et al., 2008), a 17-item measure of the social and

therapeutic atmosphere of psychiatric wards and the Inpatient Treatment Alliance Scale (ITAS; Blais, 2004). Results found that since the introduction of the service there was an increase in people leaving hospital with a plan for their wellbeing and/or a crisis plan and a reduction in likelihood of readmission shortly after discharge. Positive patient feedback from the inpatient groups indicated that talking helped reduce perceived isolation and led to an increase in people's experiences of being helpful to others. The authors commented on the similarities between this feedback and Yalom's (2005) ideas regarding the usefulness of inpatient psychology groups. Due to the methodological approach used, it is not possible to establish a causal link between the psychological input and these outcomes. Whilst the quality of reporting was relatively good, with adequate consideration of the study's limitations, the methodological approach limits the extent to which clinically meaningful results can be interpreted.

Gibson et al. (2008) reported an observational case series study based at a 19-bed male acute psychiatric ward in a London mental health hospital over a six-month period, focusing on the provision of multi-disciplinary therapy input. A part-time (0.5 working time equivalent) psychologist recorded 204 contacts during the six-month period, offering 117 individual sessions to inpatient service-users. Results indicated a high level of service-user engagement in the project. There was a reported 26% reduction in incidents on the ward over the duration of the project, compared to the previous year. However, there were no significant differences between pre and post scores using the patient-staff conflict checklist (Bowers et al., 2006), which measures changes in frequency of reports of aggression, rule-breaking, drug and alcohol use, plus uses of restraint. The authors reported the use of feedback questionnaires given to assess staff, service-user and carer views. This found that the psychology service was valued; for example, having the opportunity to talk and reflect. The authors commented on the low response rate for the questionnaire feedback.

Additionally, it is not clear what questionnaire was used or how many were completed. Significant methodological issues and a lack of adequate information about the treatment intervention mean that the findings must be interpreted with caution and impact the generalisability of the findings.

Discussion

Summary of findings

This review presents a summary of the available evidence that explores the value of inpatient psychological interventions. The main findings are as follows:

1. Brief CT for psychosis can lead to remission at four weeks compared to SC and TAU (Lewis et al, 2002).

2. Brief CT and SC can lead to a significant reduction in positive and negative symptoms of psychosis 18-months post-treatment (Tarrier et al., 2004).

3. Brief CBT and SC interventions can reduce psychotic symptoms at discharge and two-year follow-up (Haddock, Tarrier et al., 1999).

4. One or two sessions of CBT can significantly increase: confidence in coping with mental health issues, internal locus of control and ability to express emotions (Durrant et al., 2007).

5. Finding a group CBT intervention 'enjoyable' is a predictor of re-attendance, whereas 'learning something to reduce distress' is a low significant predictor of re-attendance (Ruane & Daddi, 2011).

6. A group CFT intervention can increase service-user calmness and decrease distress, although attendance in the inpatient setting can be difficult (Heriot-Maitland et al., 2014).

7. CT in the context of individual, group and family work can lead to a reduction in positive psychotic symptoms after seven weeks, maintained at six-month follow-up (Drury et al., 1996a, 1996b).

8. An eclectic psychological intervention for AN can lead to a reduction in psychiatric symptomology post-discharge, and continuity of treatment in the community leads to greater improvements (Long et al., 2012).

9. A formulation group for staff members can lead to short-term positive changes in staff perceptions of service-users (Berry et al., 2009).

10. A reflective practice group has been perceived as useful in helping manage and work with service-users by staff members (Shepherd & Rosebert, 2007).

11. A collaborative therapeutic relationship is possible as part of a CAT intervention delivered in a brief, four session format (Kerr, 2001).

12. Service-users have reported feeling 'normal' and gaining a new understanding of their issues following psychological input in the inpatient mental health setting (Kennedy et al., 2003).

13. Inpatient psychological interventions have been reported to reduce isolation for service-users and have shown high levels of ward engagement. Input appears to be valued by service-users and staff members (Gibson et al., 2008; Kerfoot et al., 2012).

General Critique

Tentative evidence. Inpatient psychological input is a broad topic area with a small and tentative evidence base. There are few UK studies that adopt sufficient empirical rigor, with many papers limited in the reliability and validity of their findings, and lacking in generalisability. Despite these issues, there are a number of optimistic findings about the benefits of inpatient psychological provision, which warrant further exploration.

There are claims relating to the role of psychology in the restoration of insight and more rapid recovery, particularly for individuals with a first episode psychosis diagnosis. Specifically, CT and CBT were found to lead to a reduction in psychotic symptoms and that these effects were maintained at follow-up. Some inconsistencies were found in terms of the superiority of these interventions compared to SC; therefore, further research would be useful.

A common conclusion is that inpatient psychology is valued by staff members and service-users, as exemplified through multi-agency calls for increased psychological provision in this setting. Relevant papers reported that it was possible to develop a collaborative and therapeutic relationship, despite the brevity of the interventions. There was evidence to suggest that maintenance of this relationship during the discharge transition might lead to greater improvement.

It has been claimed that psychological input in this setting can help individuals feel 'normal' and gain an understanding of their problems (Kennedy et al., 2003), although there is no causal evidence to support this to date. Further research should seek to explore these issues further; specifically to address the extent to which normalisation and increased understanding of issues can be clinically meaningful, and whether effects can be maintained.

Methodology. Controlled investigations of therapy for inpatients have been limited thus far to studies exploring the effect of adding therapy to other forms of treatment used in medical models or eclectic milieus (Wright, 1996). This review found a limited number of controlled and comparative studies, and a lack of researcher blinding and randomisation to groups. For the papers that did present methodologically sound studies, there were concerns about the generalisability of the findings given the majority of white male participants and focus on diagnoses such as psychosis and schizophrenia (Haddock, Tarrier et al., 1999; Lewis et al., 2001; Tarrier et al., 2004). The current literature predominantly focuses on

schizophrenia/psychosis, and treatments that are informed by cognitive and behavioural models. There was also a disappointingly limited discussion within the papers of the routine inpatient care received, and the possible impact of this on recovery.

Just over half of the relevant papers failed to report standardised outcome measures, or gave insufficient detail to describe outcome measurement or statistical analyses (Appendix E). This limits the reliability, validity and generalisability of findings. An alternative to these problems could be the use of the reliable change index (Jacobsen & Truax, 1991) as a way of exploring pre and post differences on a case-by-case basis.

Environmental challenges. Kerfoot et al. (2012) stated that randomisation would have been difficult to achieve on the basis that the majority of patients were exposed to some indirect psychological intervention (e.g. staff training, joint working or formulation groups). This highlights the inherent difficulties in empirically testing the broad role of a psychological practitioner in the inpatient setting.

Durrant et al. (2007) stated that they were constrained by sample size in terms of statistical analyses, citing low response rates for post-therapy measures. These difficulties are echoed by Haddock, Tarrier et al. (1999), who acknowledged a high refusal rate for participation in their study. Gibson et al. (2008) suggested that motivational and concentration difficulties commonly experienced by people with mental health problems may have been a barrier to the completion of questionnaires, plus the fact that staff already felt overwhelmed with the amount of routine paperwork they were expected to complete.

Tarrier et al. (2004) explained that the mean number of therapy hours was below the target of 15 to 20 hours, citing that this was due to logistical problems and high levels of participant distress. This emphasises the limitations of providing psychological input in the acute mental health hospital setting.

Implications

Clinical practice.

Most of the papers demonstrate that inpatient psychological services are feasible and well received by staff members and service-users. However, the majority of research focuses on psychological treatment for individuals with a diagnosis of psychosis or schizophrenia, limiting the clinical implications for the transdiagnostic inpatient mental health setting. For those papers able to demonstrate that a psychological intervention had been effective for some, it was also clear that this approach may not suit everybody. This appears to highlight the importance of specialist psychological assessment, collaborative formulation, and clear goals that reflect service-user, staff member and organisational aims. Long et al. (2012) reported increased benefits for interventions continued during the discharge transition and in the community. This finding has been replicated in therapeutic community settings (Cheisa & Fonagy, 2000; Cheisa, Fonagy & Holmes, 2003). Research has highlighted the importance of the therapeutic relationship during the discharge transition period (Tierney & Fox, 2009) and therefore it may be important to consider how and when treatment is terminated in the inpatient setting.

Durrant et al. (2007) commented on how psychological therapy is often postponed until discharge from acute mental health hospitals, which may be a contra-indication of the recovery model. It is suggested that a crisis is the right time for individuals to "make sense of their situation" (Durrant et al., 2007, p124). The BPS (2011) has suggested that psychological formulation can help service-users feel understood and contained, increasing a sense of meaning and hope.

Service provision.

The evidence indicates that direct, indirect and strategic interventions are feasible in this setting, and are valued by service-users and staff members. The current research on the

clinical efficacy of psychological interventions in the inpatient setting is not conclusive; however, there are calls to increase this provision (Sainsburys Centre for Mental Health, 1998). There is some support for the capacity for brief interventions to reduce symptomology and feelings of isolation, and increase feelings of calm and a sense of understanding for people. Commissioners of inpatient mental health services are responsible for service provision and it may be prudent to encourage the routine clinical use of standardised outcome measures, and engagement with service evaluation, to inform local or regional decisions about access to psychology.

Despite limited evidence, it would appear that there is a strong policy emphasis on the importance of access to psychological assessment and treatment (The National Framework for Mental Health; DoH, 1999). The National Institute for Health and Care Excellence (NICE) guidelines recommend family work and CBT as acute phase interventions for psychosis or schizophrenia (NICE, 2009). A meta-analysis of international-based studies found a robust and significant small effect for inpatient psychological interventions in the case of depression when compared to TAU or pharmacotherapy (Cuijpers et al., 2011). This demonstrates the need to gain a better understanding of how psychology can be useful, and its relationship to change in UK settings.

Future research.

Kerfoot et al. (2012) stated that developments in the provision of inpatient psychology in acute mental health settings appear to be exceeding the evidence base. Despite this, there is a clear sense of enthusiasm and passion in further researching and evaluating inpatient psychology services, with a particular focus on the continued development of therapeutic and positively experienced inpatient ward environments.

It is clear that there are setting-specific challenges to conducting research with rigorous experimental designs in this setting. Clinicians must think in creative ways in order

to adapt the 'gold standard' RCT to this environment. Randomisation of participants and double-blinding of researchers/clinicians is likely to be extremely difficult in this setting, although demonstrable (Lewis et al., 2001; Tarrier et al., 2004). Unpredictable lengths of admission, high levels of distress, and a demanding workload for staff members may affect study engagement. It may be more useful for future research to adopt an exploratory approach to research in this setting, firstly establishing how staff members and service-users conceptualise the value of inpatient psychological provision.

The National Institute for Health and Clinical Excellence (NICE) and the National Collaborating Centre for Mental Health (NCCMH) have recommended service-user experiences as an outcome in the evaluation of care, and report that many people place a great deal of importance on the value of the therapeutic relationship in acute mental health services (NCCMH, 2011; NCCMH, 2012; NICE, 2011).

Review limitations

Inpatient-based psychology is a relatively under-researched area. This review found that few studies adopted methodologically rigorous methods and sufficient reporting. This limits the conclusions that can be drawn from such a review, but highlights the importance of further research if the calls for an increase in inpatient psychology provision are to be taken seriously.

This review excluded papers that explored interventions for children and young people, and older adults in the inpatient mental health setting; therefore, conclusions cannot be generalised beyond working-age adults. Unpublished papers were not included in this review; therefore, findings may be subject to publication bias (Rosenthal, 1979).

Conclusion

The broad findings of this systematic search and review suggest that a range of psychological interventions are feasible in this setting, such as: individual and group CBT, CFT, reflective practice for staff, and mixed therapeutic approaches. It is clear that current literature exploring the efficacy and effectiveness of inpatient psychological input in the UK is limited and requires further evidence. This may be particularly pertinent given the continued pressure to increase the provision of such input.

Psychological input is valued by staff members and service-users in the acute inpatient mental health setting. The next step is to establish what it is that is valued about this approach, and whether the connections made between psychology and 'value' are clinically meaningful.

Given the difficulties in conducting research in this setting, it is likely that clinicians and researchers will need to think creatively about a flexible research approach that considers the inherent unpredictability of the acute inpatient ward. Involving both inpatient staff members and service-users in this research would be a useful way of triangulating experiences. Further research and evidence for this approach is imperative for the continuation of the provision of psychology in the inpatient setting.

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Eloise G. DONAGHAY-SPIRE BSc (Hons) MSc

INPATIENT PSYCHOLOGICAL INTERVENTIONS

MAJOR RESEARCH PROJECT

SECTION B: EMPIRICAL PAPER

AN EXPLORATION OF SERVICE-USER AND STAFF MEMBER

NARRATIVES OF PSYCHOLOGICAL INPUT IN ACUTE

INPATIENT MENTAL HEALTH SETTINGS

For submission to Psychology and Psychotherapy Theory Research and Practice

ACCURATE WORD COUNT: 7,980 (474)

Abstract

Objectives

Literature suggests that individuals experiencing acute mental health difficulties can benefit from psychological input, with calls to increase psychological provision in inpatient mental health settings in the United Kingdom (UK). Despite this, there is limited research to support this demand, which may in part be due to inherent difficulties in conducting research in this setting.

Design

This paper used an interview design to examine experiences of inpatient psychological interventions in National Health Service (NHS) inpatient mental health settings.

Methods

Narrative analysis was conducted to explore staff members' and service-users' experiences of psychological input.

Results

Evidence was found to support the use of direct, indirect and strategic interventions, and formulation and the therapeutic relationship were conceptualised as common features of such input. Connections between inpatient psychology and change within the stories suggested that interventions can help people make sense of a crisis, improve relationships and contribute to meaningful recovery. Barriers were also presented, suggesting that psychological input in this setting might not be right for everybody.

Conclusions

This paper demonstrates that psychological input in the acute inpatient mental health setting is perceived as meaningful and can lead to changes. There is also a sense that this provision can be challenging, highlighting the need for further research.

Practitioner points:

- Psychological input in the inpatient setting, such as formulation and developing a therapeutic relationship, is possible and valued by staff members and service users.

- Staff members and service users made connections between psychological input and change, suggesting that interventions can: improve relationships, help people make sense of a crisis, and contribute to meaningful recovery.

- There are significant barriers and challenges to providing psychological input in this setting, and some participants suggested that this approach might not be right for everyone.

- Further research should be conducted to explore the clinical and cost-effectiveness of psychological input in the inpatient mental health setting.

Key words: Inpatient, Acute mental health, Psychology, Change, Narrative Analysis.

An exploration of service-user and staff member narratives of psychological input in

acute inpatient mental health settings

Inpatient environments

There is a desire for greater provision of psychological practitioners in the acute inpatient

mental health sector (British Psychological Society; BPS, 2002; Clarke, 2009; Department of

Health; DoH, 2002; Kinderman, 2005; Sainsburys Centre for Mental Health, 1998; Short,

2007). However, there is a lack of evidence to support this development (Holmes, 2002;

McGowan & Hall, 2009). This may be partly related to the inherent challenges of carrying

out empirical research in the inpatient setting, such as: unpredictable lengths of stay, the

complex mixture of diagnostic groups, the uncertainty of diagnoses and constant pressure for

new admissions (Clarke, 2009).

Inpatient psychological provision

The role of psychological practitioners in the acute setting is often far broader than providing

individual therapy, combining direct client work with indirect work in the wider team, and

strategic work within the care environment (Manpower Planning Advisory Group, 1990;

Nicolson and Carradice, 2002). Input to the psychological thinking of the team in the form of

consultation, reflective practice and supervision may enhance staff members' ability to

reflect, empathise, and demonstrate mentalisation in relation to others, which is considered

essential for the therapeutic relationship (Steadman and Dallos, 2009). Such input may

support service users and staff members to "bear the anxiety and uncertainty of the change

process" (Menzies-Lyth, 1986, p466).

       Empirical evidence.

Much of the evidence for psychological therapies focuses on outpatient services, which are

fundamentally different in terms of levels of patient distress, levels of prescribed medication,

and the level of therapeutic input received (McGowan and Hall, 2009). Few well-constructed

trials of psychological interventions have been published in the UK, with a predominant

focus on the effect of Cognitive Therapy (CT) and Cognitive Behavioural Therapy (CBT) on

psychiatric symptoms, rates of relapse and re-hospitalisation for individuals with a psychosis

or schizophrenia diagnosis (Drury, Birchwood, Cochrane & MacMillan, 1996a, 1996b;

Drury, Birchwood & Cochrane, 2000; Lewis et al., 2001; Tarrier et al., 2004). The findings

of these studies are likely to be limited in terms of their application to the transdiagnostic

inpatient mental health setting. Clinicians have proposed a number of theoretical arguments

for the benefits of application of psychology in NHS acute inpatient mental health settings;

but there is still a need for robust empirical evidence to support this demand.

Mental health crises may be seen as critical turning points in an individual's life,

offering opportunities for resolution and growth (Roberts, 2005). There is potential for an

emerging framework, focused on inpatient psychological input enabling change at an

individual and organisational level.

Formulation.

In hospital settings, distressing mental health experiences are predominantly conceptualised

as 'mental illnesses'. The Division of Clinical Psychology (DCP, 2013) highlights the

theoretical and empirical limitations to the 'disease model'. Kennedy (2009) argues that

formulation can be useful for understanding the experiences of inpatient service-users and

client-staff-environment interactions, informing treatment and discharge transition.

Johnstone (2013) acknowledges the limited research on the impact of formulation, but

suggests that it is an approach welcomed by inpatient staff members. Summers' (2006)

qualitative study, based in a mental health rehabilitation ward, reported that formulation can

encourage tolerance and patience, and increase empathy in staff members. In terms of

strategic change, formulation can arguably achieve a consistent team approach; generate new

ways of thinking; help staff manage risk; and increase team understanding, empathy and reflectiveness (DCP, 2011).

Direct psychological interventions.

Individual psychological interventions for the acute inpatient mental health setting typically draw on theoretical models developed in community-based settings (e.g. Kerr, 2001). Given the unique aspects of the inpatient setting, interventions are often adapted to meet the needs of the environment (Heriot-Maitland, Vidal, Ball & Irons, 2014). However, evidence suggests that altering the format of interventions, such as brief provision of CT, can only offer minimal effects compared to supportive counselling in the inpatient setting (Lewis et al., 2001; Tarrier et al., 2004). Studies have shown that brief CBT interventions can lead to significant treatment effects, but only when provision is intense and considers individual, group and family work (Drury et al., 1996a, 1996a).

Emotion coping skills groups have been promoted in the UK acute mental health setting, based on Linehan's (1993a) principles of Dialectical Behaviour Therapy (DBT) for emotion regulation (Rendle & Wilson, 2009). DBT is based on a biosocial understanding of overwhelming emotion and aims to teach mindfulness, emotional regulation, distress tolerance and interpersonal effectiveness skills (Linehan, 1993b). Evidence suggests that when provided as part of a partial hospitalisation programme in an NHS therapeutic community, DBT can lead to significant improvements in symptomology at six, 12 and 24 months post-treatment (Cheisa & Fonagy, 2000; Cheisa, Fonagy & Holmes, 2003). Whilst this treatment setting differs significantly, these findings warrant further research exploring the benefits of DBT in the acute inpatient mental health setting.

Indirect psychological interventions.

The DoH (2002) recommends that staff members should have space for reflection, thinking and understanding as part of acute mental health inpatient care provision. Facilitation of reflective practice is suited to psychological practitioners, requiring clinicians to draw effectively on a wide range of theories and models, such as: CBT, systemic approaches and influences of countertransference (Cowdrill & Dannahy, 2009). It is thought that the process of reflection can improve and enhance clinical practice (Paget, 2001). There is little evidence to date that supports this claim, although a pilot evaluation of an inpatient reflective group facilitated by psychological practitioners indicated that staff members found it useful in helping work with, and managing service-users' distress on the ward (Shepherd & Rosebert, 2007).

Future research

The theoretical framework for the application of psychology in the acute inpatient mental health setting has received insufficient research attention. It is proposed that inpatient psychologists work in this setting in varied and flexible ways, although evidence to support the value of this is limited. Further research should seek to explore current service models of inpatient psychological provision, in order to understand the role of psychology in an inpatient setting, what it can achieve, and how it does this.

The need for qualitative research.

Qualitative research is useful in exploring experiences, and further elucidating inpatient service-users' and staff members' experiences of psychological provision in this setting. This may enable greater understanding of the scope of inpatient psychological provision, and whether the tentative conceptual understanding presented by the literature makes sense to those who have experience of psychology in this setting.

Narrative analysis specifies an interpretative approach, considering the sequences of events and relationships 'unfolding in time' (Riessman, 2008). Ricoeur (1991) argues that human experience in time can be understood only through the stories that we tell. Narrative analysis privileges participants' views and responses; their interpretation of events; and the importance of contextual elements, such as the co-construction of the narrative between participant and researcher.

Aims

A qualitative method was chosen to address some of the inherent difficulties in conducting research in an acute inpatient mental health setting. A narrative approach was used to consider the role of inpatient psychology as they feature in service-users' and staff members' stories, in an attempt to capture the complexities in the experience of recovery from mental health crises. Narrative analysis was chosen rather than a thematic or observational method, in order to specifically consider the sequential elements of participant experiences, and to adequately capture the inherent relational complexities in therapeutic work and how these develop over time. This research sought to further understand what happens when psychological input is offered in the inpatient setting, and how service-users and staff members understand and portray these experiences through the stories that they tell.

Research questions

a. What types of psychological input feature in the stories of service-users and clinicians?

b. What stories do service-users and clinicians tell about how psychological thinking fluctuates over time?

c. What connections, if any, do service-users and clinicians make between inpatient psychological input and change?

d. What parallels and divergences exist in the stories told about inpatient psychological

input?

Method

Design

This paper employed an interview design. Semi-structured interviews were conducted,

whereby the researcher facilitated 'narrative telling' of experiences of inpatient psychology

(Riessman, 1993, p54). It is thought that people make sense of, and describe connections

between, sequential events and ideas through narrative and stories (Bruner, 1990). Narrative

analysis is thought to adequately preserve the complexity of contextual and interpersonal

interactions, and the idiosyncrasy of individual experiences. The exploratory nature of the

narrative approach suited the relative lack of research in this area.

Participant selection.

Recruitment. Recruitment took place between June 2013 and January 2014, in three

inpatient hospitals and four community services within a mental health NHS Foundation

Trust. A purposive sampling method was used (Marshall, 1996).

Inclusion and exclusion criteria. The inclusion and exclusion criteria were informed

by the research questions.

Service-user criteria:

1) Experience of psychological input during an acute admission to a mental health hospital

in the last six months.

2) Capacity to consent to participation.

3) Sufficient command of the English language to engage in the data collection process.

4) Participation unlikely to cause undue distress.

Staff-member criteria:

5) Employed by the mental health NHS Trust at the centre of this study.

6) Experience of working with a service-user participant recruited to the study within the last six months.

7) Consent from service-user participant to discuss their care with the staff member.

Exclusion criteria:

8) Service-users considered at high risk to themselves or others.

9) Service-users with a primary diagnosis of substance misuse. These individuals are not typically seen by psychological practitioners in an inpatient setting within this NHS Trust.

Sample characteristics. Ten people consented to participate (Appendix H): four service-users and six staff members (Table 1). One interested service-user declined due to personal commitments and another due to concerns about his admission, which had been a traumatic experience. Eight staff members met the inclusion criteria, and six consented to participate (Table 2). Two staff-members declined: one due to work commitments. The other did not respond to telephone or email contact from the researcher.

Table 1

Service-user participants

Pseudonym	Inpatient	Community location	Input* Individual (group)	Ethnicity	Interview**
Louise	Hospital 1	Community 1	14 (0)	White British	54.86
Maggie	Hospital 2	Community 2	2 (4)	White British	40.37
Lee	Hospital 1	N/A: current inpatient	46 (4)	White British	55.24
Jane	Hospital 3	Community 3	7 (10)	White British	89.17

* Approximate hours of direct and ward-based psychological input.

**Interview length in minutes

Table 2

Staff-member participants

Pseudonym	Location	Job title	Ethnicity	Interview*
Dr Martin	Community 1	Consultant psychiatrist	White Irish	33.46
Peter	Community 2	Occupational therapist	White British	25.00
Yusef	Community 1	Senior social worker	Black African British	21.58
Joe	Community 3	Mental health nurse	White British	25.86
Laura	Hospital 1	Staff nurse	White British	40.95
Crystal	Hospital 2	Ward manager	Black Caribbean	18.40

*Interview length in minutes

Interview schedules.

Interview schedules were developed after consulting members from a volunteer research group with inpatient experience, and holding discussions with the lead research supervisor. Open questions invited service-users to relate their experience of a recent inpatient admission and staff members to relate their experience of working with this service-user during this time (Appendix J). Where possible, the researcher prompted the participant with questions such as "Can you tell me more?" or "What happened next?" in line with Wells' (2011) guidance.

Ethical considerations.

The study was approved by an Independent Research Review at Canterbury Christ Church University, a Research Ethics Committee (REC; Appendix F) and the NHS Foundation Trust Research and Development department (Appendix G). On completion of the research, the REC were notified (Appendix V) and a summary report was sent (Appendix W). Participants were notified that in the event of any observed or disclosed risk issues, information would be passed on to the relevant clinician involved in their care. At all times, the British Psychological Society's Code of Ethics and Conduct was adhered to (BPS, 2009).

Procedure.

Ward-based psychologists identified service-users meeting the inclusion criteria and gave them a copy of the participant information sheet (Appendix K). The researcher telephoned service-users within seven days to arrange an initial meeting to discuss consent. Interviews took place in inpatient or community settings within the Trust. Service-user interviews took place first, as this was an opportunity to establish staff members' meeting inclusion criteria. Eligible staff members were given a copy of the participant information sheet and were contacted by telephone or email within seven days. Interview length varied depending on individuals' stories and lasted between 18-90 minutes. Interviews were audio recorded and transcribed verbatim by the researcher.

Data Analysis and Quality Issues

Methodology.

Narratives have been defined as sequential and meaningful, showing transformation and change (Squire, 2008). Narrative analysis can be a way of exploring aspects of development that might otherwise be overlooked, such as the relational experiences inherent in clinical work (Wells, 2011). The narrative analysis was carried out by hand (Appendix L) and in stages (Table 3). This included: transcription, marking narrative features and developing initial themes (Appendices N); in-depth analysis (Appendices O); and generating grand narrative themes and codes (Appendix M). This strategy was adapted from Emerson & Frosch's (2004) approach to critical narrative enquiry. Throughout the analysis, attention was paid to patterns, themes and regularities; as well as contrasts, paradoxes, and irregularities (Coffey & Atkinson, 1996), to draw thematic links between participants' experiences (Polkinghorne, 1995).

Table 3

Analysis of narrative content, structure and context

	Stage	Description	Detail
1	Transcription	Audio recording transcribed verbatim. Poland's (2002) notional system was adapted to include:	Pauses and expressive sounds Overlapping/garbled speech Emphasis and held sounds Paraphrasing others
2	Marking narrative features	Narrative text was highlighted and coded using Labov's (1972) criteria:	Abstract Orientation Complicating event Evaluation
3	Initial themes	Initial thoughts and ideas for complete narratives	Summary by stanzas Individual/reciprocal actions
4	In-depth analysis	Sections chosen for core narrative analysis	Emerging themes Sequential features
5	Grand themes	Synthesis of the data	Drawing out themes within and between stories

Validity and reliability.

Service-users were recruited with experience of different wards located in three different mental health inpatient units, and staff members were recruited from two inpatient and three community locations. Triangulation, whereby research questions are analysed from multiple perspectives, can be used to establish the parallels and divisions between experiences and viewed as an opportunity to uncover deeper meaning in the data (Patton, 2002).

Participants were invited to take part in member-checking (Creswell, 2007), by reviewing a summary of their interview (Appendix P), and evaluating the extent to which this reflected their experiences and story (Appendix Q). Following completion of the study, a summary report was sent to participants (Appendix W).

Reflexivity. In order to assess possible researcher-specific factors within narratives, bracketing interviews were conducted between an independent researcher and the researcher before data collection and after data analysis (Appendix S). The structure of these broadly followed Aherne's (1999) guidance, whereby reflexivity is used to identify areas of potential bias and 'bracket' them to minimise their influence on the research process. The bracketing interview highlighted that the researcher had invested in finding out whether psychology in the inpatient setting can be useful, Additionally, the researcher has experience of working psychologically in the inpatient setting; these experiences are likely to act as a lens through which narratives were viewed and interpreted (Appendix T).

The researcher's role in the interviews varied: for example, during Peter and Jane's interviews there was little input other than non-verbal utterances to demonstrate listening: "Hmm, hmm". In contrast, the researcher contributed much more in Dr Martin and Louise's interviews, providing more explicit direction and asking more questions. Jane's story had been the longest (89.17 minutes), partly because she had disclosed that she was "not as happy as I thought I would be" (Ja.628), leading to a discussion about sharing information from the interview, with the clinicians involved in her care. Yusef's quotations feature more infrequently within the themes; perhaps because his story was relatively short (21.58 minutes).

Member checking. Subjectivity is an important feature of narrative enquiry; member-checking and attempting to address how the researcher's experiences may have influenced interpretation. Member-checking summaries were sent to all participants';
however, feedback was only received from one service-user and three staff members. Whilst the available feedback confirmed that participants had felt that the researcher had understood their story, it would have been useful to have received this from all participants.

Inter-rater reliability. Riessman (1993) suggests that validation in narrative analysis can be addressed by attending to the persuasiveness and coherence of an interpretation. Following the development of the grand narrative themes, the researcher discussed the themes with an independent researcher and the lead research supervisor helped gauge to what extent the themes and codes reflected a common sense approach to the data (Elliott, 2005). Using a fully-crossed design, a subset of quotations were rated by two coders (Rater A and Rater B; Table L6) based on the coding manual (Hallgren, 2012). Inter-rater reliability analysis was conducted, whereby SPSS was used to calculate the Kappa statistic to determine consistency among raters (Light, 1971). The inter-rater reliability for rater A (researcher) and B (independent researcher) was found to be Kappa = .64 (p <.001), 95% CI (0.57, 0.72), indicating substantial agreement (Landis & Koch, 1977).

Results

A summary of service-users' and staff members' stories is presented, providing context for the results that follow. The themes are ordered in relation to the research questions. Quotations are identifiable by italicised text, followed by the first two letters of the participant's pseudonym and the transcript line number.

Narrative summaries

Louise: A service-user's perspective.

Louise's narrative coherently communicated her struggle with distressing thoughts and her need for support from inpatient services: "I felt like I needed help and I *wasn't* able to rectify it on my own" (Lo.12). Louise received 14 inpatient CBT sessions, and a further 14 sessions with the same psychologist in the community. She explained that her admission had been traumatic and her narrative describes hard, confusing times on the ward. Louise tells how she used the psychology sessions to reflect on "things that *I've* found quite difficult in my past" (Lo.360-361).

Dr Martin: A consultant's perspective.

Dr Martin's narrative focused largely on his work with Louise in the community. He explained that he felt the psychology sessions had "helped, restore, a sense of reality at an earlier stage in the recovery process" (Dr.347-348). He stated that the psychological intervention "led to greater stability and it ensured that her recovery followed in a fairly step-wise way" (Dr.350-352).

Yusef: A social worker's perspective.

Yusef's story reflected a largely positive experience of psychology in terms of his care coordination work with Louise in the community. CBT sessions had helped in terms of "managing her symptoms and perhaps, getting ways of addressing the general situation she was in" (Yu.132-133). He explained that he felt that psychology was not right for everyone, particularly those who "would find it hard to talk about, they struggle to confront any difficult emotions" (Yu.253-254).

Maggie: A service-user's perspective.

Maggie's story started when she was struggling to cope and had suicidal thoughts; she decided to access inpatient mental health services "just to be safe" (Ma.29). Maggie attended three talking therapy group sessions and one family session, totalling approximately six hours of psychological input. She described how the group had been helpful in recognising issues to work on: "we identified that I had, erm, my main problems are my relationship with my dad" (Ma.153-154). From the outset, Maggie appeared to know what needed to be in place in order to be able to move forward, so that she could be "happily discharged then, I was feeling much better" (Ma.251).

Crystal: A ward manager's perspective.

Crystal's narrative succinctly described her involvement with Maggie on the ward. Her role was to co-facilitate the talking therapy group and to be part of the family work with Maggie,

her father and the psychologist. Crystal emphasised that the psychological input enabled

Maggie to feel less isolated with her issues and helped her and her father understand each

other's experiences; this helped Maggie in terms of: "building, [and] working on their

relationship" (Cr.52).

Peter: An occupational therapist's (OT) perspective.

Peter described Maggie's positive engagement with services during her transition from the

ward to the community. Peter felt less clear about Maggie's psychology work on the ward,

but understood that it had led to a referral to a community based talking therapy group. He

expressed his view of psychological input as: "meaningful, understanding their own issues

and taking control, erm, because *they've* got the right help to reflect, to create a thinking

space for, erm, their own recovery process" (Pe.284-286).

Lee: A service-user's perspective.

Lee's story was a moving account of his current hospital admission: a clear chronological

narrative. Lee received over 40 weekly individual psychology sessions, informed by CBT,

Schema Therapy and DBT approaches. Lee was extremely positive about the psychological

treatment he received, and reflected on how it had helped him increase contact with his

family: "And then week by week, slowly, I was ringing them and it was getting easier, it was

slowly getting easier" (Le189-190). Despite the clarity of Lee's story, there was also a sense

of complexity in terms of his ambivalence regarding his progress and the difficulties he

continued to encounter.

Laura: A mental health nurse's perspective.

Laura worked with Lee during his lengthy admission and psychological input. She was

unsure how far psychology had been helpful, acknowledging that: "I think in parts it was

helpful. Erm, and parts it wasn't helpful, but not because psychology's not helpful but just

because the sheer complexity of, of the case" (La.350-352). Laura valued the psychological

input for nursing staff on the ward, stating that they: "can give you little, little tips or things that help keep us going in between" (La.560-562).

Jane: A service user's perspective.

Jane's story described incredibly difficult and traumatic experiences, leading to three recent admissions to a mental health hospital. She reflected on her fear and need for help, leading to admission: "it felt like I was losing the reins to life. I had no control" (Ja.39-40), "I just wanted to die" (Ja.47). Jane attended the ward-based talking therapy group eight times, an emotional coping skills group twice, and she met with the psychologist individually for seven sessions. Jane said meeting the psychologist "was nice, because *I'd* never had that before. It was a new experience, for me" (Ja.158-159), highlighting how the psychologist listened and was understanding.

Joe: A mental health nurse's perspective.

Joe began working with Jane as her care coordinator just before her third recent admission. He talked about how the psychologist had been 'key' in terms of safety and care planning with the ward based medical team. Joe reflected on how the psychology input had also enabled a discussion between him and Jane about their relationship, leading to improvements in communication.

Grand themes

Nineteen grand themes were generated from the ten stories, and these were categorised in terms of relevance to the research questions (Table 4). The themes are described, using examples from the text to illustrate interpretations. Particular attention is paid to the themes relating to the connections participants' made between psychology and change.

Table 4

Grand narrative themes generated from ten participant stories

Research question	Grand theme
Defining psychological input	Variety of acute psychological input
	Psychology as a 'different approach'
	Barriers to inpatient psychology
Changes in thinking over time	Recovery narrative
	Individual focus
	Collaborative focus
	Medical discourse
	Psychological discourse
Connections between psychology and change	Formulation as a way of making sense of a crisis
	Interpersonal: Improving relationships
	Intrapersonal: Individual recovery
Parallels and divergences between and within stories	Medication
	Difficult ward environment
	Uncertainty
	Access issues
	Safety
	Acute psychology work possible and valued

Defining inpatient psychological input.

Psychological input included: talking therapy groups informed by Yalom's (1983) model; emotional coping skills groups based on DBT principles; individual sessions of CBT and schema therapy; and family sessions informed by systemic approaches. Within participants' stories, there were accounts of indirect therapeutic work, such as input to care planning, liaison and signposting. There were reports of work with the inpatient staff team, such as teaching psychological skills to staff members, case discussion groups and reflective practice.

Service-user and staff members' stories reflected a sense that ward-based psychology offered a different and positive approach compared to the routine care received in an inpatient mental health hospital. There was a sense that both service-users and staff members understood the unique aspects of the therapeutic relationship and its importance in psychology: "[the psychologist] had time to listen to me. Her warmth. And she was in, she was genuinely interested in helping me" (Ja.75-76).

Several barriers or challenges in terms of inpatient psychological input were presented. A common theme was the limited access to psychology, and references to the fact that high levels of distress could interfere with psychological input on the ward: "I probably *wasn't* really sort of listening because I had my own thoughts that were going in my head" (Lo.142-144). Peter, an OT with ward-based experience, indicated that he felt psychology was not possible at times of acute distress: "sometimes a crisis is so intense that, that, [psychology] *that's* too difficult, too *painful*" (Pe.214-215). A perspective within staff member stories in particular was that psychology might not be the best approach for everyone, and that some may be "more action oriented" (Yu.276). A significant barrier highlighted by service-users was that some therapeutic gains from psychological work were not always maintained. For example, Jane talked about how the psychology input helped in the short-term, but that this didn't seem to last: "I would feel better for a while after. But, it would all be still there" (Ja.112).

Stories of how thinking fluctuates over time.

Recovery narrative. Lee talked about the progress he felt he had made: "*I've* come a long way" (Le.223). However, recovery appeared to be conceptualised as a fluctuating and complex process: "but deep down, I *wasn't* I *wasn't, I wasn't* coping" (Ja.138), "I was a little bit, erm, apprehensive about going home, which sounds a bit strange seeing as I *couldn't* wait to get out" (Lo.204-305). Staff members' narratives of service-users' experiences

seemed to echo this. Laura said: "he's [Lee] moved sort of forwards and then backwards and then forwards again and backwards again" (La.126-127), and Joe explained: "it was very different to how she [Jane], how she was before. And it was sort of, yeah changed." (Jo.46-47). Given the importance of individual differences in posttraumatic responses and recovery (Harvey, 1996), it might be expected that variations in service-users' trauma experiences had an impact on their sense of improvement or progress.

Individual and collaborative focus. There was a sense of fluctuation in service- users narratives focused on individual and collaborative experiences. For example, Lee referred to his individual experience of progress "*I've* come a long way" (Le.222) and also his collaborative experience: "*we've* come a long way" (Le.201). Louise referred to her individual experience: "it was just the way that I was perceiving things" (Lo.280-281), although acknowledged she had needed to work with others too: "Because I felt like I needed help and I *wasn't* able to rectify it on my own" (Lo.12). In contrast, Maggie's narrative seemed consistently fixed on the self throughout: "I think that *I'm* quite an intelligent person, and I KNOW when things are not working out and I know WHY" (Ma.50).

Medical and psychological discourses. Louise and Dr Martin's narratives reflected a dominant medical discourse: "delusions and hallucinations which we are taught to believe to, you know, dopamine over-activity in a particular part of the brain" (Dr.457-459), "Like your brain has gone from being in sort of a normal way, like rational" (Lo.178-179). Maggie's narrative seemed to draw on a medical discourse as a way of describing her experiences in a way that made sense to others: "people understand unwell rather than if you say I *wasn't* well they say *'ohh,* you *wasn't well',* whereas if you say *'No* I was *anxious'* they *wouldn't* necessarily associate that with being unwell" (M.509-511).

Within both service-user and staff member narratives was also a strong sense of a psychological discourse; for example, Louise referred to her understanding of the link

between her distress and "things that *I've* found quite difficult in my past" (Lo.360-361).

Psychological discourses were also a prominent feature of the sections of participant

narratives that drew connections between inpatient psychological input and change.

Connections between inpatient psychological input and change.

Formulation: Making sense of a crisis. Service-users' stories presented connections

between the inpatient psychological input and making sense of a crisis: identifying what's

happened: "*it's* tried to draw attention to things that *I've* found quite difficult in my past"

(Lo.360-361); recognising issues to work on: "I think it, *it's* definitely made me realise that

we need to do more work. I think *it's* opened a door" (Ma.383-384); talking about what's

helped in the past: "it [medication] helped me to carry on, and to get me back on my feet and

working" (Ja.132-133); and what can help now: "Sometimes I make the wrong decision, and I

do, you know? And I, *that's* what *we're* working on, not jumping to the wrong decision"

(Le.384-385). Staff member narratives reflected similar ideas: "I think psychology played a

role in terms of getting Maggie to sort of be able to understand her difficulties. And identify

how she can be able to work on those difficulties that *she's* experiencing" (Cr.70-72).

The therapeutic relationship appeared to be conceptualised as linked to an increased

ability to 'open up', greater understanding of experiences and distress, and meaningful

recovery: "by enabling her [Louise] to look specifically at the psychotic experiences that had

left her feeling sort of distressed" (Dr.347-350). Specifically, the psychological formulation

appeared to contribute to care planning: "I think with psychology, identification of difficulties

if not treatment, identification erm, and, further to that then, erm, the actual appropriate

referrals on, can really make a big difference" (Pe.280-282).

Interpersonal: Improving relationships. In terms of interpersonal change,

psychologists were presented as offering trust and a space to explore, work and build on

relationships: "on the ward she saw the psychologist, erm, which was very helpful because

she had more of an in-depth conversation, and also about relationships with other people

including myself" (Jo.63-65). There was a central idea that psychology could improve

interpersonal communication, through reflecting and expressing thoughts and feelings with

others: "I managed to write to my mum and dad, but the psychologist said to try, I was trying

to write, I managed to write to them" (Le.168-170). The experience of sharing with others on

the ward appeared to help service-users feel as if their experiences were normal, and part of

common human experience, increasing a sense of belonging or feeling less alone:

> "it gave her [Maggie] a, a very comfortable environment where she was able to
>
> EXPRESS how she was feeling and not feel in any way isolated because it was in a
>
> room with people who experienced similar difficulties like she was experiencing, so
>
> she *didn't* feel erm, extraordinary in that space*"* (Cr.33-36).

It appeared that the therapeutic relationship with the psychologist was an important

factor in terms of interpersonal change; for example, Joe talked about how Jane's trust in the

psychologist had enabled a useful group discussion about the difficulties Joe and Jane had

experienced: "the psychologist talked about possibly repairing that relationship... And we

had a conversation about, how things were between us, and how she saw *me...* that went

well, we shook hands, you know" (Jo.70-91).

Intrapersonal: Individual recovery. The therapeutic relationship was also positioned

in relation to intrapersonal change, and appeared to contribute to a sense of recovery for

individuals: *"the* psychologist appeared and said *"here's* a space to talk, *we're* all

listening". And I think it just makes such a difference. It just made the whole stay a bit more

bearable. I felt more human" (Ma.232-234). Trust and honesty featured, related to support:

> "*I've* put trust in them [psychologist and nurse]. Telling them, like *I've* been honest
>
> with them all the way through and *they've* been honest with me, you know? Um, so *I'd*

say support was a big thing. Talking about it, and just helping along the way, you know?*"* (Le.377-379).

Empathy and understanding from psychologists was a central element to the service-user's stories, and was conceptualised as helping people 'open up' and feel listened to: "But the psychologist was just so different. She was more understanding, and-and she would listen" (Ja.174-175). There was a sense for Louise that opening up about issues increased understanding and a sense of reality, which helped in the processing of experiences, and lowered distress:

> "*It's* tried to draw attention to things that *I've* found quite difficult in my past. And kind of trying to address them, because I think if you *don't,* then *they're* always kind of there in the background" (Lo.360-362).

This was reinforced by Dr Martin's experience:

> "[The psychology sessions] allowed opportunities for her [Louise] to enter in to, say erm, opportunities for reality testing. For-for-for questioning the specific, experiences and events that-that-that were causing her such distress" (Dr.359-360).

Lee discussed how the psychology sessions had helped him begin to tolerate the emotions related to his experiences: "I *couldn't* talk about it at the start but I slowly, you know, it was getting it out of my system I was, first of all I was crying I was shaking, I was you know really anxious" (Le.101-103). Yusef also highlighted similar changes for Louise: "she was becoming a bit more open, about her emotions and erm, looking back about things she could have faced before, erm, it is very important, the psychology was quite good for her" (Yu.196-198).

There was a common connection between psychology and individual hope within the stories: "*We've* come a really long way because in January I *didn't* feel there was no hope at all. But I can talk about it" (Le.229-230). Reduction in distress following psychology

sessions appeared to be associated with increased independence and autonomy: "I think that, having been able to take some of that distress out of the picture, she was able to become involved more in the planning ahead process sooner" (Dr.360-362). There was also a sense that identifying and understanding issues with the psychologist gave people meaningful direction and focus for the future:

> "The actual appropriate referrals on can really make a big difference, in, in where people just carry on in the community going in a direction, rather than revolving back in because *they've* got something that starts to be meaningful" (Pe.281-284).

Lee reflected on how the psychology sessions might have helped him manage his suicidal ideation and behaviour: "*I'm* still, well I suppose *I'm* still alive, which, I might not have, I might not have been" (Le.231-232).

Parallels and divergences between stories.

Medication. Medication was not a feature within all of the narratives, although Louise and Jane spoke about the ways in which medication had been a helpful approach on the ward: "an anti-anxiety [medication] definitely helped me with all the anxiety that I was *feeling...* I think that kind of got me through" (Lo.270-275); "*it's* like putting a lid on the inside of you and it contains *it...* it used to numb me. So I could, I could carry on" (Ja.129-134). Peter said medication had helped Maggie in her recovery: "her medication was changed and there was a process of two and a half weeks where she was stabilised" (P.151-152). Dr Martin acknowledged the benefits of the psychological intervention in terms of Louise's distress but also stated that "It does need to be borne in mind that it was administered, if I could use that word, erm, in conjunction with, erm medication" (Dr.299-300).

Difficult ward environment. A parallel within the narratives was that the ward environment was often very difficult: it "was a bit traumatic *I've* kind of blocked events out"

(Lo.24-26), "you felt as though you were like trapped, and you, you (short pause) you were kind of a bit misunderstood, or a bit brushed under the carpet" (Lo.408-410). There was a sense that inpatient care had been rushed and was "very slap-dash" (Ma.78) and that staff members lacked compassion: "they *didn't* come back and say like *"h*ow are you *feeling?"...* So there was no, no compassion really." (Ja.170-173).

Uncertainty. Contrasting with Maggie and Louise's stories that made clear connections between the psychological interventions and change, Laura and Lee's stories seemed less clear. For Lee, this may have reflected his ambivalence about getting better, which Laura also discussed. Laura seemed uncertain about the benefits of psychological input for Lee. She commented on Lee's improvements, but appeared to struggle to name the possible mechanisms for change; "obviously some things have shifted, but I *don't* really know exactly what was helpful" (La.447-448).

Access issues. In terms of access to psychology at times of heightened distress, there seemed to be divergences between stories. Louise suggested that, whilst she struggled to think, there had been benefits in the latter stages of the treatment due to input from someone who had been with her through the admission. In contrast, Maggie, Lee and Jane all referred to initially not being 'ready' to talk and think at the beginning of their admission.

Safety. There was a strong sense within the service-user narratives that the inpatient admission was intended as a way of helping to feel safe: "I was relieved (short pause) that I was going to be safe" (Ja.46). However, Maggie's experience seemed mixed: "I think it made me feel safe in the fact that I *wasn't* able to kill myself. But, I *wasn't* safe from being attacked by other patients" (Ma.491-492). Additionally, Lee talked about how the inpatient admission did not prevent him from attempting to end his life: "there has been times, you know, when *I've* purposely cut my throat and *I've* wanted to you know, to die" (Le.278-279).

The value of acute psychological work. Despite the challenges and barriers to inpatient psychological input, there was a strong sense that this approach is possible and valued: "I'm amazed at HOW many different people this psychologist sees actually, and spend time with" (Jo.297-304). Staff members commented on their positive experiences of psychologists who worked on the ward: "a lot of the patients do comment that they find it really easy to talk to him" (La.494), "I think *it's* excellent. It has helped a lot of the patients on my *ward"* (Cr.237-240). There were also positive experiences of psychology within service-users' stories: "it was *good…it* was *nice…almost* like I was there for a reason and I was there to work towards getting better" (Ma.325-327), "if they *hadn't* have worked with me I *wouldn't* have been able, *wouldn't* be where I am now" (Le.363-364).

Discussion

This research sought to explore service-user and staff member experiences of psychological input in the inpatient mental health setting. There was support for the broad range of interventions that psychologists provide in this setting, as proposed by Nicholson & Carradice (2002) and the MPAG (1990). In line with previous findings, there was a sense that psychology was valued on the ward (Gibson et al., 2008; Kerfoot, Bamford & Jones, 2012)) and that it was a 'scarce resource' (Kennedy, Smalley & Harris, 2003). The high distress levels of inpatient service-users were presented as a challenge for the provision of inpatient psychology, and there was also evidence that it was not always possible to maintain the therapeutic gains in this setting. Psychological thinking within the stories seemed to fluctuate, reflecting the inherent complexity of the recovery process (Royal College of Psychiatrists, 2010). Whilst there were common underlying themes, there were also nuances in the service-users stories, indicating the individuality of experiences.

The results found evidence in each of the stories of connections made between psychological interventions and change. Anthony (1993) suggested that recovery from

mental health experiences involved the development of new meaning and purpose. This research found support for this, as participants drew links between psychology, making sense of a crisis, improvements in relationships, and meaningful recovery. There was a sense that both staff members and service-users perceived that psychology had led to increases in understanding of issues, hope, autonomy and had also helped them process and tolerate emotions and experiences. These themes appeared intrinsically linked to some of the unique elements to psychology, such as trust, warmth, understanding and empathy in the therapeutic relationship.

Dr Martin highlighted the role of psychological interventions in the hospital setting, which in conjunction with medication, were perceived to restore a sense of reality sooner than with psychiatric treatment alone. Peter presented the clinical benefits of a psychologically informed care plan, and his view that psychological interventions could reduce the number of 'revolving door' patients.

Contrastingly, Laura and Lee's stories demonstrated that whilst they had perceived the psychological treatment as beneficial, it was difficult to describe how the psychological input had led to change. Whilst the service-users' stories valued the therapeutic process, Lee, Jane and Maggie indicated that some therapeutic gains were not always maintained. Central to this were ideas that timing of input is important and that people needed to be 'ready' to talk and think about their difficulties. This might suggest that assessment and formulation are crucial in informing treatment, particularly as the threshold of distress is thought to be rising in acute inpatient mental health settings. Complexity and high levels of distress were common themes for inpatient service-users; therefore, it is likely to be crucial that psychological work is approached with flexibility and sensitivity, in order to meet individuals' fluctuating recovery needs.

A counter argument to this was Louise's acknowledgment that, whilst she was not able to fully engage with the therapeutic intervention initially as she 'couldn't think', the contact had been helpful for her at the latter stages of treatment. She described how knowledge of 'what you were like inside' had helped her make sense of her crisis and the admission, although it is unclear whether this would have been possible from input from other inpatient staff members.

General critique

Methodological limitations.

This research adopted an interpretive analytical approach, which means that the findings are based on participants' stories. Outcomes were based on features of the narratives rather than measured using standardised clinical outcomes, which affects the reliability and validity of the findings. Given the qualitative and uncontrolled nature of this study, it is not possible to establish the clinical or cost effectiveness of the psychological interventions, nor is it possible to establish a reliable cause and effect relationship.

It is expected that the co-construction of the narratives impacted the stories that emerged. It is not possible to say how far participants relied on preconceptions of inpatient psychological provision based on the dominant rhetoric, rather than direct experiences. Participants' may have censored their stories due to the researcher's role as a psychologist or concerns about the impact of their stories; for example, on the ongoing care service-users might receive.

Generalisability.

The findings of this study have been developed from analysis of ten unique service-user and staff member narratives, which limits the generalisability of the findings. Service-user participants had been offered psychological interventions as part of routine clinical care; therefore, it is not possible to generalise these findings to the wider inpatient population.

Although environmental triangulation was used, whereby data was collected over three wards located in three geographically different locations, these were within one NHS mental health Trust. Therefore, it is likely that there are elements of these narratives that are specific to the structure of this Trust and the services it provides. It is possible that the people who chose to participate in this research were quantitatively different from those who declined.

Despite these limitations, the outcomes of the narrative analysis can be used to help service-users, staff members and psychological practitioners develop an understanding of their roles and experiences in this setting (Polkinghorne, 1995). This research did not attempt to achieve total objectivity, although attempts were made to bracket researcher assumptions to minimise their influence on the research process (Aherne, 1999).

Theoretical implications

There is a strong theoretical foundation for the application of community-based psychological interventions for individuals with mental health problems, with evidence to support the application of a range of psychotherapeutic approaches (Roth et al., 2006). The acute inpatient environment is essentially different from community services, making generalisation of outcomes difficult. However, findings from previous research and this study suggest that theoretical frameworks for community-based psychological interventions can be adapted for the inpatient setting. This research provides evidence that the essential components for change, such as the therapeutic relationship, may be the same. Research in community based services has indicated that short-term interventions may not be effective (Hansen, Lambert & Forman, 2002); further research should seek to explore whether these findings can be generalised to inpatient services.

Research has suggested that the main curative component for community-based psychological interventions is the therapeutic relationship (Lambert & Barley, 2001). This

research indicates that it is also an important factor for inpatient-based interventions, and that the service-users and staff members believed that the therapeutic relationship can lead to improvements in relationships, reduce distress and enhance individual recovery.

There is extensive research of the theoretical and psychological principles that underpin formulation, such as: attachment theory, developmental psychology and CBT (DCP, 2013). The results of this research emphasise the importance individuals ascribe to the meaning-making process, suggesting that developing an understanding of issues and problems can help people feel listened to and can normalise and validate experiences. Maggie's experience of hers and others' increased understanding of her situation was associated with feeling less alone, whilst Louise and Lee said that talking about, and making sense of difficult past experiences enhanced their sense of recovery.

Clinical Implications

This research found tentative evidence of service-users' and staff members' perceptions about the meaningful outcomes that psychology can achieve in the inpatient setting. This supports the growing theoretical, research and policy literature that supports access to psychological provision in mental health hospitals. However, it was also suggested that there are likely to be a number of challenges in such provision, which can be translated as clinical implications.

One hypothesis is that people experiencing high levels of distress, or those who are seeking practical support, might not be ready for psychology. This is not a new proposition: assessments for psychological interventions are often informed by Maslow's (1943) hierarchy of needs. Service-users in this research commented on feeling unsafe and alone, and that the inpatient admission and psychological intervention had helped them to feel safe and as though they belonged. This might indicate that psychological interventions in this

setting might be more effective if they are able to focus on addressing the basic needs of individuals.

This research highlighted that service-users and staff members perceived changes for both brief interventions of no more than six hours (e.g. Maggie) and longer-term interventions in excess of 20 sessions (e.g. Louise and Lee). This seems to suggest that when individuals are deemed suitable for psychology, short-term interventions can be useful; particularly when they are informed by specific aspects of a collaborative formulation and can lead to signposting or referrals in the community. Regarding longer-term work, Louise talked about how the continuity of her psychological intervention in the community had been useful as it had helped her develop insight and a deeper understanding of her inpatient admission. This continuity of care approach has been addressed in similar settings, such as therapeutic communities, and there is evidence to suggest that this is effective, particularly for individuals with a diagnosis of borderline personality disorder (Chiesa & Fonagy, 2000; Chiesa, Fonagy & Holmes, 2003).

Given the lack of comparative studies exploring the clinical and cost-effectiveness of this service model, it is important for psychological practitioners to evaluate their clinical practice in terms of clinical outcomes and user feedback.

Future Research

The findings of this research suggest that service-users' and staff members' perceptions of the role of psychology in the acute inpatient mental health setting support the proposed theoretical and clinical models for such provision. There is also evidence of the challenges or barriers to such provision. These findings indicate that further research is necessary in order to be able to conclude whether psychology in the inpatient setting can be clinically meaningful and cost-effective.

Further research should seek to answer the following questions, in order to progress our understanding of psychology in this setting:

1) What is the cost and clinical effectiveness of providing psychology in the inpatient setting compared to community settings?

2) What individual and environmental factors are important when considering whether people receiving acute mental health care are 'ready' for psychology?

3) Can the therapeutic gains achieved in inpatient mental health settings be maintained post discharge?

It has been claimed that the same challenges to the provision of psychology can be applied to conducting research in the mental health hospital setting. However, researchers should take the lead from research in similar hospital settings, which may be able to provide a framework in which to negotiate these challenges without compromising methodological rigour and high quality of reporting (Bateman & Fonagy, 1999; 2006, Lees, Manning & Rawlings, 1999). A study adopting a longitudinal, pragmatic design (Zwarenstein, 2009) is suggested as the next logical step in the research process, and is necessary in order to inform clinicians, services and commissioners regarding decisions about provision of and access to psychology.

Conclusion

Despite the limited and inconclusive evidence base, there are calls to increase the provision of psychology in the inpatient mental health setting. This has been supported by psychological theory, a number of health organisations, and UK health policy. One of the reasons for the small literature base is the challenging nature of the inpatient environment in terms of providing psychological input and conducting controlled studies. In order to address these issues, this paper adopted a qualitative interview design to explore how service-users and staff members have experienced inpatient psychology.

The findings highlighted that psychological interventions in this setting include direct, indirect and strategic interventions, which are valued by staff and service-users. Participants' made connections between psychology and change, for example: that interventions helped people make sense of a crisis; led to improvements in relationships between service-users', families and staff; and contributed to meaningful recovery. There was also support for the idea that psychology might not be appropriate for everybody, and that high levels of distress could interfere with psychological work.

This paper suggests that service-users' and staff members' perceptions of psychology in this setting are not dissimilar to the theoretical arguments for such provision. The methodological approach limits the generalisability of the findings; however, these indicate that further research would be valid and necessary for the development of psychological provision in NHS inpatient mental health hospitals in the UK.

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Eloise G. DONAGHAY-SPIRE BSc (Hons) MSc

INPATIENT PSYCHOLOGICAL INTERVENTIONS

MAJOR RESEARCH PROJECT

SECTION C: SUPPORTING INFORMATION AND APPENDICES

Appendices

Appendix A: Systematic search strategy

Table A1

Terms and words used in systematic search strategy

Participants (P)	Exposure (E)	Outcome (O)
Mental health hospital	Psychotherapy/therapy	Effectiveness
Psychiatric hospital	Psychology	Efficacy
Psychiatric units/acute inpatient unit	Psychological therapy/ Therapeutic processes	Change
Psychiatric hospitalisation	Reflective practice	Psychotherapeutic outcome
Psychiatric hospital staff	Reflectiveness	Treatment outcomes
Psychiatric inpatient	Formulation	Outcome
Psychiatric hospital programmes	Case conceptualisation	Treatment evaluation

Note: Each term within the PEO groups were combined using the Boolean operator *'OR'*.

The results of each PEO group were then combined with the Boolean operator *'AND'*.

Appendix B: Flow chart for systematic search process
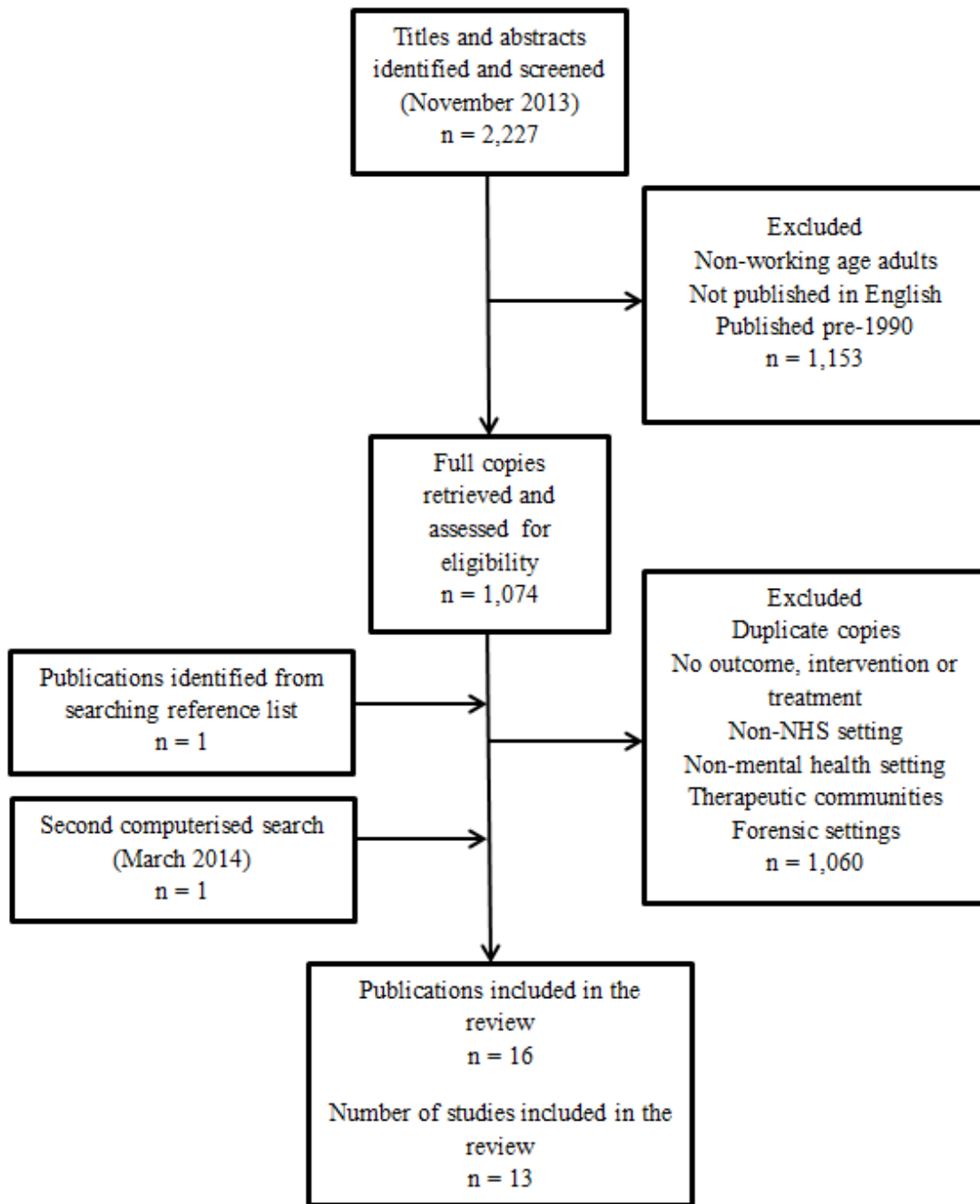
Figure B1

Flow chart of systematic search process

Appendix C: Systematic search results

Table C2

Systematic search results

Search	PsycINFO	Web of science	Medline	EBM databases	CINAHL	Total
Population	21,592	24,166	28,882	345	2,573	271,898
Exposure	336,533	495,858	120,184	25,509	41,147	1,019,231
Outcome	496,996	4,848,951	2,349,666	333,954	274,052	8,056,619
Combined results	1,216	704	185	71	51	2,227
Limit*	386	552	56	65	15	1,074

*Results were limited to papers published in English, post-1990 and those that focused acute mental health inpatient provision for working age adults.

Appendix D: Table of relevant studies included in the review

Table D3

Characteristics of relevant studies included in the review

No.	Paper (year of publication)	Design	N	Age	Gender	Population	Intervention	Outcome measures
1	Berry, Barrowclough & Wearden (2009)	Quasi-experimental: before-and-after study	30	(M=39.87 SD=8.01)	15 females (50%), 15 males (50%)	Staff-members	Formulation meetings with staff members	Brief Illness Perception Questionnaire (IPQ) Illness Perception Questionnaire for Schizophrenia (IPQ-S) Measures of staff understandings of the problems, negative feelings towards service-users and confidence in work
2	Drury, Birchwood, Cochrane & Macmillan (1996a)	Randomised control trial: parallel group	40	21-52 years (M=32.7)	14 females, 26 males	Diagnosis of non-affective psychosis (first psychotic episode)	Cognitive therapy (individual, group, family work and activity programme) 8 hours per week, <6 months	Psychiatric Assessment Scale (PAS) Belief and Convictions Scale (BCS) Early Signs Scale (ESS) Insight Scale Personal Beliefs about Illness Questionnaire (PBIQ) Medical and case notes
3	Drury, Birchwood, Cochrane & Macmillan (1996b)							
4	Drury, Birchwood & Cochrane (2000)		34	32.5 (median)	17 females, 17 males			

5	Durrant, Clarke, Tolland & Wilson (2007)	Quasi-experimental: before-and-after study	14	Females 26-50 years (M=42) males 21-60 years (M=43)	7 females, 7 males	Various, including: Depression Personality disorder Schizophrenia	Brief CBT (Woodhaven approach)	Mental Health Confidence Scale (MHCS) Locus of Control and the Behaviour Scale (LCB) Personal Questionnaire Rehabilitation Evaluation Hall and Baker Scale (REHAB) Living with emotions measure Clinical Outcomes in Routine Evaluation (CORE)
6	Gibson et al. (2008)	Observational study: case series	Not reported	Not reported	Not reported	Not reported	Mixed therapeutic approach	Programme engagement and referral pathways Frequency of incidents Patient staff conflict checklist Feedback questionnaires (service-users, staff and carers)
7	Haddock, Tarrier, Morrison, Hopkins, Drake & Lewis (1999)	Controlled study: parallel group	21	CBT group (M=28.1, SD=7.24) SC group (M=30, SD=7.90)	2 females, 19 males	Schizophrenia Schizoaffective disorder (with psychotic symptoms)	CBT and Supportive Counselling (SC)	Brief psychiatric rating scale (BRPS) Psychiatric rating scale (PSYRATS) Medical and case notes (frequency data)
8	Heriot-Maitland, Vidal, Ball & Irons (2014)	Quasi-experimental:	57	Not reported	Not reported	Transdiagnostic inpatient population	Group CFT	Non-standardised rating questionnaire Semi-structured interviews with small selection of participants

		before-and-after study						
9	Kennedy, Smalley & Harris (2003)	Service-evaluation	Not reported	Not reported	Not reported	Mixed diagnostic service-user group Staff members	Multi-level working: direct and indirect work	Tick-box audit with questions based on multi-level working objectives to rate collaboration in treatment, access, communication, usefulness, education and change influence
10	Kerfoot, Bamford & Jones (2012)	Quasi-experimental: before-and-after study	309	Not reported	Not reported	Not reported	Mixed therapeutic approach	Essen Climate Evaluation Schema (EssenCES) Inpatient Treatment Alliance Scale (ITAS) Service-user feedback questionnaires Service use frequency data
11	Kerr (2001)	Observational: case study	4	50, 30, 25, 23 years	4 males	Bipolar affective disorder	CAT	Not reported (assumed not used)
12	Lewis et al. (2002)	Randomised control trial: parallel group	309	27.4 (median)	216 males, 93 females	Schizophrenia and 'related disorders'	CBT vs. supportive counselling	Positive and Negative Syndrome Scale (PANSS) Psychiatric rating scale (PSYRATS)
13	Tarrier et al. (2004)		307	Reported for each group/ location	Reported for each			

				group/ location			
14	Long, Fitzgerald & Hollin (2012)	Observational study: case series	34	18-57 years (M=33)	34 females	Anorexia nervosa	Mixed therapeutic approach	Morgan-Russell Assessment Schedule (MRAS) Eating Disorder Inventory (EDI) The Body Shape Questionnaire (BSQ) Overcoming Anorexia Nervosa Questionnaire (OANQ) Anorectic Behaviour Observation Scale (ABOS) Brief Symptom Inventory (BDI) Culture-Free Self-Esteem Inventory (CFSEI) Health and Daily Living Form (HDL)
15	Raune & Daddi (2011)	Observational study: case series	111	(M=39.6, SD=14.1)	54 females (48.6%) , 57 males (51.4%)	Transdiagnostic	Group CBT	Clinical records Service-user feedback
16	Shepherd & Rosebert (2007)	Service evaluation	12	Not reported	Not reported	Inpatient staff members	Reflective practice group	Staff member questionnaire

Appendix E: Checklist for quality assessment for studies included in the review

Table E4

Checklist used to assess the methodological rigour of studies and quality of reporting

	Methods								Results			Discussion			Score
	Design	P	Interventi on	Control group	Blind	Outcomes	Sample size	Statistical methods	Recruitme nt	Baseline data	Outcomes and estimation	Limitation	Generalisa bility	Interpretat ion	Out of 14
Berry et al., (2009)	Y	Y	Y	N	N	Y	N	Y	N	N	Y	Y	N	Y	8
Drury et al., (1996a)	Y	Y	N	N	N	Y	N	Y	N	Y	Y *	Y	Y	Y	8
Drury et al., (1996b)	Y	N	N	N	N	Y	N	Y	N	N	Y *	Y	N	N	5
Drury et al., (2000)	Y	N	Y	N	N	Y	N	Y	N	N	Y *	Y	N	Y	7
Durrant et al., (2007)	N	N	Y	N	N	Y	N	Y	N	N	Y	Y	N	N	5
Gibson et al., (2008)	Y	Y	N	N	N	Y	N	N	N	N	N	Y	N	Y	5
Haddock et al., (1999)	N	N	Y	Y**	N	Y	N	Y	N	N	N	Y	Y	Y	7

	Methods								Results			Discussion			Score
	Design	P	Intervention	Control group	Blind	Outcomes	Sample size	Statistical methods	Recruitment	Baseline data	Outcomes and estimation	Limitation	Generalisability	Interpretation	Out of 14
Heriot-Maitland et al., (2014)	Y	Y	Y	N	N	N	N	Y	N	N	N	Y	Y	Y	7
Kennedy et al., (2003)	Y	N	N	N	N	N	N	N	N	N	N	N	N	Y	2
Kerfoot et al., (2012)	Y	Y	N	N	N	Y	N	N	Y	N	N	Y	N	Y	6
Kerr (2001)	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	1
Lewis et al., (2001)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y*	Y	N	Y	13
Long et al., (2012)	N	Y	Y	N	N	Y	N	Y	N	N	Y	Y	N	Y	7
Tarrier et al., (2004)	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	13
Ruane & Daddi (2011)	Y	Y	Y	N	N	N	N	N	Y	Y	N	Y	N	Y	7
Shepherd & Rosebert (2007)	Y	N	Y	N	N	N	N	N	N	N	N	N	N	Y	2

Note: Adapted from the CONSORT Checklist of information to include when reporting a randomised trial (CONSORT, 2010), guidance for the reporting of pragmatic trials (Zwarenstein et al., 2009) and the Critical Appraisal Skills Programme (CASP, 2013a; 2013b) checklists.

*No effect sizes reported

Appendix F: NHS Research Ethics Committee approval letter

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Appendix G: Research & Development approval letter

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Appendix G: Research & Development approval letter

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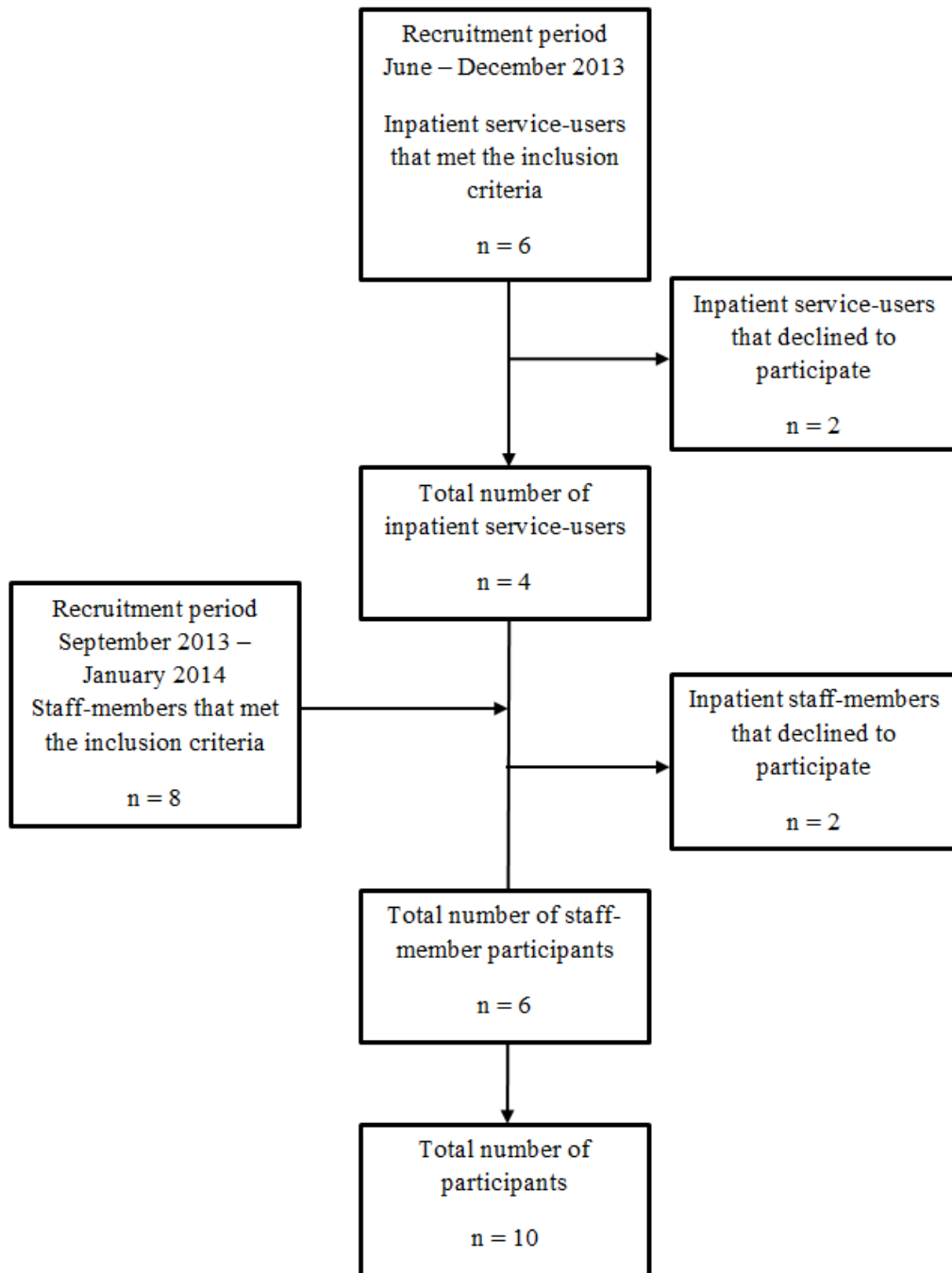**Appendix H: Recruitment process and sample selection**

Figure H2

Flow diagram to show the recruitment process and sample selection

Appendix I: Participant consent form

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Appendix J: Participant interview schedule

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Appendix K: Participant information sheet

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Appendix L: Coding manual: Narrative Analysis

Coding Manual

Introduction

This coding manual describes the process by which the transcripts with service-users and staff members were analysed, using a narrative approach. Information is provided to show an audit trail of one theme ('Intrapersonal changes: individual recovery').

Transcription

Instructions: Every word that was spoken was recorded, with no paraphrasing or summarising. Each line was numbered and table two shows the notional system used.

Table L1

Description of the notional system used to transcribe interviews

Event	Notional system	Example
Pauses	Pauses of four or more seconds in parentheses	(long pause)
	Pauses of less than four second in parentheses	(short pause)
	For brief pauses less than one second use a comma	He was, I mean he is
Expressive sounds	Insert in parenthesis the relevant word for a non-verbal communication	(laughing) (crying) (signing)
Overlapping speech	Insert a hyphen where interruption occurs and then insert in parenthesis where overlapping speech occurs	T: He said that was impos-; (overlapping) P: Who said that? T: Bob
Garbled speech	Enclose in brackets a word that has been transcribed for one that was difficult to hear clearly	[resigned]
	Use the letter x to indicate each word that cannot be understood	xxxx
Emphasis	Use capital letters to denote emphasis through volume or pitch of speech	WHAT?
Held sounds	Repeat sounds that are held, separated by hyphens	No-o-o-o-o
Paraphrasing others	Use quotation marks to indicate when the speaker is parodying what someone else said or expressing an inner voice	I thought "I'm in control now"

Adapted from Poland (2002).

Marking narrative features

The transcribed interviews were colour-coded in terms of Labov's (1972) narrative features:
  i)   Abstract (A)
  ii) Orientation (O)
  iii) Complicating event (CO)
  iv) Evaluation (E)
  v)   Resolution (R)

Initial themes.

Initial themes were developed by attending to following detail within the transcripts:
  a. Listing the characters in each story and describing their role in the narrative.
  b. Summarising the narratives by sectioning in to stanzas (to capture the sequential elements of the story).
  c. Listing all emerging themes within the text, not confined to the research questions but thinking more broadly about the story. These will be focused on:
      i.   The narrator-specific factors (content brought by the participant).
      ii. The researcher-specific factors (content brought by the trainee).
      iii. Factors specific to the reciprocal relationship and the co-construction of the narrative.

Core narrative analysis.

Sections of each transcript were chosen to carry out analysis of the core narratives. These were chosen based on the relevance of the interview content to the research questions (see below). Particular attention was given to the sequential nature of the text coded as complicated action (CA), evaluation (E), and resolution (R), specifically focusing on the content and structure of the text.

Research questions
Sections of the transcripts were selected based on their relevance to the research questions. One these sections were chosen, each line was coded as shown in table four. Notes were added in cases where text could be coded as relevant to one or more of the research questions. General themes relating to these sections and coded text were noted at this stage in the analysis.

Table L2
Coding of core narrative analysis based on the research questions

	Research question	Coding colour
A	What types of psychological input feature in the stories of service users and clinicians?	
B	What stories do service users and clinicians tell about how psychological thinking fluctuates over time?	
C	What connections, if any, do service users and clinicians make between inpatient psychological input and change?	
D	What parallels and divergences exist in the stories that inpatient and community staff members tell about inpatient psychological input?	

Grand themes

Table L3
Development of grand themes

Grand theme	Code	Coding reference
Defining inpatient psychological input		
Variety of acute psychological input	Care planning	A1.1
	Formulation	A1.2
	Formulation sharing	A1.3
	Talking therapies group	A1.4
	Family sessions	A1.5
	Assessments	A1.6
	Individual sessions	A1.7
	Risk management	A1.8
	Liaison: Formal and informal communication	A1.9
	Signposting/referrals to community services	A1.10
	Teaching psychology skills to nursing staff	A1.11
	Reflective space for staff	A1.12
	Focused on relationships on the ward	A1.13
Psychology as a 'different approach'	Non-medical approach	A2.1
	A space to talk and think	A2.2
	Offering a therapeutic relationship	A2.3
Barriers to inpatient psychology	Lack of trust in the inpatient setting	A3.1
	People in a crisis 'not ready' for psychology	A3.2
	Power dynamics	A3.3
	Access issues	A3.4
	Discharge focused, can feel rushed	A3.5
	Talking therapy 'not right' for some people	A3.6
	Therapeutic gains not maintained	A3.7
	People find it difficult to connect emotionally	A3.8
Changes to psychological thinking over time: Narrative style		
Recovery narrative	Recovery as a fluctuating process, with chronological progression but also 'forwards and backwards'.	B1
Individual focus	Predominant use of "I"	B2
Collaborative focus	Reference to "us" or "we"	B3
Emphasis on others	Talk of the roles of others; "they"; "them"; "he"; "she"	B4
Distancing	Suggesting a lack of emotional connection with narrative content	B5
Medical discourse	Use of medical explanations or terminology	B6
Psychological discourse	Use of psychological explanations or terminology	B7
Connections between inpatient psychological input and change		
Formulation as a way of making sense of a crisis	Identifying through listening: What happened? Why?	C1.1
	Recognising: Issues to work on What has helped in the past? What can help now?	C1.2

	Understanding: Sharing information/opening up can increase understanding, can contribute towards a meaningful recovery (and care planning for staff)	C1.3
Interpersonal: Improving relationships	Trust: A space to explore, work and build on relationships	C2.1
	Communication: Reflecting on experiences and expressing thoughts and feelings with others; increasing understanding of other perspectives (including staff)	C2.2
	Belonging/normalising: Feeling like experiences are 'normal' and part of common experience; leading to feel less alone, or part of a group	C2.3
	Therapeutic relationship: Engagement through containment on the ward, achieved with therapeutic relationship	C2.4
Intrapersonal: Individual recovery	Therapeutic relationship: Trust, empathy, understanding helped people feel listened to and 'open up'.	C3.1
	Processing experiences: Opening up/understanding about issues, 'coming to terms with it'; helping people process their experiences, lowering distress.	C3.2
	Tolerating: Emotions and experiences	C3.3
	Hope: Psychology sessions as a way of introducing the positive, and hope for the future; that things can be better.	C3.4
	Autonomy: Reduction in distress associated with becoming more involved in plan for recovery and taking control; increased independence.	C3.5
	Direction: Identifying/recognising/understanding can help give people a direction or focus to work towards	C3.6
	Improving ward experience: Admission easier/better with psychology input	C3.7
	Surviving: Being alive, surviving experiences	C3.8
Parallels and divergences in the narratives		
Medication	Managing feelings, alleviating delusions and contributing to recovery	D1
Difficult ward environment	Traumatic, distressing, unhappy, frightening.	D2.1
	Rushed, slapdash, not enough compassion from nursing staff.	D2.2
	Busy, medically oriented, lack of understanding	D2.3
	Pressures on ward staff for beds.	D2.4
Uncertainty	Not having a clear sense of what the psychology work involved	D3
Access issues	Long waiting lists in the community	D4
Safety	Inpatient admissions to help keep people safe	D5
Acute psychology work possible and valued	Working psychologically with people in a crisis is possible in an inpatient mental health setting	D6

Inter-rater checks

The second rater (Rater B) and research supervisor were given two interview transcripts; one service-user's story (Louise) and one staff-member's story (Yusef). They were asked to read and check the text of the transcripts and additional information to check their understanding of process of the narrative analysis.

The researcher and Rater B coded fifty selected quotations based on the grand themes generated by stage five of the analysis. Following this, discussions between the researcher, Rater B and the research supervisor took place to explore the approach to analysis, and to contribute to the further development of the grand themes. The coding of these quotations were analysed using SPSS to calculate Cohen's Kappa to give an indication of inter-rater reliability.

Quotations for inter-rater checks

Table L4
Fifty quotations for inter-rater reliability checks.

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Appendix M: Theme development: 'Intrapersonal change: Individual recovery'

Table M5

Codes and quotations for the *'Intrapersonal change'* theme

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Appendix N: Interview transcription and marked narrative features (Louise, service-user)

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Appendix O: Notes on the co-construction of the narrative: Louise's story

Researcher's contribution to Louise's story

Open questions:	"Can you tell me more, <u>what</u> happened next?"
	"What was that like?"
	"<u>How</u> did that feel?"
	"How did you get from that point?"
	"How have you been able to use that work with [psychologist]?"
Closed questions:	"Were you able to think about…?"
	"Did that have an impact on how you felt at the time?"
Reassurance:	"yeah, that's fine"
Paraphrasing:	"So something about the interaction was just a bit easier?"
Offering direction:	To discuss work with psychologist on the ward, to establish how contact was made.
	Orientating Louise in questioning: "How did you get from that point?"
	Noticing that the story is coming to an end.
	Acknowledging the end.
	Focus on evaluating the inpatient episode: Was this useful? What can be improved?

Reflection: Was my focus on service improvement a response to avoid uncomfortable feelings? Or was it to re-orientate Louise to the focus on psychology? I think that this was based on my own interests and curiosities, rather than being pertinent either to Louise's story or the research questions.

Reciprocal features and co-construction of narrative

Many of the stanzas transition with researcher input, which seems to prompt Louise in the content of her story. This helps move the story along, but also may in part disrupt the flow of Louise's chronological understanding of events. In places, the researcher asks questions orientating the story to time and place, which is likely to have been in an attempt to make sense of the story 'in the moment'. I wonder whether fewer questions would have allowed a less 'hurried' approach to the telling of the story, and may have helped Louise feel less anxious about not necessarily being able to recall all of her memories of the admission. Perhaps this was driven by enthusiasm from the researcher (this being the first participant interview) and a desire to get to the 'story' or elements of the narrative that suited the research questions.

Reflection: Missed opportunities. Drawing on the inpatient experience as difficult and painful- was this then something to work on with the psychologist? (Given that she said that this was a core feature of her work with him). I was keen to end the recording, although our conversation continued about what would happen next, but also reflecting on what it was like to talk about her inpatient experiences (as they were painful and distressing). It would have been useful to have kept recording, although I had assumed that it would be respectful to have this conversation without recording, as Louise seemed more relaxed when she was not being recorded.

Appendix P: Letter summarising individual interview (Louise, service-user)

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Appendix Q: Respondent feedback letter from Louise

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Appendix R: Inter-rater reliability calculations

<u>Rater A and B</u>

Table Q1

Cohen's Kappa calculation output from SPSS for Rater A and B

Symmetric Measures					
	Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.	
Measure of Agreement Kappa	.642	.076	10.891	.000	
N of Valid Cases	50				

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Appendix S: Bracketing interviews

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Appendix T: Reflexive statement

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Appendix U: Research diary

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Appendix V: Letter to Research Ethics Committee

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Appendix W: Summary of research findings

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An exploration of service-user and staff member narratives of psychological input in acute inpatient mental health settings

Summary

Background

It is suggested that people experiencing acute mental health difficulties can benefit from psychological input in their care, and there are calls for an increase in access to psychology in NHS inpatient mental health hospitals. However, partly due to the difficulties in carrying out research in this setting, there is limited evidence to support this.

Aims

This research aimed to explore what happens when psychology is offered in the inpatient setting, and how service-users' and staff members' understand and talk about these experiences through the stories that they tell. It aimed to answer the following questions:

a. What types of psychological input feature in the stories of service users and clinicians?

b. What stories do service users and clinicians tell about how psychological thinking fluctuates over time?

c. What connections, if any, do service-users and clinicians make between inpatient psychological input and change?

d. What similarities and differences are there in the stories told about inpatient psychological input?

Method

This research used an interview design. Interviews were carried out with four service-users who had psychology experience in an inpatient mental health setting, and six staff members involved in their care. Interviews were audio recorded and transcribed and then analysed in a way that considers each interview as a story (narrative analysis).

Results

Table one shows the main themes found within the staff member and service-user stories.

Table W1. Narrative themes generated from ten participant stories

Research question	Grand theme
Defining psychological input	Variety of acute psychological input
	Psychology as a 'different approach'
	Barriers to inpatient psychology
Changes in thinking over time	Recovery narrative
	Medical discourse
	Psychological discourse
Connections between psychology and change	Formulation as a way of making sense of a crisis
	Interpersonal: Improving relationships
	Intrapersonal: Individual recovery
Parallels and divergences between and within stories	Medication
	Difficult ward environment
	Uncertainty
	Access issues
	Safety
	Acute psychology work possible and valued

Evidence was found for a variety of inpatient psychological interventions, and the stories seemed to consider psychology as a 'different approach' to the routine care in inpatient mental health hospitals. The stories also presented barriers to psychology, suggesting that psychology might not be right for everybody. There was a sense that recovery was a complex process, and sometimes moved 'forwards and backwards'. Despite challenges, the stories made connections to psychology input on the ward and changes, including: making sense of a crisis, improving relationships, and contributing to a meaningful recovery.

Conclusion

This paper demonstrates that psychological input in the acute inpatient mental health setting is perceived as meaningful and can lead to changes. There is also a sense that that this provision can be challenging, highlighting the need for further research.

Appendix X: Notes to publisher for the journal Psychology and Psychotherapy Theory Research and Practice

<u>Psychology and Psychotherapy: Theory, Research and Practice</u>

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<u>Author Guidelines</u>

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