Current psychological interventions on acute inpatient wards: An exploration of service users' experience of mindfulness

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List of abbreviations

ACT .....Acceptance and commitment therapy

AMED .....The allied and complementary medicine database

AS.....Activity scheduling

ANCOVA .....Analysis of covariance

BPS .....British psychological society

CASP.....Critical appraisal skills programme

CBT .....Cognitive behavioural therapy

CINAHL .....Cumulative index to nursing and allied health literature

CFT.....Compassion focused therapy

CMHT .....Community Mental Health Team

DBT .....Dialectical behaviour therapy

DoH .....Department of Health

GI.....Guided Imagery

HDAS.....Healthcare database advanced search

IPA.....Interpretative phenomenological analysis

MANOVA ..... Multivariate analysis of variance

MBCT .....Mindfulness based cognitive therapy

MBMP.....Mindfulness based pain management programme

MBSR .....Mindfulness based stress reduction

NHS.....The national health service of the United Kingdom

NICE.....The national institute of clinical excellence

PICU.....Psychiatric intensive care unit

RCT .....Randomised control trial

REC.....Research ethics committee

SU.....Service user

TAU .....Treatment as usual

UK.....United Kingdom

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Thesis Abstract

This thesis focuses on understanding psychological interventions in acute inpatient services. A review of the literature highlights some benefits of psychological interventions on acute wards both for service users (SUs) enhancing their wellbeing and acquiring new learning and also economically, reducing admissions and the number of inpatient beds. It is acknowledged that research in this area is limited and therefore to better understand SUs experience of psychological interventions on acute inpatient wards, a study was completed focusing on SUs experience of a mindfulness intervention. Using Interpretative Phenomenological Analysis (IPA), the resultant themes included a process towards self-actualisation, mentalization, locus of control and cognitive strategies. These findings are discussed in relation to clinical implications for health care professionals on acute inpatient wards. It is highlighted that SUs would benefit from having choices of interventions such as mindfulness, and that these interventions are delivered as a ward ethos in which both staff members and SUs engage in the practice of mindfulness. The researcher mindfully reflected on the research journey considering reflexivity, epistemology and ethical issues.

Total world count (excluding references and journal submission guidance): 18,804

Paper 1: Literature Review

Exploring the current psychological interventions within acute adult inpatient units: A review of the literature

Word count: 7,219 (excluding references)

Abstract

Objective

There is limited research exploring psychological interventions in acute inpatient settings. Policies have recommended the use of psychological interventions, therefore this literature review aims to understand the current psychological interventions utilised in acute adult inpatient services.

Method

A systematic approach was taken in which 13 research articles were selected. Seven articles were quantitative, two were qualitative and four were mixed methodology papers. The articles were described within four categories including: service users' (SUs) perspective of psychological interventions, stand-alone sessions or interventions, cognitive behavioural therapy (CBT) techniques and long term effects of psychological interventions.

Results

An adapted thematic analysis method approach was used (Ayeyard, 2010) to analyse the data. Four themes were identified including: acquired learning of skills and planning for the future; SUs wellbeing, mostly having a positive impact; cohesion amongst SUs; and treatment value both economically and in providing interventions near to admission.

Conclusion

Psychological interventions provided at admission are likely to have a beneficial effect for SUs. The psychological interventions currently used on acute inpatient wards mainly include psychoeducation, psychological skills and discharge planning. CBT is the main approach, which fits with the current recommended evidence base (National Institute of Clinical Excellence [NICE], 2004).

Key words: Inpatient, psychotherapy, acute care, literature review, qualitative research, quantitative research.

Introduction

Acute inpatient services within the United Kingdom are designed for those who are at risk of harm to themselves or others and require mental health treatment for a broad range of mental health disorders in which the treatment cannot be provided in the community (Joint Commissioning Panel for Mental Health, 2013). Inpatient costs are one of the most expensive within the healthcare system, therefore it is important to improve the acute care pathway to reduce rates of readmission and improve recovery rates. The Department of Health (DoH, 2014) has made mental health a priority and has given support to increased access to the National Institute of Clinical Excellence (NICE) approved psychological therapies. An important area relating to the acute care pathway is psychotherapeutic interventions. The delivery of these varies across trusts with varied definitions of what constitutes psychological interventions.

Hospitalisation for people with acute mental health difficulties has changed over the past 30 years with needs increasingly being managed within the community. This has resulted in shorter stays within acute mental health hospitals and increased admissions for people with severe mental health difficulties where there is risk of harm to self or others (French, Smith, Shiers, Reed & Raid, 2010). There has been a reduction in beds due to a movement towards community care, resulting in a rise in the threshold for admission (Brooker, Ricketts, Bennet, & Lemme, 2007).

Changes to acute inpatient wards have impacted upon the delivery of services. The quality of care has been criticised by both patients and staff (Greenwood, Key, Burns, Bristow & Sedgwick 1999; Rose, 2001). A survey by Mind (2004) reported that 53% of respondents found their surroundings did not contribute to their recovery and 31% thought it had made them worse. Concerns of acute inpatient services have also related to overcrowding, personal safety and lack of therapeutic activities (Joint Commissioning Panel for Mental Health, 2013). NICE recommends that patients should be able to access evidence based treatments such as CBT to help facilitate recovery, particularly for those diagnosed with schizophrenia (NICE, 2010), bipolar (NICE, 2006), post-traumatic stress disorder (NICE, 2007) and personality disorders (NICE, 2009); which are common diagnoses on acute inpatient wards (British Psychological Society [BPS], 2012). This was evidenced in the use of CBT for inpatients with a diagnosis of schizophrenia in which there was a 25-

50% reduction in recovery time (Drury, Birchwood & Cochrane, 1996). In addition, Clarke (2004) recommends that acute inpatient wards utilise a bio-psychosocial model rather than a medical and risk management perspective.

The Sainsbury Centre for Mental Health Report (2004) found that therapeutic interventions such as psychosocial interventions were not routinely available and ward managers reported less than 20% of people were offered CBT on the wards, despite the evidence base. Recommendations have been made to make psychological interventions available, in particular problem-solving interventions, NICE approved treatments and availability of both individual and group treatments (Joint Commissioning Panel for Mental Health, 2013). This is further promoted by initiatives such as a SU led website STARWARDS to aid development of inpatient wards (Bright, 2006).

An absence of staff trained in psychological therapies is also a difficulty in providing psychological interventions on the wards. Clinical psychologists can have an influential role in providing skills and supervision for other staff grades on the ward (BPS, 2012). However, a survey of acute inpatient wards found that 87% of wards surveyed had no dedicated clinical psychologist (Bower et al. 2007). Limited research has been carried out in acute inpatient settings in comparison to other healthcare environments. Current reviews of the literature have focused on medications within acute care (Owiti & Bower, 2011), and relationships between patients and staff (Cleary, Hunt, Horsfall & Deacon, 2012).

Rationale for Literature Review

Little is known about the availability and delivery of psychological interventions on acute inpatient wards since the recommendations were made by the Sainsbury Centre for Mental Health's Report (2004). There are variations in therapeutic approaches delivered within acute wards. It is important to gain an understanding of the current psychological approaches that are being utilised. The government initiative of a payment system based on mental health 'clusters' is being developed further in which a payment system could reflect the quality of activities in adult mental health services (Department of Health [DoH], 2014). This could have implications for wards and what resources they receive. Therefore, valuable learning could be achieved by an increased knowledge of what psychological interventions are provided within acute inpatient wards.

This literature review looks at research undertaken to review current psychological interventions provided on acute inpatient wards. The literature review therefore aims to answer the question *'What is currently known about psychological interventions delivered on acute adult inpatient wards?'*

Method

Structure of Review

The literature review has been completed in a systematic way; therefore the search strategy is described in detail to ensure it is replicable (Boland, Cherry & Dickson, 2014). The meta-search engine EBSCO host was used to search the databases PsychInfo, Academic Search Complete and CINAHL Plus Full Text. The database Web of Science and search engine host HDAS, including databases EMBASE and AMED, were searched and duplicates removed. A screening procedure was then applied to the search results in which the inclusion and exclusion criteria were applied. Each eligible paper was then critically reviewed using a set of critical appraisal questions.

To analyse the articles, an adapted thematic analysis approach was used (Ayeyard, 2010). A meta-summary was developed, (Thorne, Jensen, Kearney, Noblit & Sandelowski, 2004) in which the 13 papers are described within four categories; these were identified by clustering together papers with similar topics. The strengths and limitations for the papers are provided alongside the implications for future research.

Inclusion and Exclusion Criteria

Inclusion criteria: Relating to an acute adult inpatient setting (a ward in which the person cannot be treated within the community, is at risk to themselves and/or others); focus of the article relates to individual or group based psychological intervention (based on a psychological theory and/or framework); intervention is designed for inpatients on the ward; based in a country with a universal health care system; there is a clearly described method; written in the English language.

Exclusion criteria: Treatment intervention using solely medical procedures or drugs; relating to specialist units including forensic, eating disorder, mother and baby units; majority of the intervention takes place in an outpatient setting.

Results

Search Strategy

The initial searches were conducted between July and November 2014 (Appendix B) and the final search took place on 25th November 2014 in which the following search terms were entered (inpatient ti OR “in-patient”ti) AND (“mental health” ab OR psychiatric ab) AND (psychotherap* OR “group psychotherap*” OR “psychotherapy* group” OR “individual psychotherapy*” OR “psychological intervention” OR “psychological treatment” OR “cognitive behavioural therapy” OR “dialectical behavioural therapy” OR “cognitive analytical therapy” OR “mindfulness” OR “psychodynamic” OR “systemic therapy” OR “compassionate focused therapy” OR “acceptance and commitment therapy” ab), into EBSCO Host with limiters imposed for peer reviewed journal articles and for the time period 2004-2014 which provided 123 peer-reviewed search results. Fifty-six were provided from PsychINFO database, 63 from Academic Search Complete and four from CINAHL Plus with Full Text. Following removal of duplicates there were 90 results. Using the same search terms with the database Web of Science, this provided 232 search results. Using the HDAS host database with the same search terms produced seven search results, six from EMBASE and one from AMED when duplicates had been removed. A screening process was then administered to determine appropriate articles, filtering initially by title (A), then by abstract (B) and finally by full paper (C; Appendix C). All eligible papers were then subjected to a further screening of the papers’ references using the previously described manual screening procedure.

Screening Results.

Following the screening process, 13 articles were found to meet the inclusion criteria.

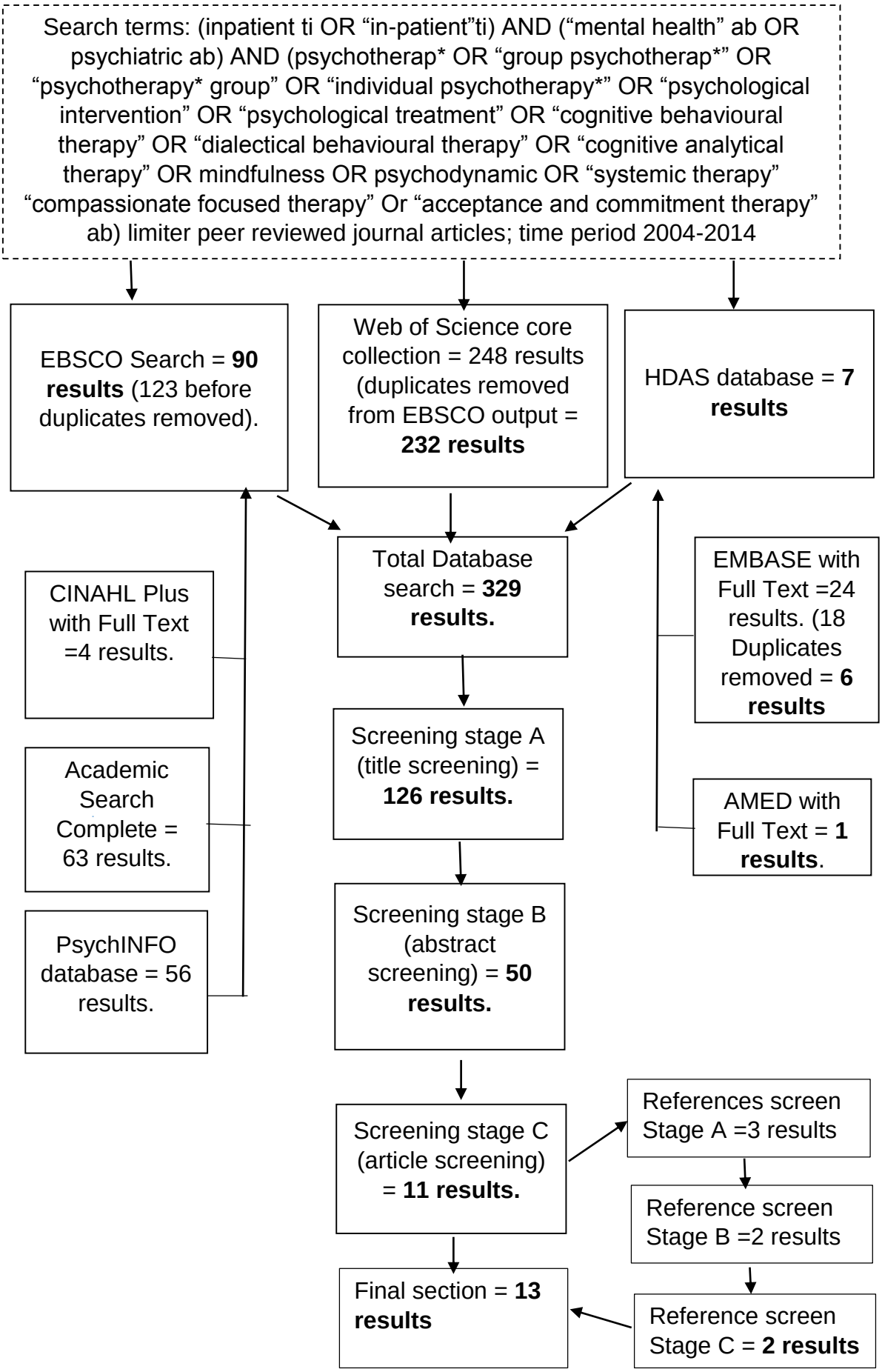


Figure 1. Literature review screening process flow chart

Critical Review.

In order to determine the quality of the papers within the review, two sets of critical appraisal questions have been developed. For qualitative papers, 16 questions (appendix D) were devised from a Critical Appraisal Skills Programme (CASP) for qualitative research (2014) and from guidelines set by Elliott, Fischer and Rennie (1999). For quantitative papers, 20 questions (appendix E) were devised by using the CASP for cohort studies, CASP for randomised control studies and a checklist for both randomised and non-randomised studies by Downs and Black (1998). The papers quality are determined by scoring the assessment tool. One point was given when questions were fully answered, half a point was given when questions were partially answered and no point was given if the question was not answered. A percentage was then calculated for each paper to indicate the extent the paper meets the critical appraisal tool criteria (Table 4).

From the 13 papers, seven papers used quantitative methods (Table 1), two papers used qualitative methods (Table 2) and four papers used mixed methods (Table 3). Following analysis of the papers the four categories described are as follows:

1. Service users perspectives of psychological interventions…….Page 22
2. Stand-alone sessions or interventions……..Page 23
3. Cognitive Behavioural Therapy techniques……..Page 26
4. Long term effects of psychological therapies……...Page 27

Table 1

Quantitative Results included in the Critical Review

Authors, publication year and country	Methodology/ measures used	Therapeutic Intervention	Participants	Setting	Purpose/ Aims	Effect size	Findings
Sachsse, Vogel & Leichsenring (2006), Germany	Two sided t-tests; MANOVAs/ Dissociative Disorders Interview Schedule (DDIS), Global Assessment of Functioning Scale (GAF), Clinical Global Impressions (CGI), Borderline Personality Inventory (BPI), Dissociative Experience Scale (DES), Impact of Events Scale (IES), Symptoms Check List (SCL), Beck Depression Inventory (BDI)	Psychodynamic trauma-focused intervention for women with post-traumatic stress disorder associated with borderline personality disorder	Group 1 = 87 Group 2 = 75 Group 3 = 30	Inpatient ward	To report treatment results for patients who are admitted for stabilisation and assessment and took part in trauma-therapy treatment and to assess long term effects	Primitive defence mechanism = 0.63 DES score = 0.52 Absorption =0.63 Avoidance =0.77 Moderate-large effect	End of treatment use of primitive defence mechanisms, dissociation and avoidance decreased, with stable outcome after a year follow-up
Schramm et al. (2007), Germany	ANCOVA; Hamilton Depression Rating Scale (HAM-D), BDI, GAF.	Interpersonal psychotherapy for depressed inpatients with medication	124 participants	Acute psychiatric hospital	Determine efficacy of a psychotherapy program combined with pharmacotherapy versus medication and TAU for depressed SUs	General acute treatment effect =0.62, moderate effect	Significantly greater reduction of depressive symptoms, rates of remission not significantly different. Treatment gains at 3 months, lost at 9 months follow-up.

Raune & Daddi (2011), UK	Pearson's Chi square/ Patient feedback scale, re-attendance rates.	Group CBT	137 participants	Two acute inpatient wards	To assess feasibility and acceptability for inpatients to choose group therapeutic targets for a stand-alone session.	Not reported	75% of respondents rated the group to be useful, enjoyable, reduce distress and would re-attend. Women and those with bipolar without psychosis were more likely to re-attend.
Durrant, Clarke, Tolland & Wilson. (2007), UK	Dependent t-tests/ Mental Health Confidence Scale (MHCS); Locus of Control of the Behaviour Scale (LCB); Goal Setting; Living with Emotions; Clinical Outcomes in Routine Evaluation (CORE).	Modified brief CBT, focus on emotion and coping skills.	7 female 7 male	Acute ward and a PICU	Following the intervention self-efficacy, locus of control and emotional coping will improve, increased confidence in emotional coping skills and visual analogue scale will show improved goal attainment.	Not reported	Increased self-efficacy of participants and internal locus of control, significant increase in self-efficacy (coping style only subscale to have increased). Significant improved confidence to express emotions, significant increase in achieving goals.
Kohler et al. (2013), Berlin	Analysis of covariance, Pearson chi square/ HAM-D; BDI; GAF; CGI Brief Symptom Inventory (BSI); Dysfunctional Attitude Scale (DAS);	CBT for depression	206 women	Psychiatric ward	Whether CBT offered in addition to acute routine psychiatric treatment results in better outcomes	HAMD = 0.31;BDI = 0.32;BSI-GSI =0.49;DAS-G= 0.16;CGI= 0.61;GAF= 0.32, Small-moderate effect	Greater reduction of depressive symptoms than TAU. Higher remission rates

Apostolo & Kolcaba (2009), Portugal	Repeated measures analysis of variance, chi-square, t-tests/ The Psychiatric Inpatients Comfort Scale (PICS); Depression, Anxiety and Stress Scales (DASS-21);	Guided imagery intervention for depressive patients	40 male 20 female	Three psychiatric units	Those who use the intervention will have a higher comfort score and lower depression, stress and anxiety	Not reported	Significantly higher comfort scores and a significant decreased depression, anxiety and stress
Veltro et al. (2006), Italy Veltro et al. (2008), Italy	Analysis of variance and chi-square/ Questionnaires, readmission rates and rates of physical restraints	Manualised cognitive-behavioural group therapy	Year before intervention = 150 Year one = 171 Year 2 = 181 Year 3= 129 Year 4= 102	Psychiatric inpatient unit	To measure the effectiveness of manualised cognitive behavioural group therapy on an inpatient unit	Not reported	Readmission rates declined, compulsory admissions reduced, excellent patient satisfaction

Table 2

Qualitative Results Included in the Critical Review

Authors, publication year and country	Methodology/ measures used	Therapeutic Interventions	Participants	Setting	Purpose/ Aims	Findings
York (2007), UK	Thematic analysis	Mindfulness group	8 participants (4 males and 4 females)	Plymouth acute inpatient mental health service	Explore the experience of individuals in a mindfulness group	Appears to allow participants to make cognitive changes, reports of increased concentration, experienced a sense of peace and relaxation
O'Donovan & O'Mahony (2009), Ireland	Thematic content analysis	Therapeutic group for emotional expression and coping skills	8 participants (5 women and 3 men)	Acute psychiatric unit	Understand the experience of service users of a nurse led therapeutic group programme	Four themes: value service users placed on the programme, benefits gained, unhelpful aspects experienced, factors influencing their participation

Table 3

Mixed Methods Results Included in the Review

Authors, publication year and country	Methodology/ measures used	Therapeutic intervention	Participants	Setting	Purpose/ Aims	Findings
Iqbal & Bassett (2008), UK	Beck depression inventory-II, descriptive data; questionnaire; content analysis	Activity scheduling	16 inpatients 14 nursing staff	Two acute inpatient wards	To evaluate participants perceived usefulness of activity scheduling	All participants found activity scheduling useful, positive effect on mood and recovery
Heriot-Maitland, Vidal, Ball & Irons (2014), UK	Thematic analysis. A range of ratings scales; descriptive data	Compassionate-focused therapy group	57 participants (quantitative) 4 participants (qualitative)	Acute inpatient wards	Assess the feasibility of running a compassionate focused therapy group on an acute inpatient setting	Decrease in distress and increase in calmness. Themes; understanding compassion, experience of positive affect, experience of common humanity
Tickle, Regan & Moss-Morris (2009)	Evaluation form, descriptive data; thematic content analysis	Stand-alone session; group 1 CBT skills; group 2 CBT skills relevant to psychosis.	Study 1: 32 females, 34 males Study 2: 13 females, 7 males	Two acute inpatient wards	To evaluate 'stand-alone' groups on the wards	Participants found the group 'useful', 'helpful' and 'friendly'. Increased confidence speaking on the ward and improved ward culture
Fell & Sams (2005)	Written evaluation, descriptive data; thematic analysis	Stand-alone rolling group with a CBT framework	88 participants	Two acute inpatient wards	Describe the experience of setting up, running and evaluating the group	Themes of guidance, catharsis, universality, self-understanding, group cohesiveness, instillation of hope

Table 4

Criteria met by critical appraisal tool

Author, Publication Year, County	Criteria met by critical appraisal tool (%)
Schramm et al. (2007), Germany	90%
York (2007), UK	88%
O'Donovan & O'Mahony (2009), Ireland	84%
Sachsse, Vogel & Leichsenring (2006), Germany	78%
Kohler et al. (2013), Berlin	73%
Apostolo & Kolcaba (2009), Portugal	73%
Veltro et al. (2006), Italy; Veltro et al. (2008), Italy	63%
Durrant, Clarke, Tolland & Wilson (2007), UK	55%
Raune & Daddi (2011), UK	53%
Heriot-Maitland, Vidal, Ball & Irons (2014), UK	53%
Iqbal & Bassett (2008), UK	45%
Fell & Sams (2005), UK	42%
Tickle, Regan & Moss-Morris (2009), UK	39%

Category 1: Service users' perspectives of psychological interventions. York (2007) explored the perspectives of eight participants that took part in a mindfulness group on an acute inpatient ward. The group included a range of mindfulness techniques with the aim of improving concentration and awareness. Ten themes were described and all themes were supported with narratives from the data. The themes included: a sense of peace and relaxation, acceptance, exposure to problem thoughts, feelings and beliefs, awareness, self-management, the use of mindfulness after discharge and negative experiences. Cognitive change was a key theme, where participants were able to separate themselves from their thoughts impacting positively on their emotions. Rigor was demonstrated by the interpretations of the data being subject to peer review, however a lack of supporting quotes

limits the replicability of the research. Overall, the research highlights potential benefits of a mindfulness approach on an acute inpatient unit.

O'Donovan and O'Mahony (2009) explored SUs experiences of a nurse-led therapeutic group on an acute inpatient ward. The group consisted of ten elements that related to psychoeducation, relaxation, managing emotions, confidence building and relapse prevention. Eight participants took part in the study and engaged in semi-structured interviews about their experiences. The findings revealed four themes, the programme value, benefits, unhelpful aspects and influential factors on participating. The most important theme was relating to others. Helpful content was described, particularly in relation to the confidence session and the relaxation session was viewed as valuable. Participants highlighted repetition as unhelpful and described irrelevant aspects of the group. A strength of the research was that data collection ceased when saturation had been achieved. All themes were credible and supported by several narratives from SUs.

Heriot-Maitland, Vidal, Balls and Irons (2014) completed a pilot study exploring the feasibility and SU's experience of a compassionate-focused therapy (CFT) group on an acute inpatient unit. A mixed methods design was used to assess 82 participants' distress and calmness along with four participants interviewed about their experience of the group. The CFT sessions consisted of psychoeducation, mindfulness, compassion and imagery. From initially recruiting 82 participants, a total of 57 participants completed the quantitative measures. No standardized outcome measures were used therefore caution is needed when interpreting the findings. The outcomes revealed the imagery session had the largest effect on pre-post comparison measures for reduced distress and calmness. Most of the sessions were perceived 'very' or 'extremely' helpful with no significant difference between the sessions. The qualitative findings revealed three themes namely understanding compassion, experience of positive affect and experience of common humanity. A strength of this research is that quotes were given by several participants to support the themes.

Category 2: Stand-alone sessions or interventions. Apostolo and Kolcaba (2009) explored the use of a guided imagery (GI) intervention for SUs on an acute inpatient ward. The GI intervention was provided on a compact disc (CD) and incorporated deep diaphragmatic breathing, progressive muscle

relaxation and imagery exercises. The aim was to assess the participant's perception of comfort, depression, stress and anxiety with a hypothesis that following 10 days, the patients would have significantly higher comfort and lower depression, stress and anxiety scores.

Participants were recruited from three psychiatric wards. The treatment group was initially recruited followed by the control group so that there would be no contamination between groups. Those in the treatment group were given GI CDs to listen to for 10 days. The findings revealed significantly lower depression, stress and anxiety and higher comfort scores in the treatment group. A strength of the research is the use of a power calculation to increase the accuracy of the findings. Those who dropped out from treatment were not included in the findings and this may therefore have biased the results.

Raune and Daddi (2009) explored a CBT group in a stand-alone session format where group members chose their therapeutic targets. The group took place on two acute inpatient wards with the aim of teaching core skills including labelling emotions, evaluating negative thoughts and coping skills. Psychoeducation and CBT methods were used within the group. A large sample of 137 participants took part in the research. A quantitative method was used in which participants were given a feedback questionnaire developed by the researchers at the end of the group. The findings revealed females and those with a diagnosis of bipolar without psychosis were significantly more likely to re-attend the group. The outcome of finding the group enjoyable was the strongest predictor for re-attending. Feasibility of the group was demonstrated with 90% indicating the group to be useful. Not being able to relate participants' feedback to demographic or diagnostic factors, impacts on the generalisability of the findings.

Fell and Sams (2004) completed a service evaluation of a stand-alone CBT group for SUs on two acute inpatient wards. The group was designed as a rolling programme that consisted of three topics: managing physical and psychological anxiety, challenging unhelpful thoughts, and communication skills. The delivery of the group evolved as imagery techniques were used within the topic of anxiety. It is known from the results that 88 participants were recruited. Participants completed an evaluation form at the end of the group in which they rated the helpfulness of the group and answered three qualitative questions.

Descriptive data is given for the quantitative data in which 96.5% of participants found the group helpful, however without statistical analysis, this finding lacks precision and it is therefore unclear if the findings demonstrate a true effect. The qualitative data was categorised using Yalom's (1983) 12 factors. Primary themes that emerged were guidance, catharsis and universality. Guidance was the most mentioned theme, however, there were no extracts from the data to understand how this theme emerged. Some extracts had been provided for the other two themes. Overall, the participants described the group to be useful and helpful.

Tickle, Regan and Moss-Morris (2009) completed a service evaluation of standalone group work on two acute inpatient wards. The group was based on Yalom's (1983) model for stand-alone sessions. The first group consisted of psychoeducation, coping skills and CBT skills, framed around the topics of anxiety, avoidance, negative thinking, motivation and dealing with emotions. The second group was adapted for those who experienced psychosis, which consisted of information on the stress-vulnerability model, relapse prevention, identifying and challenging thinking distortions, coping with voices and substance misuse.

The aims of the evaluation were not clear although it was inferred from the background literature that the group may help increase participants' sense of agency, hope and universality. SUs were interviewed and completed an evaluation form where they selected words from a list which they thought endorsed the group. This method may have biased the findings. Participants rated the group for content, support, learning and feeling accepted. The qualitative findings from the first study indicated that participants found the group useful, helpful, and friendly. Findings revealed three themes: group content, in which relaxation skills, dealing with avoidance, goal setting and discussing emotions were most helpful; group therapeutic factors, which included feelings of cohesiveness and universality and decreased isolation; and practical concerns relating to adequate space and lack of disruptions. In the second study participants indicated the group to be useful, interesting, helpful, supportive, friendly, encouraging, positive and hopeful. There were three themes from the qualitative data: active participation, where participants found it helpful to talk; group content, perceived as interesting and informative; and recommendations for future groups, making groups more available and

increasing attendance to groups. Overall the groups were found to have a positive impact on the ward and the format of stand-alone sessions were achievable.

Category 3: Cognitive behavioural therapy techniques. Durrant, Clarke, Tolland and Wilson (2007) completed a pilot study to evaluate a CBT based group on an acute adult inpatient ward. The group incorporated 'third waves CBT' approaches including dialectical behavioural therapy and mindfulness. The aim of the group was recovery focused. Group members would set themselves a goal at the start of therapy. It was hypothesised that following the intervention, self-efficacy, locus of control and emotional coping would improve. In addition, participants would have more confidence in their coping strategies and would feel more able to achieve their goals.

Durrant et al (2007) performed limited statistical analysis due to the small sample size of 14 participants. However, a dependent t-test on pre and post scores revealed a significant increase in self-efficacy with the element of 'coping style' being the only scale to have significant increase on post scores. Internal locus of control increased with no significant change for external locus of control. Expressing and coping with emotions also increased following the intervention. Regarding goal attainment, 57.15% met at least one goal indicating all participants made improvements attaining their goals.

Kohler et al. (2013) conducted a naturalistic study on an acute inpatient setting, examining the effectiveness of combining psychopharmacology with CBT. A large sample of 260 inpatients, diagnosed with unipolar depression, were recruited for the treatment condition compared to inpatients who received treatment as usual (TAU). The intervention was based on Beck, Rush, Shaw and Emery's (1979) depression model for CBT and incorporated psychoeducation, activity planning, cognitive treatment, social skills training and relapse prevention. Analysis of the data for the interaction effect of time by treatment revealed a high reduction in depression in the CBT group compared to TAU with a small effect size. Significant effects for remission rates were also found in the CBT group with the primary measure HAMD but not with other measures.

Iqbal and Bassett (2008) explored the usefulness of activity scheduling (AS) for acute inpatients with a diagnosis of depression. Within the group, SUs identified their current activity levels and rated levels of mastery and pleasure,

then introduced pleasurable activities into an activity schedule with the aim of positively reinforcing these activities. A large component of the intervention relied on SUs completing a homework assignment. The researchers were interested in how useful participants perceived the intervention, because perceiving the intervention as useless would result in reduced engagement (Persons, Davidson & Tompkins, 2001).

Both staff and SUs were recruited using a convenience sample from two acute inpatient wards. Due to the limited sample of 16 inpatients and 14 staff members, only descriptive analysis are reported on the quantitative data. All participants found the intervention useful and helped with their recovery. Increased confidence, enabled socialising, distraction from difficulties, learning process and enjoyment were reported. Contrasting views from SUs included feeling not good enough*,* feeling they had failed, finding the intervention boring and not being challenging enough. Staff thought the intervention allowed SUs to interact, improved SUs confidence and autonomy. More information was thought to be needed and more time was required to provide the intervention on the ward. Overall SUs had pleasure, satisfaction and a sense of achievement from AS which corresponds with current literature. Future recommendations included that the level of AS should be matched with the level of experienced depression, as SUs with mild depression found the intervention boring.

Category 4: Long term effects of psychological therapies. A high quality study was completed by Schramm et al. (2007) who conducted a randomised control trial (RCT) comparing interpersonal psychotherapy intervention and pharmacotherapy to TAU, which consisted of psychoeducation and support, along with medication for inpatients with depression. It was hypothesised that depressed inpatients' who received five weeks of psychotherapy in combination with pharmacology would have reduced depression and increased remission rates compared to TAU and a follow-up period would show better symptomatic and psychosocial outcomes with lower relapse rates.

Participants were recruited from an acute psychiatric hospital. A total of 124 participants took part in the study and were randomly assigned to either the intervention or the TAU group. There was limited information regarding the nature of the psychotherapy intervention; however, information about the length

and frequency of the intervention was provided. Information was provided about the medicine prescribed to participants and statistical analysis revealed both treatment conditions were similar.

An ANCOVA was used to analyse the data. Findings revealed that over time both treatment groups showed improvements. The outcome was significantly higher for interpersonal psychotherapy across the three time points measured, with the outcome having a moderate effect size. Response rates were significantly higher for interpersonal psychotherapy and remission rates were higher, although not statistically significant. Global functioning was also significantly higher. At follow-up, there was a greater reduction on HAMD scores and fewer patients relapsed in the interpersonal psychotherapy group with beneficial effects being maintained at both three and 12-month follow-ups. Overall, an intensive delivery of therapy at the acute stages had a treatment advantage for those with severe depression. It is recommended that psychotherapy be offered at this time rather than waiting for a period of stabilisation.

Veltro et al. (2006) explored the longer term effects of a CBT group intervention on an acute inpatient ward. The CBT group was based on the stress-vulnerability model (Falloon & Fadden, 1993) and included identifying early warning signs, communication skills, problem solving skills, understanding medication and discharge planning. Additional themes were discussed within the group relating to symptoms of mental health difficulties. The aim was to assess the effectiveness of the intervention using a pre-post design, in which follow-ups were conducted over a four year period (Veltro et al. 2008). A large sample was recruited, in which 90% of inpatients admitted participated in the research; the remainder were excluded.

To assess the effectiveness of the intervention, numerical data was collected relating to violent incidents, readmissions and length of hospital stay. Both parametric and non-parametric statistical analysis were conducted revealing a significant reduction in readmission over two years, increased satisfaction, improved ward atmosphere and reduction in physical restraints. Although there was a reduction in length of stay, this was not significant. Follow-up data for the third and fourth year explored the impact of diagnosis and economic outcomes. There was significant reduction in admission for those diagnosed with schizophrenia and bipolar disorder, but not for depression and

personality disorder. A Diagnostic Related Groups (DRG) system was used to assess the economic value of the intervention and the mean value increased each year over the four year period (Veltro et al. 2008). A reduction in the number of inpatient beds was recorded over the research period, which may be related to the impact of the intervention.

Sachsse, Vogel and Leichsenring (2006) conducted a naturalistic study of female acute inpatients with a diagnosis of borderline personality disorder who were engaging in a psychodynamically oriented trauma-focused therapy. This intervention included Eye Movement Desensitization and Reprocessing (EMDR; Shapiro, 1995) and a stabilizing psychodynamic treatment. A large sample of 153 participants took part in the first phase of the research. This phase was the comparison group and consisted of information, diagnosis, stabilisation and imagination exercises. A wait period followed which was the second phase. The third phase was the trauma-focused therapy condition and the fourth phase was follow-up one year later. The intended outcomes for the research were that TAU would not have a significant therapeutic effect for participants, that the trauma-focused therapy would have positive effects and that these would be stable over a year follow-up period.

Within the first TAU phase, a two-tailed t-test revealed no significant positive change for participants. For treatment completers in the trauma-focused therapy group, there were significant improvements in primitive defence mechanisms, dissociation and stress reactions with a moderate to large effect size. No overall significant effect on symptom distress was found when a Bonferroni correction was applied. Within the follow-up year a MANOVA revealed there were no significant improvements, however, the results remained stable; participant's scores did not worsen within the follow-up period. In addition, the average number of inpatient days dropped significantly a year following treatment. Providing psychotherapy in acute inpatient services is cost-effective.

Strengths and Limitations of Studies Reviewed

All the studies had clear rationales, particularly identifying that limited research had been conducted in the area of psychological interventions for acute inpatient wards (York, 2007; O'Donovan & O'Mahony, 2009; Heriot-Maitland et al. 2014; Schramm et al. 2007; Veltro et al. 2006). Schramm et al. (2007) particularly highlighted that a RCT had not previously been completed in

this area. They also had a clear recruitment strategy in which all eligible participants were recruited and randomly assigned to TAU and intervention. Other research also had clear protocols (Apostolo & Kolcaba, 2009; O'Donovan & O'Mahony, 2009). It is unclear whether the participants were appropriate from the remaining papers as there was limited information on demographics and the recruitment strategy.

A strength of some of the quantitative papers, in the review, is the reported attrition rates that were taken into account in the results (Schramm et al. 2007; Kohler et al. 2013). The attrition rates were reported in other papers but not taken into account in the results which may have impacted on the validity of the findings (Heriot-Maitland et al. 2014; Apostolo & Kolcaba, 2009; Sachsse et al. 2006). A common theme in the qualitative papers was a lack of reporting the researchers' epistemological stance (York, 2007; O'Donovan & O'Mahony, 2009; Iqbal & Bassett, 2008; Heriot-Maitland et al. 2014; Tickle et al. 2009; Fell & Sams, 2005). Not all researchers believe in-depth discussions are necessary in the research report, however, this would have improved the understanding of the development of the themes. Willig (2013) acknowledges the need to consider reflexivity within qualitative research. Thematic analysis was a common qualitative methodology used within the papers. In some instances when the researchers were exploring the participants' experience of a phenomenon (York, 2007), it may have been more appropriate to use interpretative phenomenological analysis (IPA).

A number of studies used measures that were valid and reliable which provides strength to the findings of the variables that were measured (Apostolo & Kolcaba, 2009; Durrant et al. 2007; Schramm et al. 2007; Sachsse et al. 2006; Iqbal & Bassett, 2008). Veltro et al (2006) reported on reliability of the measure of ward atmosphere, in contrast, Kohler et al. (2013) did not report on the validity and reliability of measures. Iqbal and Basset (2008) used a measure that was self-designed, exploring the utility of an intervention. Fell and Sams (2009) also used a measure that was self-designed which had not been validated. Internal consistency reliability checks would have been useful for the measures that had been designed by the researchers (Clark-Carter, 2009).

A limitation of the qualitative papers was that themes were not substantially reported by participants' quotes (York, 2007; Tickle et al. 2009; Iqbal & Bassett, 2008) limiting the reliability of the findings. No negative case

analysis appeared to be considered within the research, limiting the extent to which the themes have emerged (Willig, 2013). O'Donovan and O'Mahony (2009) used respondents' validation allowing participants to make corrections to their transcripts which is a strength of the research. Power calculations were used in some quantitative studies which improves the likelihood of finding a true effect in the results (Apostolo & Kolcaba, 2009; Schramm, 2007). The chances of a type II error may have increased for those articles that did not appear to use a power calculation (Raune & Daddi, 2009; Kohler et al. 2013; Heriot-Maitland et al. 2014; Veltro et al. 2008).

The generalisability of some of the research is limited. A small sample size has been acknowledged by several of the researchers (Durrant et al. 2007, Iqbal & Bassett, 2008 & Tickle et al. 2009; O'Donovan & O'Mahony, 2009). Durrant et al. (2007) discussed the difficulties with recruitment in relation to the context of an acute inpatient ward. The provision of demographic information was helpful as this allowed the reader to understand the generalisability of the research (Kohler et al. 2013; Schramm et al. 2007). Confounding variables were considered in relation to the findings of the research, such as the consideration of any contextual changes on the ward (Apostolo & Kolcaba, 2009; Veltro et al. 2006). It is possible that contextual changes could have occurred with other research, particularly for those where recruitment took place over a longer period of time and this had not been discussed in relation to the findings (Kohler et al. 2013, Schramm et al. 2007, Sachsse et al. 2006). The effect size was not always reported, therefore it is unclear if there was a true effect between the independent and dependent variable (Raune & Daddi, 2009; Heriot-Maitland et al, 2014; Durrant et al. 2007; Veltro et al. 2006, Apostolo & Kolcaba, 2009). Sachsse et al. (2006) found a moderate to large effect for reduction in defence mechanisms from a psychodynamic intervention. Schramm et al. (2007) found moderate effects for reduced depression from an interpersonal therapy intervention and Kohler et al. (2013) found small to moderate effects for a reduction in depression for a CBT intervention. The majority of the articles did not include a follow-up; this would have been helpful to understand the longevity of the effects of the interventions. Follow-ups were included for three research articles (Sachsse et al. 2006, Schramm et al. 2007, Veltro et al. 2008).

Summary of Review Findings

In addition to the categories, and the strengths and limitations identified within the review, four themes have been developed across all the papers. Codes were assigned to the findings of each of the articles, then similarities in codes were drawn together to create a theme. Once the initial themes were developed, they were then checked against the original codes to ensure confidence in the themes (Aveyard, 2010). The percentage of papers from the review which represent each theme are shown in table 5.

Table 5

Percentage of papers from the review representing themes

Theme	Percentage of papers from the review
Theme 1: Acquired learning	85%
Theme 2: Impact on wellbeing	69%
Theme 3: Treatment value	46%
Theme 4: Cohesion	38%

Theme 1: Acquired learning. Acquired learning was a main theme from all the papers within the review. A sub-theme within acquired learning was gaining skills, including problem solving, communication (Veltro et al. 2006), socialising (Kohler et al. 2013), self-efficacy (Durrant et al. 2007), and attention and confidence (O'Donovan & O'Mahony, 2009). Acquired learning is further supported as a theme by participants finding interventions that were repetitive, basic and irrelevant, to be unhelpful (O'Donovan & O'Mahony, 2009). CBT and 'third wave' therapy approaches were most commonly reported (Durrant et al. 2007; Iqbal & Bassett, 2008; Raune & Daddi, 2009). York (2007) identified cognitive change to be a key factor for participants engaged in mindfulness. Other therapeutic approaches, such as psychodynamic therapy, found participants had improved skills in recognising defence mechanisms (Sachsse et al. 2006). Another sub-theme included specific psychological techniques of activity scheduling (Kohler et al. 2013), thought challenging (Fell & Sams, 2009; Iqbal & Bassett, 2008) and mindfulness (York, 2007). Imagery was reported as an effective technique (Apostolo & Kolcaba, 2009). Heriot-Maitland et al. (2014) reported imagery as the most effective technique within the intervention and Tickle et al. (2009) found relaxation to be helpful. Participants were often

provided information at the start of the intervention, including psychoeducation and normalisation of experiences (Raune & Daddi, 2009). A sub-theme was the participants' ability to plan for the future; Veltro et al. (2008) identified that recognising warning signs was useful within the intervention. Durrant et al. (2006) identified that participants were able to set and achieve their goals and Kohler et al. (2013) found relapse prevention planning to be useful to participants.

Theme 2: Impact on wellbeing. The focus on improved well-being was a strong theme that was reported on by all the papers within the review. Attending the psychological interventions improved self-esteem (Veltro et al. 2008) and mood, in particular, reducing depression (Kohler et al. 2013, Schramm et al. 2007). Hope and optimism were also reported by Durrant et al. (2007) using a CBT intervention and peacefulness was reported by York (2007) within a mindfulness intervention. Heriot-Maitland et al. (2014) found a CBT intervention to reduce distress and improve calmness and feelings of comfort. Improved feelings of comfort were also identified by Apostolo and Kolcaba (2009). Participants expressed a sense of enjoyment and satisfaction from the interventions (Veltro et al. 2008; Iqbal & Bassett, 2008; Raune & Daddi, 2009). In contrast, and to a lesser extent, there were some instances when well-being was affected negatively; participants reported boredom, feeling not good enough and that they were failing (Iqbal & Bassett, 2008).

Theme 3: Treatment value. Treatment value of psychological intervention was a theme that was less evidenced from the papers included in the review. The theme was, however, drawn from some of the papers that have demonstrated high quality from the critical appraisal (Schramm et al. 2007; Kohler et al. 2013; Sachsse et al. 2006). This theme includes a subtheme of economic value. The provision of psychological treatments contributed to reduction in readmissions and inpatients' length of stay on acute wards (Sachsse et al. 2006; Veltro et al. 2008). This had been described to contribute to effective reallocation of resources to day hospitals. The interventions were also described as inexpensive and are therefore a valuable resource to acute services (Iqbal & Bassett, 2008). In some instances, the provision of the intervention could reduce costs, such as providing CBT interventions (Kohler et al. 2013). Treatment value was discussed in relation to the sub-theme of timing of the interventions. The provision of interventions near to admission was found

favourable in comparison to waiting for a period of stabilisation (Schramm et al. 2007).

Theme 4: Cohesion. The theme of cohesion was reported to a lesser extent from some of the papers within the review. Heriot-Maitland et al. (2014) identified that through the intervention, group members benefited from sharing, relating and learning about themselves and others. This was also reported by O'Donovan and O'Mahony (2009) who in addition to learning from others, found that participants felt supported and understood, which helped decrease their sense of isolation; a sense of reduced isolation was also found by Tickle et al. (2009). A sense of cohesion and being part of a group was reported, particularly regarding a CBT intervention (Veltro et al. 2008). Improved empathy was reported in which participants were able to learn from others and reflect about themselves, thus allowing for feelings of acceptance (Fell & Sams, 2009).

Conclusion

A total of 13 articles were included within the review, considering the recent publications of policies and guidelines (The Sainsbury Centre for Mental Health Report, 2004); it was expected that there would be a larger number of relevant papers. Preliminary search strategies (Appendix B) resulted in a vast number of articles. However, initial screening in accordance with the stringent inclusion and exclusion criteria provides confidence in the articles included within this review. The papers are representative in understanding the current psychological interventions in adult acute inpatient services. All papers found some benefits for providing psychological interventions on acute inpatient wards. The majority of interventions included psychoeducation, core skills and discharge planning. The findings correspond to some extent with current policies, in that evidence-based interventions are being provided on acute inpatient settings; however, it appears more limited than expected. Overall the quality of the studies included within the review have extensive methodological limitations. Given that research within acute settings is novel, it is a strength that qualitative data is provided, yet there is no consideration of reflexivity within the papers. Due to the setting, naturalistic designs have been utilised, in that some researchers have explored participants' experiences in their natural setting which at the time was the acute inpatient ward. However, a lack of reliable controls impacts on the quality of the papers. Follow-up data to

demonstrate if treatment gains had been maintained was included for only three studies.

Strengths and Limitations of the Current Review

Cross checking the papers with a second reviewer (supervisor) when screening for selection provides further confidence in the representation of the papers included in the review. The absence of a second reviewer for quality assessment may limit the credibility of the results. Exclusion of non-English literature may result in missed information that may have contributed value to the review.

A number of study samples were homogenous to inpatients with a particular diagnosis. This has implications on the extent to which the findings can be generalised. A number of studies only collected data from one inpatient unit, which limits the generalisability. The inclusion criteria stated the study needed to be in a country with a universal healthcare system so that homogeneity amongst the papers would allow for clear synthesis of the findings. However, a limitation was the extent to which the findings could be generalised between countries when inpatient services have different structures.

Clinical Implications

The provision of a brief psychological intervention at the acute stages of admission can contribute to economic value for the healthcare service providers. It appears that providing the intervention near to admissions is likely to have the most beneficial impact. The provision of the interventions may also impact on the length of hospital stay and readmission rates. Healthcare professionals would benefit from offering an intervention that includes psychoeducation, core skills and discharge planning. A theme from the papers within the review identified a sense of cohesion from attending the interventions. Currently, healthcare professionals on acute inpatient wards have one to one time with SUs on the ward. It could be beneficial to utilise some of this time to provide group based interventions which could help reduce feelings of isolation and increase feelings of being supported.

It is also important for healthcare professionals to consider the content of the intervention, so that there is an appropriate match in level of learning for those attending the intervention, in order to reduce the possibility of boredom and a sense of lack of learning. Consideration of the content of the session is

also important regarding the clinical presentation of the SU, as SUs with a diagnosis of schizophrenia and bipolar disorder have reduced remission rates when attending a CBT intervention, which is consistent with the NICE (2006; 2010) guidelines. However, reduced remission rates following CBT was not found for those with a personality disorder diagnosis. Instead, a psychodynamic intervention was found to be beneficial for SUs with a borderline personality disorder diagnosis. It is important that healthcare professionals carefully consider and plan interventions based on the specific needs of SUs on acute inpatient wards. Gaining feedback from SUs following the interventions and responding to this feedback would be important, because SUs were more likely to re-attend the intervention if they found it enjoyable. Provision of these interventions is likely to improve the wellbeing of SUs and improve their skills in managing their own mental health distress. Overall, psychological interventions on acute inpatient settings include the provision of skills, which are mainly based on CBT interventions. There are currently insufficient quality papers to understand the benefits beyond these interventions.

Future Research

Some of the papers within this review used measures that had been developed by the researchers. Variation between the measures used within the papers, made it difficult to compare the findings. Therefore, it would be beneficial for further studies to validate measures such as perceived usefulness (Iqbal & Bassett, 2008), in order that the findings between studies are more comparable. Several of the papers included in the review also focused on specific patient groups, such as those with a diagnosis of depression (Schramm et al. 2007; Kohler et al. 2013; Apostolo & Kolcaba, 2009). Given that acute inpatients have a variety of diagnoses (BPS, 2012), future research should include a broader range of client presentations to explore the use of psychological interventions for all patients within an acute inpatient ward.

With limited research exploring psychological intervention on acute inpatient wards, it would be useful for further qualitative research to be conducted, in which the studies address the limitations highlighted within this review, such as reflexivity and epistemological positions. Following exploration using qualitative research approaches, quantitative research using RCT's would then allow for further understanding of the contribution of psychological interventions on acute inpatient wards. In addition, further literature reviews in

this area may also needed in order to conduct a meta-synthesis which would then make it possible for decisions to be made about changes to relevant policies (Boland et al. 2014).

Paper 1 References

Apostolo, J.L.A., & Kolcaba, K. (2009). The effects of guided imagery on comfort, depression, anxiety and stress of psychiatric inpatients with depressive disorders. *Archives of Psychiatric Nursing, 23,* 403-411. http://dx.doi.org/10.1016/j.apnu.2008.12.003.

Aveyard, H. (2010). *Doing a Literature Review in Health and Social Care: A practical guide* (2nd ed.). Berkshire: Open University Press.

Beck, A.T., Rush, A.J., Shaw, B.F., & Emery, G. (1979). *Cognitive Therapy of Depression. New York, NY*: Guildford.

Boland, A. M., Cherry, G., & Dickson, R. (2014). *Doing a Systematic Review: A Students Guide*. London: Sage Publications.

Bowers, L., Whittington, R., Nolan, P., Parkin, D., Curtis, S., Bhui, K., Hackney, D., Allan, T., Simpson, A., & Flood, C. (2007). *The City 128 Study of Observation and Outcomes on Acute Psychiatric Wards*. London: City University.

Bright (2006). *Star Wards: Practical Ideas for Improving the Daily Experiences and Treatment Outcomes of Acute Mental Health In-patients*. London: Bright. Retrieved December 2014 from www.starwards.org.uk.

British Psychological Society. (2012). *Commissioning and Delivering Clinical Psychology in Acute Adult Mental Health Care: Guidance for Commissioners, Service Managers, Psychology Managers & Practitioners*. London: British Psychological Society.

Brooker, C., Ricketts, T., Bennet, S., & Lemme, F. (2007). Admission decisions following contact with an emergency mental health assessment and intervention service. *Journal of Clinical Nursing, 16*, 1313–1322. 10.1111/j.1365-2702.2005.01302.x.

Critical Appraisal Skills Programme (2014). CASP Checklists. Retrieved December 18th 2014, from http://www.casp-uk.net/#!casp-tools-checklists/c18f8

Clark-Carter, D. (2009). *Quantitative Psychological Research: The complete student's companion.* Hove: Psychology Press.

Cleary, M., Hunt, G.E., Horsfall, J., & Deacon, M. (2012). Nurse-patient interaction in acute adult inpatient mental health units: A review and synthesis of qualitative studies. *Issues in Mental Health Nursing, 33* (2), 66-79. 10.3109/01612840.2011.622428.

Clarke, S. (2004). *Acute Inpatient Mental Health Care: Education, training and continuing professional development for all*. London: NIMHE/SCMH.

Department of Health (2014). *Closing the gap: priorities for essential change in mental health*. London: Department of Health.

Downs, S.H., & Black, N. (1998). The feasibility of creating a checklist for the assessment of the methodological quality of both randomised and non-randomised studies of health interventions. *Journal of Epidemiology Community Health, 52*, 377-384. http://dx.doi.org/10.1136/jech.52.6.377.

Drury, V., Birchwood, M. & Cochrane, R. (1996). Cognitive therapy and recovery from acute psychosis: a controlled trial. II. Impact on recovery time. *British Journal of Psychiatry 169,* 602–607. http://dx.doi.org/10.1192/bjp.169.593.

Durrant, C., Clarke, I., Tolland, A., & Wilson, H. (2007). Designing a CBT service for an acute inpatient setting: a pilot evaluation study. *Clinical Psychology and Psychotherapy, 14,* 117-125. 10.1002/cpp.516.

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields, *British Journal of Clinical Psychology, 38*, 215–229. http://dx.doi.org/10.1348/014466599162782.

Falloon, I.R.H., & Fadden, G. (1993). *Integrated Mental Health Care*. Cambridge: Cambridge University Press.

Fell, A., & Sams, N. (2004). In-patient groups: Setting up, running and evaluating ‘stand alone’ groups on adult acute in-patient wards. *Clinical Psychology, 42,* 5-8.

French, P., Smith, J., Shiers, D., Reed, M., & Raid, M. (2010). *Promoting Recovery in Early Psychosis: A Practical Manual*. West Sussex: Blackwell.

Greenwood, N., Key, A., Burns, T., Bristow, M., & Sedgwick, P. (1999). Satisfaction with inpatient psychiatric services. Relationship to patient and treatment factors*. The British Journal of Psychiatry, 174,* 159-163. http://dx.doi.org/10/1192/bjp.174.2.159.

Heriot-Maitland, C., Vidal, J.B., Ball, S., & Irons, C. (2014). A compassionate-focused therapy group approach for acute inpatients: Feasibility, initial pilot outcome data, and recommendations. *British Journal of Clinical Psychology, 53*, 78-94. 10.1111/bjc.12040.

Iqbal, S., & Bassett, M. (2008). Evaluation of perceived usefulness of activity scheduling in an inpatient depression group. *Journal of Psychiatric Mental Health Nursing, 15,* 393-398.

Joint Commissioning Panel for Mental Health (2013) *Guideline for Commissioners of Acute Care: Inpatient and Crisis Home Treatment*. London: JCP-MH.

Kohler, S., Hoffmann, S., Unger, T., Steinacher, B., Dierstein, N., & Fydrich, T. (2013). Effectiveness of Cognitive-Behavioural Therapy Plus Pharmacotherapy in Inpatient Treatment of Depressive Disorders. *Clinical Psychology and Psychotherapy, 20*, 97-106. 10.10002/cpp.795.

MIND (2004) Mind's Report on Hospital Conditions for Mental Health Patients [online]. London: MIND. Available at: www.mind.org.uk [accessed December 2014].

National Institute for Clinical Excellence (2010). *Schizophrenia: Core Interventions in the Treatment and Management of Schizophrenia in Adults in Primary and Secondary Care (update).* London: Author.

National Institute for Clinical Excellence (2009). *CG78 Borderline Personality Disorder Quick Reference Guide.* London: Author.

National Institute for Clinical Excellence (2007). *Post-traumatic Stress Disorder (PTSD): The management of PTSD in adults and children in primary and secondary care*. London: Author.

National Institute for Clinical Excellence (2006). *Bipolar Disorder: The management of bipolar in adults, children and adolescents, in primary and secondary care.* London: Author.

National Institute for Mental Health in England (2004). *Acute In-patient Mental Health Care*. London: Author.

National Institute for Mental Health-England (2003). *Personality Disorder: No Longer a Diagnosis of Exclusion*. London: Author.

O'Donovan, A., & O'Mahony, J. (2009). Service users' experience of a therapeutic group programme in an acute psychiatric inpatient unit. *Journal of Psychiatric and Mental Health Nursing, 16,* 523-530. 10.1111/j.1365-2850.2009.01409.x.

Owiti, J.A., & Bowers, .L (2011). A narrative review of studies of refusal of psychotropic medication in acute inpatient psychiatric care. *Journal of Psychiatric & Mental Health Nursing, 18*, 637-647. 10.1111/j/1365-2850.2011.01713.x.

Persons, J., Davidson, J. & Tompkins, M. (2001). *Essential Components of Cognitive Behavior Therapy for Depression.* Washington: American Psychological Association.

Raune, D., & Daddi, I. (2011). Pilot study of group cognitive behaviour therapy for heterogeneous acute psychiatric inpatients: treatment in a sole-standalone session allowing patients to choose the therapeutic targets. *Behavioural and Cognitive Psychotherapy, 39*, 359-365. http://dx.doi.org/10.1017/51352465810000834.

Rose, D. (2001). *Users Voices. The Perspective of Mental Health Service Users on Community and Hospital Care.* London: Sainsbury centre of mental health.

Sachsse, U., Vogel, C., Leichsenring, F. (2006). Results of psychodynamically oriented trauma-focused inpatient treatment for women with complex posttraumatic stress disorder (PTSD) and borderline personality disorder (BPD). *Bulletin of the Menninger Clinic, 70*, 125-144.

Sainsbury Centre of Mental Health (2004). *Acute Care 2004: A national survey of adult psychiatric wards in England*. London: Sainsbury Centre for Mental Health.

Schramm, E., Van Calker, D., Dykierek, P., Lieb, K., Kech, S., Zobel, I., … & Berger, M. (2007). An intensive treatment program of interpersonal psychotherapy plus pharmacotherapy for depressed inpatients: acute long-term results. *American Journal of Psychiatry, 164,* 768-777. http://dx.doi.org/10.1176/appi.ajp.164.5768.

Shapiro, F. (1995). *Eye Movement Desensitization and Reprocessing (EMDR): Basic principles; protocols, and procedures*. New York, NY: Guildford Press.

Thorne, S.E., Jensen, L., Kearney, M.H., Noblit, G., & Sandelowski, M. (2004). Qualitative metasynthesis: reflections on methodological orientation and ideological agenda, *Qualitative Health Research*, *14*, 1342-1365.

Tickle, A., Regan, E.E. & Moss-Morris, B. (2009). Stand-alone group work on inpatient wards, *Clinical Psychology Forum, 200*, 28-33.

Veltro, F., Falloon, I., Vendittelli, N., Oricchio, I., Scinto, A., Gigantesco, A., & Morosini, P. (2006). Effectiveness of cognitive-behavioural group therapy for inpatients. *Clinical Practice and Epidemiology in Mental Health, 2* (16), 1-6. http://dx.doi.org/10.1186/1745-0179-2-16.

Veltro, F., Vendittelli, N., Oricchio, I., Addona, F., Avino, C., Figliolia, G., & Morosini, P. (2008). Effectiveness and efficiency of cognitive-behavioral group therapy for inpatients: 4-years follow-up study. *Journal of Psychiatric Practice, 4*, 281-288. http://dx.doi.org/10.1097/01.pra.0000336755.57684.45.

Willig, C. (2013). *Introducing Qualitative Research in Psychology, third edition*. Berkshire: Open University Press.

Yalom, I.D. (1983). *Inpatient group psychotherapy*. New York, NY: Basic Books.

York, M. (2007). A qualitative study into the experience of individuals involved in a mindfulness group within an acute inpatient mental health unit. *Journal of Psychiatric and Mental Health Nursing, 14*, 603-608.

Paper 2: Empirical Paper

Mindfulness in Acute Inpatient Wards: An Interpretative Phenomenological Analysis of Service Users' Experiences

Word Count: 7,779 (excluding references)

Abstract

Introduction

The Department of Health (2014) recommend that psychological interventions should be available for service users (SUs) on acute inpatient wards. However, currently there is limited availability of these interventions (Joint Commissioning Panel for Mental Health, 2013). Mindfulness has increasingly demonstrated efficacy for those with mental health difficulties in western society (Jacobsen, Morris, Johns & Hodkinson, 2010). This study aims to explore SUs experience of mindfulness on acute inpatient wards.

Method

Nine inpatients from three acute adult wards took part in a qualitative study where interpretative phenomenological analysis (IPA) was used to analyse participants interviews, in which they were asked about their experience of a mindfulness intervention on the ward.

Results

Four superordinate themes emerged: *a process towards self-actualisation, locus of control, mentalization*, and *cognitive processes*.

Discussion

Unique findings of the process towards self-actualisation and mentalization were found from participants' experience of mindfulness on the ward. Recommendations for clinical practice and future research are provided.

Key words: *Mindfulness, acute inpatient, interpretative phenomenological analysis, self-actualisation, mentalization.*

Introduction

Acute Inpatient Setting and Psychological Interventions

Mental health is a government priority and support has been given to increase access to evidence based psychological interventions (Department of Health [DoH], 2014). Therapeutic interventions have been recommended for those in an acute inpatient setting, in particular to help reduce boredom, violence and enhance recovery (DoH, 2002). It is also important that acute inpatient wards provide therapeutic interventions that allow SUs to gain control of their own recovery (Royal College of Psychiatrists, 2011). However, limited therapeutic activities are available on acute inpatient wards (Joint Commissioning Panel for Mental Health, 2013). The National Institute of Clinical Excellence (NICE) recommends that those with mental health disorders should be able to access psychological therapies such as Cognitive Behavioural Therapies (CBT), particularly those diagnosed with schizophrenia (NICE, 2010), bipolar (NICE, 2006), post-traumatic stress disorder (NICE, 2005) and personality disorders (NICE, 2009a); these are common diagnoses on acute inpatient wards (British Psychological Society [BPS], 2012). Some research has been conducted that supports the use of CBT on acute inpatient units (Durrant, Clarke, Tolland & Wilson, 2007; Raune & Daddi, 2011; Kohler et al. 2013; Veltro et al. 2008).

Third wave approaches of CBT were first categorised by Hayes (2004) in which the CBT interventions target the inner experiences indirectly, rather than targeting the content of the experience. These approaches have been researched; for example, York (2007) explored a mindfulness intervention and found participants reported cognitive changes in how they related to their thoughts and a sense of peace and relaxation. In addition, Heriot-Maitland, Vidal, Ball and Irons (2014) explored the use of compassion-focused therapy finding participants had an increased sense of calmness and reduced distress.

Mindfulness and the origins

Mindfulness originated in Buddhist philosophy and practice (Hyland, 2011). In more contemporary mindfulness practice, it is described as “paying attention in a particular way: on purpose, in the moment, and nonjudgmentally” (Kabat-Zinn, 1994, p.4). Mindfulness allows for moment-by-moment, non-

judgmental awareness and with loving kindness, in order to gain a deeper understanding of the self (Kabat-Zinn, 2003). In the last three decades, mindfulness has been of interest in mainstream psychology (Davis & Hayes, 2011). In a meta-analysis review of 21 studies evaluating mindfulness programmes in out-patient settings, mindfulness has been found to be helpful in reducing difficulties such as pain, stress, anxiety, depression and eating disorders (Baer, 2003).

Developments in mindfulness

A number of mindfulness programmes have been developed including Mindfulness-Based Stress Reduction (MBSR; Kabat-Zinn, 1990), which later gave rise to Mindfulness-Based Cognitive Therapy (MBCT; Segal, Williams & Teasdale, 2002). Both these programmes consist of a number of mindfulness exercises including sitting meditation and yoga. Studies have shown that MBCT is an effective intervention for people with depression in reducing residual depressive symptoms and improving quality of life when compared to antidepressant medication (Kuyken et al. 2008) and more recently similar results were also found by Hossein, Neda and Foroozan (2012). In addition, NICE (2009b) guidelines recommends MBCT for those who have experienced three or more episodes of depression. Dialectical Behavioural Therapy (DBT) also incorporates mindfulness skills. This approach has been utilised with SUs who have been diagnosed with borderline personality disorder and the approach has been found to be helpful in managing impulsive behaviours (Perroud, Nicastro, Jermann & Huguelet, 2012). Mindfulness is also a core principle used in Acceptance and Commitment Therapy (ACT; Hayes, Strosahl & Wilson, 1999). More recent mindfulness programmes have been developed such as Mindfulness-Based Pain Management Programmes (MBMPs). This intervention has been found to improve the mental and physical health of people experiencing chronic pain, in particular, the intervention helps with perceived control over pain (Brown & Jones, 2013).

Mindfulness on acute inpatient wards

Mindfulness could be a helpful intervention in an acute inpatient setting as it promotes tolerance and non-judgment and provides a calming atmosphere (Didonna, 2009). Mindfulness can also help SUs develop a more

holistic self-view (Winship, 2007) which can help increase holistic self-awareness. For people experiencing psychotic symptoms, mindfulness can help reduce feelings of distress (Chadwick, Newman & Abba, 2005; Jacobsen et al. 2010). Practicing mindfulness has helped enable people to use new coping responses and reduced the likelihood of relapse (Ma & Teasdale, 2004). An acute inpatient ward could provide a setting which allows the person the time and space to engage in private mindfulness practice providing an opportunity to increase awareness of thoughts, feelings and physical sensations (Knight et al. 2012).

There are challenges in providing a mindfulness intervention in an acute inpatient unit including SUs using prescribed psychotropic medication as this may impact on SUs ability to concentrate during the intervention (Didonna, 2009). Furthermore, SUs may have a disturbed relationship with their body due to experiences such as trauma, which may exacerbate feelings of distress (Yorston, 2001). However, more recent research challenges this view (Chadwick, Hughes, Russell, Russell & Dagnan, 2009), finding positive effects of mindfulness for SUs with psychosis, particularly with improved clinical functioning and ability to apply mindfulness to distressing thoughts and images. It is important that mindfulness programmes are adapted both to the population and environment. Shorter sessions with an external focus may be required initially on an acute inpatient ward and group facilitators may also need to adapt the group based on the SUs clinical presentations (Didonna, 2009). Mindfulness groups that are appropriately modified can lead to improved clinical functioning in people experiencing psychosis (Chadwick et al. 2005). Jacobsen et al. (2010) found SUs in an acute inpatient unit were able to engage in a mindfulness group that included short-sitting meditation and were able to reflect on their experiences.

Although research has established the clinical effectiveness of mindfulness, less is actually known about what SUs experience when practising mindfulness. This current study aims to address the gap and asks the question: *What are SUs experiences of a mindfulness intervention on acute inpatient wards?* This study will provide an understanding of the experience of a mindfulness intervention on an acute inpatient ward, in particular, understanding the meaning of mindfulness to SUs, the findings of

which can contribute to how psychological care is provided on acute inpatient wards.

Method

Participants

Nine participants were recruited from three NHS acute adult inpatient units in the West Midlands, UK. Val was a 51 year old, white British female of Christian belief, diagnosed with bipolar disorder and spent eight weeks on the acute ward attending four group mindfulness sessions. John was a 24 year old, white British male diagnosed with psychosis and spent nine weeks on the acute ward attending five group mindfulness sessions. Millie was a 59 year old, white British female of Christian belief, diagnosed of manic depression and spent 9 weeks on the acute ward attending three individual mindfulness sessions. Ivan was a 37 year old, white British male diagnosed with paranoia and spent three weeks on the acute ward attending six individual mindfulness sessions. Rebecca was a 36 year old, white British female of Christian belief diagnosed with anxiety and depression and spent eight weeks on the acute ward attending five individual mindfulness sessions. David was a 23 year old, white British male of Christian belief diagnosed with schizophrenia and spent seven weeks on the acute ward attending 4 group mindfulness sessions. Bob was a 47 year old white British male of Christian belief diagnosed with bipolar disorder attending five individual mindfulness sessions. Peter was a 46 year old white British male diagnosed with PTSD and depression and spent 8 weeks on the acute ward attend four individual mindfulness sessions and Alison was a 47 year old white British female diagnosed with depression and spent 12 weeks on the acute ward attending three individual mindfulness sessions. The time since participants attended the last session ranged between two days to three months at the time of interview, with all participants' interviews being at least three weeks following their second session.

Procedure

Eligible participants on the ward were informed of the research in a morning meeting in which routine activities were discussed. Those who were interested in the research were provided with study information (Appendix K). A period of a minimum of 24 hours was provided for participants to decide if they wanted to take part in the research. For those who were interested to

participate in the research, prior to their interview, capacity to consent was assessed in accordance to the DoH (2009) guidelines by a relevantly trained member of staff (Appendix L). The interview was conducted after a minimum of three weeks following their second mindfulness session. This period of time was allowed for participants to have an opportunity to reflect on the mindfulness intervention. A minimum of two sessions was deemed appropriate, based on the number of sessions from previous literature (Knight et al. 2012; Winship, 2007) and the number of sessions previous SUs have attended on the wards proceeding discharge. Prior to interview, all participants provided informed consent (Appendix N). Eligible participants who had been discharged from the ward were sent a research letter (Appendix O) from a member of the staff team involved in their care with a reply slip and a pre-paid postage envelope. Following receipt of the reply slip, the researcher made contact to arrange an interview in the community.

From those who expressed an interest, one participant did not take part due to forgetting her experience on the ward. All participants had the right to withdraw until analysis of the data occurred. No participants wanted to withdraw their consent or data. All confidential documentation including consent forms were stored in accordance to the National Institute for Health Research (NIHR, 2011). Participants provided contact information on their consent form to receive a summary of the study; seven participants requested this information.

Semi-structured interview: A service-user group was contacted to give feedback on the style of questions. Most of those in the service-user group had experience of being an acute inpatient and therefore able to comment on the ability of the SUs to understand the questions. The questions in the interview schedule were open to encourage participants to provide in-depth responses (Smith, Flowers & Larkin, 2009) and the schedule was designed to be used flexibly in order to gain understanding of the participants' experience. Following the first interview, some adaptations were made to the interview schedule (Appendix S) to ensure depth of the participants' responses. The themes within the questions included engagement with the sessions, use of mindfulness on the ward, impact of mindfulness and future use of mindfulness. Example questions included: *What was the mindfulness group like? How did*

things compare on the ward after you engaged with mindfulness? What has experiencing mindfulness meant to you? How do you see mindfulness in your future?

All interviews were audio recorded in a private room on the ward or for those who had been discharged, in a private room within their home address. The researcher has substantial experience of working with SUs with acute mental health difficulties and had attended additional workshop training in conducting qualitative research interviews. The interview length ranged between 25 minutes to 61 minutes (mean 42 minutes). Interviews were transcribed verbatim with each participant being given a participant number. To maintain confidentiality, specific words that could identify the participant were initialled. A practice interview was conducted with a member of the research team to ensure dependability of the content and interview style.

Analysis

The study aims to explore the participants experience of a mindfulness intervention on an acute inpatient ward, therefore the data was analysed with Interpretative Phenomenological Analysis (IPA); this allowed for exploration of the participants' world and captured their detailed experience (Willig, 2013). The methodology is also interpretative and is informed by hermeneutics, in which the researcher makes sense of the participants' described experience (Smith et al. 2009). Therefore understanding the epistemological stance of the researcher, helps the reader to make sense of the interpretations. In this case the researcher takes a critical realist position in that there is a reality that exists independent of our thinking and that the data needs to be interpreted in order to understand the phenomena (Willig, 2013). This epistemological position fits with the methodology of IPA, as there is an acceptance that there is an ontological reality, however, this can only be known imperfectly due to our sensory capacities (Chamberlain, 2015).

The data was analysed in accordance with IPA guidelines (Smith et al. 2009; Appendix T). Validation of the analysis process was conducted with members of the research team and within a peer IPA research group. An example of the analysis is provided for John (Appendix T); the researchers initial thoughts were noted which related to the importance John attributed to being part of a group. A descriptive code of blanking out racing thoughts was

given to '*racing thoughts for many years… just being able to blank, blank them (p.6: 103-104)'.* There was an emphasis on 'blank' which was linguistically coded as the importance of a mind that is free of thoughts. Conceptually, the researcher considered what was in the space and the meaning related to emptiness or peacefulness. This led to an emergent theme of creating space. Linking back to the original data, this emergent theme appeared to correlate with *'just have a calm blank mind' (p.6:105).* Following the coding of the full transcript, the emergent codes were drawn together, in which a superordinate theme was given the category of 'empowerment'. This was subsequently drawn together across participants within the final themes table under the superordinate theme of 'locus of control'.

Research Journal

Initial thoughts following participant interviews, during transcribing and throughout the analysis were recorded in a research journal. These recordings were then revisited following the production of the final superordinate themes to ensure that the important aspects of the participants' experiences were reflected within the themes. The researcher also used the research journal reflexively to critically reflect on the self and make notes of any personal values (Polit & Beck, 2008). In addition to the researcher holding a critical realist position the researcher acknowledges a personal interest in mindfulness in which the researcher self-practised mindfulness and uses mindfulness within professional practice. Attempts were made to bracket self-perspective from the analysis process, however, it is acknowledged that the researchers own perspective may have influenced the findings as bracketing can only be partially achieved (Smith et al. 2009).

Results

All participants have been allocated a pseudonym. In total, 542 themes were identified across all the participants. Following a process of synthesising and reorganisation, this resulted in 70 case themes, four superordinate themes and 15 sub-themes (Table 2).

Table 2. Superordinate themes and sub-themes

Superordinate theme	Sub-theme	Theme present in cases
Process towards self-actualisation	1. Process of self-development	John, Ivan, David, Peter, Alison, Bob, Rebecca
	2. Self-motivation and drive	John, Millie, Ivan, David, Peter
	3. Valuing self and experiences	John, Millie, Ivan, Rebecca, David, Peter, Alison, Val,
	4. Developing a bond	Val, John, Millie, David, Bob
	5. Developing practice	Rebecca, David, Bob, Peter, Alison, Ivan, Millie. Alison
Locus of control	1. Empowerment	John, Ivan, David, Bob, Peter, Alison, Rebecca
	2. Liberation	John, Ivan, Ivan, Rebecca, David, Peter, Alison, Peter
	3. Transpersonal psychology	Ivan, David, Bob, Peter
Mentalization	1. Emotional awareness	Val, John, David, Rebecca, Bob, Peter, Alison,
	2. Clarity of mind	Val, Rebecca, Bob, Peter, David, Ivan, Alison, John
	3. Focusing the mind	Rebecca, David, Bob, Alison
	4. Differing perspectives	Val, Millie, Peter, Ivan, Bob
Cognitive processes	1. Cognitive flexibility	John, Millie, Ivan, Peter, Alison, Bob,
	2. Strategies	Millie, Rebecca, David, Bob, Peter, Alison, John
	3. Awareness of choices	Millie, Rebecca, Peter, Alison, Ivan, John

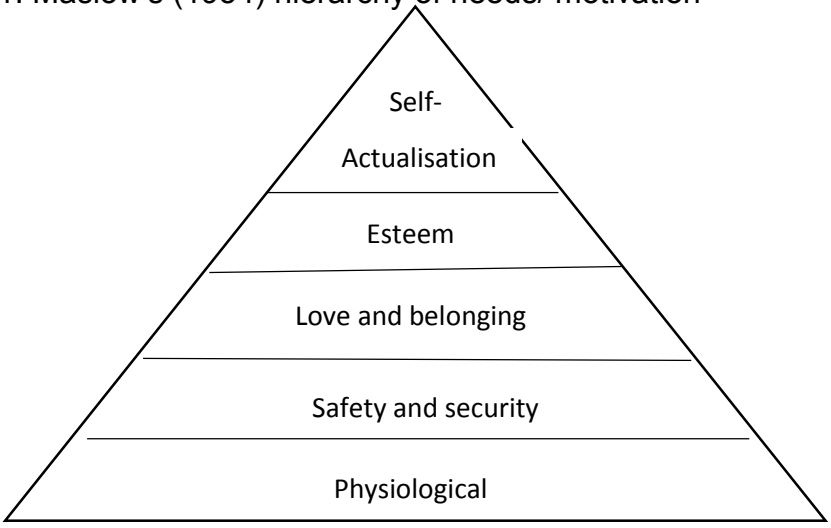
Discussion

The aim of the study was to explore inpatients' experience of mindfulness on acute inpatient wards. The findings have shown several themes which relate to personal growth of SUs and the challenges in achieving this whilst on an acute inpatient ward. The main themes that developed from interpreting participants' experiences were that participants encountered a *process towards self-actualisation*, in which they were driven and motivated, self-developed and valued themselves and their experiences. A further theme was *mentalization:* participants had emotional awareness, experienced clarity within their mind, maintained a focus and understood the perspective of themselves and others. *Locus of control* was an identified theme, whereby participants had an internal locus of control, experiencing empowerment and liberation, and an external locus of control experiencing a connection with a powerful influence outside of themselves. The final theme was *cognitive processes*, in which participants had cognitive flexibility, awareness of choices and strategies they could utilise within life.

Theme One: A Process towards Self-Actualisation

Most participants described a *process towards self-actualisation*. Maslow (2012) describes self-actualising people to be at a high level of maturation, health and self-fulfilment. Maslow (1954) describes the process towards self-actualisation to be based on a hierarchy of human needs which is represented as a pyramid from basic needs up to self-expression. Lower levels of need must be achieved before the person can move up through the pyramid (Figure 1).

Figure 1. Maslow's (1954) hierarchy of needs/ motivation



The lower level within this hierarchy of human need, includes the provision of food and drink for basic survival, both of which are provided on the inpatient wards. The level of safety and security appeared to be achieved whilst in the group, however, participants described difficulties developing their mindfulness practice on the ward. Rebecca described her experience on the ward to hinder her practice:

> *'you can always hear the hustle and bustle of what's going on in the background which can be you know, a bit difficult at times' (REBECCA; 4; 71-7)*

Bob also described a distinct difference between the environment of the group and then on the ward which impacted on this sense of safety and security:

> *'You're in another world when you do mindfulness and you come back to your normal reality, it's like a shock at first…you wish you could do mindfulness all the time. It's just a shock to the system… I wish I could stay in that mode…it can't happen you can't stay in that mode you've got to think about the rest of the day ahead of you… I find it a bit of a downer sometimes…afterwards cos your back to reality…sometimes you wish reality was mindfulness' (BOB; 14; 267-281)*

It appeared that when participants began to engage with mindfulness, this took some adjustment. Initial difficulties engaging with mindfulness for inpatient have been described by Didonna (2009) particularly regarding being in touch with their physical sensations that can create intense emotions:

> *'I suppose it shouldn't be stressful at all, but I think I found that breathing exercise at stressful at the first place' (MILLIE; 17; 311-312)*

Taking time to achieve safety within the session was important for participants. When this was achieved there was a connection with the love and belonging need and participants described a process of becoming familiar with others.

> *'I think maybe doing it in a group erm is different to doing it on your own I found it stressful to begin with…but the final session I found it quite calming being in a group, being in a circle' (JOHN; 14; 268-272)*

> *'alright now cos I know them all now don't I, when I'm not knowing at first I was a bit nervous' (VAL; 4; 69-70)*

However, when this had been established, they were able to develop more meaningful bonds with others on the ward and with those in their personal lives.

> *'I had a natural feel for everyone… I felt like I had a free flowing conversation…you normally have more happiness in them I feel. It's like you're talking to someone who's your friend' (DAVID; 22; 423-431)*

> *'I remember skipping across the field with my little girl…it really took my breath away we were doing it and then all of a sudden I realised that I hadn't done something like that for such a long time and I hadn't engaged with the children… just interacting with her was such an empowering experience' (REBECCA; 17; 318-325)*

The level of self-actualisation is described by Maslow (1954) as the need to live life to the best of a person's ability in order to be useful to ourselves and others. This appeared to be described by participants who had a deeper understanding of themselves; a better self-understanding allowed for improved connections in self and others (McKenzie & Hassed, 2012). Several participants described feeling more connected with others on the ward and with those in their personal lives. The ultimate aim within self-actualisation is to find and be true to the self (McKenzie & Hassed, 2012). This process was described by Peter.

> *'mindfulness now is the real me coming out, and I think it will take time but I think it will bring from the inside out, the person I want to be and the person I should be and the person I am going to be' (PETER; 22; 426-429)*

The process of self-actualisation can be prevented when the person becomes preoccupied and decisions are made based on fear and confusion (Maslow, 1954). Ivan described how he previously would respond to situations:

> '*old me would have been petrified, it would have worried me, it would have took over everything and* [since using mindfulness] *it wasn't such a big deal anymore'(IVAN; 35; 673-675)*

Both Ivan and Bob described a positive impact on their self-confidence, this improvement in self-confidence is likely to impact on motivation to achieve desired goals (Coon & Mitterer, 2015) and therefore help the process towards self-actualisation .

> *'it's really changed me on the outside…it's given me quite a lot of self, you a lot of confidence in what I'm doing, I've done things that I wouldn't have thought I would have done in the past' (IVAN; 17; 328-331)*

> *'I was really struggling with myself, self-confidence was quite low…going back a year I wouldn't have been speaking at all…so my confidence levels are a bit better now' (BOB; 7; 136-141)*

This links with the sub-theme of valuing self and experiences as participants described a shift from self-criticism to self-compassion.

> *'one of the most meaningful things I learnt was to treat your thoughts with compassion and that you are not your thoughts cos I spent a lot of time beating myself up about erm any thoughts I was having' (JOHN; 8; 139-142)*

The use of self-compassion in the practice of mindfulness can help reduce feelings of stress when the person holds an attitude of kindliness towards themselves (Germer & Neff, 2013). Alison described how through the process of mindfulness she had a better self-understanding and valued her self-worth:

> *'I think it's made me really sort of get to the heart of who I am as a person and what's important to me and how I see myself and its improved my self-worth, it's improved my sense of wellbeing' (ALISON: 491-494)*

Participants also described a shift in what they valued, when mindfulness' practice deepens there can be connections with the beauty and richness of experiences (Bartley, 2012). This was experienced by Alison and Val when they appreciated the experiences of nature within life.

> *'it really took my breath away…all of a sudden I realised that I hadn't done something like that for such a long time…I hadn't been able to see such a simple thing as being out in the sunshine' (REBECCA; 17; 320-324)*

> *'when I look at flowers I like, they are lovely in the garden, I look at the nice flowers, trees' (VAL; 2; 35-37)*

This renewed appreciation of experiences is described as a characteristic of self-actualizers (Coon & Mitterer, 2015). Self-determination theory describes a freedom from attachment to material possessions (Ryback, 2006), this was

described by Peter who no longer valued material possessions as highly as everyday experiences:

> *'I don't want 2.5 kids, a Labrador and a Volvo st40 on the semidetached driveway of my house… it's simply looking and appreciating what is around you for what it is at that moment in time, things that I would have missed, wouldn't have seen, wouldn't have acknowledged, wouldn't have understood, wouldn't have appreciated before' (PETER; 9; 171-177)*

Self-actualisation focuses on the relationship between human motivation, needs and values with the aim of the person to continuously search for personal fulfilment (Peterson & Park, 2010). Participants were motivated to continue to use mindfulness to improve themselves and their lives. There was a change in the way that some participants related to themselves from a process of self-criticism to encouraging self-improvements:

> *'your inner voice…are no longer demons anymore they're angels, that are like come on mate…it's like a mate behind you encouraging you to try… you think I really should do this more, and I think it will become more and more part of my life' (PETER;31; 601-612)*

Several participants also described a motivation to continue to use mindfulness to help develop themselves and their practice, this is important in order to gain stable benefits from mindfulness practices (Didonna, 2009):

> '*Definitely want it in my future, I'm hoping to you know the more you do something the better you get at it' (IVAN; 31; 592-593)*

> *'I can see how valuable it is for me so I wouldn't want to not keep using it and I think the more you practice it routinely the more impact it has generally on your life perhaps without really realising… so it becomes a maintenance kind of thing you do rather than dealing with an extreme situation' (ALISON: 468-473)*

The link between self-actualisation and mindfulness appears to be a novel link within current literature. Previously, Rogers (1961) suggested mindfulness and humanistic psychology differed in their intention of the present moment experience. Humanists describe the present moment experiences to be a goal oriented process of self-actualisation with an emphasis on emotions, whereas mindfulness has a focus on observing emotions, thoughts and internal experiences (Gehart, 2012). In a meta-

analysis of studies exploring the effects of meditation and relaxation, significant improvements were found in self-actualization (Alexander, Rainforth & Gelderloos, 1991). More recently, exploration of mindfulness and self-actualisation has shown a positive relationship between acceptance and autonomy (Beitel et al. 2014). The participants in this study appear to link these processes; they have observed their inner self through the process of mentalization and then have a desire to continue to use mindfulness to aid the process of self-development.

Theme Two: Mentalization

Mentalization was a theme that arose from the experiences of participants in which they attended to their own state of mind and the state of mind of others (Fonagy, 1991). Mentalizing also incorporates awareness of emotional states within the self and others and the ability to have a clear understanding of emotions (Allen & Fonagy, 2006). This was expressed by Bob and Peter who described the physical experience of their emotions:

> *'It's almost as if you have that first shot of vodka and you get that warn feeling going down' (PETER; 19; 363-364)*

Emotional awareness was also described in relation to noticing changes in anxiety. The process of describing and labelling mental phenomena has similarities for both mindfulness and mentalization (Goodman, 2014):

> *'I always had quite high anxiety in the group, erm but always less at the end of it' (JOHN; 2; 20-22)*

> *'by the end of doing the technique several times over I have much lower level of anxiety about it, so I think it changes the way I feel about the thought and react to that thought' (ALISON: 262-264)*

Bob described how he was able to regulate his emotions by toning down his thoughts so that he was more able to express he experience:

> '*It's like someone having the TV on and turning the volume up and then I can turn it down, it's like that, you just switch it off for a certain amount of time' (BOB; 5; 94-97)*

This process of mentalized affectivity; the capacity to manage affect (Fonagy, Gergely, Jurist & Target, 2002) was further described by Rebecca who was able to contain her emotions rather than repressing them:

> *'sometimes I would just burst into tears…I don't know whether it's actually when you just stop, and become very still and for whatever reason these emotions just seep out then, maybe you supress them for such a long time and then you take yourself to a place where I don't know they creep out' (REBECCA; 3; 41-46)*

This process links to the sub-theme of a clarity of mind as implicitly mentalizing, allows the person to deeply understand themselves through intuition (Allen & Fonagy, 2006). Ivan describes this process in having a broader perspective on himself:

> *'yeah its opening your mind…it was opening up doors, you know different doors' (IVAN; 7; 125-129)*

David described the impact of clarity within his mind and had optimism in using mindfulness to improve his quality of life:

> *'I'd imagine if I cleared my mind like that for an hour a day or every three hours a day or once a day, I'd have a better quality of living' (DAVID; 25; 476-478)*

The experience of clarity within the mind links with Rogers (1951) 'self' theory in which there is an emphasis for the capacity for inner peace and happiness (Elliot & Farber, 2010). A sense of peacefulness within the mind was described by several participants.

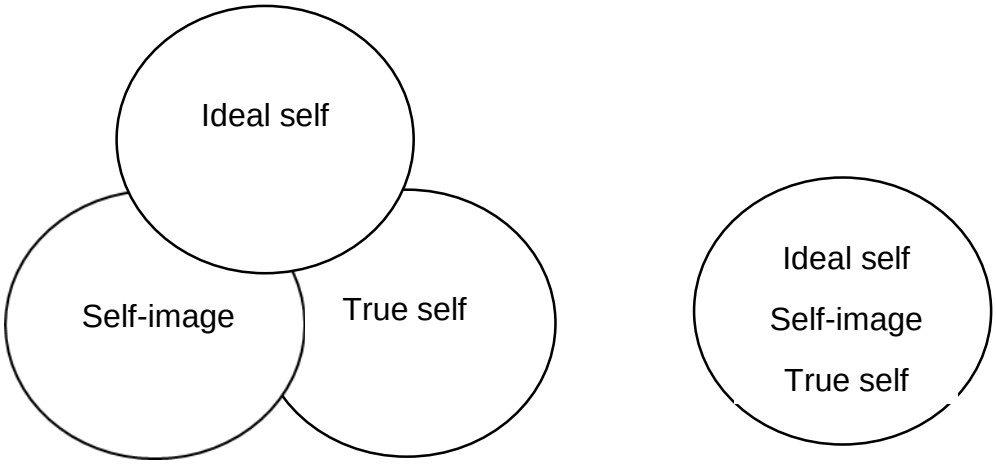
> *'kind of feeling at peace with things in my life rather than worrying about things, so it's more the absence of worrying I would say is when I feel calm' (ALISON: 60-63)*

> *'It was like a release in my head, my head felt clear, like I had a clear conscious, instead of feeling trapped and antagonised' (DAVID; 3; 58-59)*

The process is suggested to be facilitated when there is love and acceptance from others, which again links back to Maslow's (1954) idea of the love and belonging need, relevant to several of the participants. Allowing for experiences, thoughts, feelings and actions to be integrated within the self allows the person to be congruent. When the person is incongruent this

causes distress as there are inconsistencies between the self-image and true self (Figure 2). The acceptance of self and emotion was acknowledged by Rebecca when she said *'emotions just seep out'.* She acknowledged her true feelings and was able to have a more congruent view of self.

Figure 2. Incongruence and congruence in self (Rogers, 1951)



Participants described an ability to focus their mind, as described as a focus on the present rather than having a negative perception of the past or future.

> *'I'm offloading things that I've carried as a burden for a long time, erm, and just being able to focus on now…just being able to focus on now rather than keep dwelling on things' (ALISON: 114-118)*

When developing the ability to mentalize attention is drawn inwards away from external stimuli so that internal priorities can be followed (Bateman & Fonagy, 2012) Bob described how he was able to filter out stimuli and remain *'switched on'* to focus his concentration:

> *'it's like your mind has gone to a different place and your switched on to what's going on but you're not listening to all the surrounding noises that are going on outside or whatever your concentrating on what's going on ahead in front of you' (BOB; 11; 212-216)*

Mille described how engaging with mindfulness gave her the time to focus on things. Goodman (2014) described the ability to observe mental phenomena as one of the similarities between mindfulness and mentalization:

> *'I think with mindfulness you notice things, because you're having time set aside…to think about things in normal everyday life (MILLE; 6; 105-107)*

Some participants also described how the process of focusing allowed them to plan towards goals in the future, therefore having the ability to mentalize in different time frames (Allen & Fonagy, 2006):

> *'I think it just means able to plan…what I'm doing today and tomorrow and further into the future without being stuck on something that is causing me anxiety' (JOHN)*

Participants described how their own perspective differed. Bateman and Fonagy (2012) suggest flexibility in perspectives is considered to be good mentalizing:

> *'I'm looking at the glass half full, glass half empty, I suppose, trying to see there is a positive in most stuff at the end of the day but whereas I use to look at it was always negative' (IVAN; 27; 523-526)*

> *'I like to see things from as many angles as I can so I can make the right decision' (MILLE; 12; 215-216)*

A key distinction between mindfulness and mentalization is that mentalization has a specific interpersonal component (Goodman, 2014). Mentalizing allows for the generation of different perspectives of others and acceptance of these different perspectives (Bennett & Nelson, 2010). Participants recognised that others have different perspectives and considered these different viewpoints:

> *'I think the best thing you can do is mix with people and hear their opinions and you're not always going to agree with what someone is saying but it's nice to hear their opinions' (BOB; 19; 372-374)*

> *'I don't make the right decision every time nobody does but I make a more valued, a better judgement by asking other people their point of view (MILLE; 18; 338-340)*

Theme Three: Locus of Control

The theme of locus of control was described by participants, in which they referred to the belief that they had control or not over an outcome (Rotter, 1966). Increased mindfulness and an internal locus of control has been linked with increased subjective wellbeing (Hamarta, Ozyesil, Deniz & Dilmac, 2013).

Participants described an internal locus of control as empowerment, in which they experienced increased self-confidence and self-efficacy.

> *'take control of my own destiny now… now I can sit take control, by minute, hour by hour, day by day' (PETER; 29; 557-560)*

> *'it's like being a super hero sort of thing and having powers and whatever…no-one can stop you from doing anything' (BOB; 17; 331-333)*

An increase in self-empowerment is linked to people feeling able to influence their health and achieve their goals (Cutcliffe & McKenna, 2005), Ivan described how he felt more able to achieve his goals:

> '*There is possibility that I could sort of set myself goals and actually achieve them for a change rather than not be bothered or get half way and then give up' (IVAN)*

The belief to influence personal health is also linked to participants' sense of liberation, in which they described a sense of '*freeing*'.

> *'it's quite liberating, its freeing, its calming…it just allows you to move on rather than dwelling on the same thought' (ALISON: 290-292)*

The concept of liberation is described in mindfulness as the aim for freedom from suffering through a process of insight and tranquillity (DeSilva, 2014). An external locus of control was described by Ivan who felt he had been '*influenced by a higher power'.* Several references were made to spirituality by participants.

> *'The meditation itself feels like a warm embrace from god…enlightening, opening up, happy energy' (DAVID; 27; 535-544)*

> *'its power it's got over you and it seems to move across the room as they say in terms of the feeling you get towards it' (BOB; 13; 247-248)*

Transpersonal psychology includes 'peak experiences' that can help heal the mind (Miller, 2012). These peak experiences were described by Peter and David who felt '*almost euphoric'* and had '*a glimpse of inner peace'*.

Theme Four: Cognitive Processes

The theme of cognitive processes, included flexibility in participant's cognitions. Millie described how she '*put everything to one side…then you come back to it in a new light'*. The process can occur through observing thoughts without judgement and in doing so, the person can become less identified with their thoughts (Germer, Siegel & Fulton, 2013). This was experienced by John who described his relationship with psychotic thoughts:

> '*these psychotic thoughts you're having you can't just blame yourself completely for them, erm just to try and let them go sometimes and that was a big change in my way of dealing with things' (JOHN; 8; 154-157).*

The cognitive processes were often described as strategies that participants would use particularly when they experienced difficulties. David described using mindfulness when he felt '*trapped'*. David also described the importance of having something practical he could use when feeling distressed:

> *'Because the practical is what I really like about mindfulness. Mindfulness is good because I haven't never had anyone go through how to calm myself down. I've just had to deal with situations has they come' (DAVID; 10; 179-182)*

These strategies were also expressed as '*tools*' that they would use throughout life and it was emphasised that these '*tools*' were accessible as they held the skill within themselves and therefore did not need anyone else to facilitate the use of mindfulness. The ability to cultivate mindfulness does not require the interactions between a therapist and SU, therefore the emphasis is on the personal experience not the relationship (Goodman, 2014).

> *'you can use it anywhere which I found really useful. You can use it in public or you can use it by yourself' (JOHN; 16; 300-302)*

> *It's something that you can apply anywhere so, yes generally you would want to be in a quite environment…but that doesn't mean you can't use it anywhere' (ALISON: 566-570)*

Through the engagement of mindfulness, participants described noticing they had options and in doing so they were able to take a '*different route'*.

> *'I haven't done possibly what the old me would do, I've considered things and done a different route if that makes any sense, more logical' (IVAN; 19; 264-366)*

The process of making choices is described within mindfulness in becoming aware of information about experiences and preferences which allows for informed choices (Germer et al. 2013). Noticing choices was also relevant to participants in relation to medication and several participants highlighted the importance of having a choice of interventions.

> *'its good know instead of medication all the while…okay you're going to have some benefits from it but you also have many negatives from it, to have something that really can't have negatives erm, its quite important really' (REBECCA; 9; 161-168)*

> *'it means a great deal that knowing that there are other things apart from medication erm that I can use and get better at them the more that I use them' (JOHN; 11;201-203)*

It has been a government initiative that patients have choice within health care interventions (DoH, 2011). Yet participants in this study thought choices were limited and medication was the predominant treatment option.

Limitations

There are several limitations in the current study. Firstly, there are a lack of negative themes within the data. Although there was some description of initial difficulties engaging with mindfulness, overall participants described the experience as positive. This might be due to mindfulness being a palatable experience. However, participants were self-selecting, therefore they may be biased in how they report the experiences. Participants may be more inclined to give positive accounts of their experiences in comparison to SUs who had negative experiences of mindfulness.

The first interview was not as in depth as the later interviews. The interview schedule was revised following the first interview which resulted in a shorter interview with less depth than if the revised interview schedule had been used. In addition, it was unclear at times if the first participant's focus was on the mindfulness intervention or whether she was referring to groups in general. Attempts were made by the researcher to keep focus on the

mindfulness intervention, however, only a limited amount of this data was incorporated within the analysis to ensure focus on the research question.
It is possible that there may have been a power dynamic between the participants and the researcher, particularly for those who were interviewed on the ward. This power dynamic may have impacted on the participants' ability to trust the researcher, which may affect the interview depth. Attempts were made by the researcher to build a rapport, however, the time for building a rapport was brief and therefore may have impacted on the openness of the participants. It is also possible because participants could feel pressure to take part in the research as they are vulnerable adults on acute ward. It was therefore important that they were given time and support if needed to understand the research before they consented to taking part, and were explicitly made aware of their rights to withdraw from the research.
The researcher was open minded to the different ways that the data could be interpreted and was mindful not to interpret too far from the original data (Willig, 2013). Respondent validation could improve the credibility of the findings yet this was not pursued, as their context at the time of data collection would have been likely to have changed which would have added an extra dimension to the process (Dempster, 2011).

Clinical Implications

Involvement in decision making and having choices was important to participants. This was highlighted in relation to having alternatives to medication. NICE (2011b) recommend that SUs are involved in their care planning and it would be useful if options of interventions such as mindfulness could be discussed with the SU at this time. Acute inpatient services should also have psychological interventions such as mindfulness available to give SUs a choice of interventions. The use of mindfulness on acute wards would give SUs the opportunity to develop skills, such as mentalization which has been linked to psychological mindedness (Allen, Bennett & Kearns, 2004). This can sometimes be a requirement for engaging in psychological work within the community. Therefore mindfulness could help provide SUs with the necessary skills to have a more fluid continuation of care within the community upon discharge from an acute inpatient ward.

The study recruited participants from three research sites. All the sites were for adult inpatients' with acute mental health needs therefore the findings might be considered transferrable to other similar acute inpatient wards. Based on the findings of this study the context of the inpatient ward is important so that SUs have a sense of safety and security as defined in Maslow's (1954) hierarchy of needs. Participants noticed a '*sharp transition'* between practising mindfulness and being on the ward, which impacted on their ability to fully utilise mindfulness as an inpatient. The Joint Commissioning Panel (2013) describe the aims of an acute inpatient ward to be a safe and therapeutic environment, however, this was not the experience of the participants returning to the ward following the mindfulness intervention. It is recommended that where possible mindfulness should be utilised as a ward ethos rather than separate groups or individual sessions. This could be achieved by completing mindfulness practises during morning meetings, this would further promote mindfulness as a '*general*' strategy for life rather than to manage specific difficulties.

It may also be useful for staff to utilise mindfulness within their one to one sessions with SUs, as participants expressed that there were additional benefits from practising mindfulness with others and this would help to develop bonds which is important in order to proceed towards self-actualisation. Further, it would be useful for staff to be able to use mindfulness themselves. Didonna (2009) suggests that staff sharing a mindfulness-based model on the ward can increase a calming environment which would allow for emotional validation and empathy. Staff members engaging in mindfulness could increase their understanding of mindfulness concepts and impact on their work environment; perhaps to reduce the '*hustle and bustle'*.

Future Research

The current study explored acute inpatients experience of a mindfulness intervention which highlighted a discrepancy between the experience of mindfulness practice and the experience of participants on the acute inpatient wards. It would be useful to explore the impact on the use of prescribed medication and the rates of discharge when mindfulness is utilised on an acute inpatient ward. Currently limited research has been conducted exploring the use of mindfulness on acute inpatient wards. However, it is

hoped that with further qualitative studies in this area it would progress to quantitative research to understand the relationship between mindfulness, self-actualisation and mentalization. Quantitative research in this area would give rise to the findings being generalised to a wider population, based on a larger participant group.

The participants in the current study were all of white British ethnicity with either a Christian faith or no affiliation to a faith. It would be useful for future research to explore SUs experience of mindfulness from ethnic minorities and differing cultural backgrounds. Further, although SUs were involved in the early development of this study it would be important that SUs are involved more in research, so that the areas researched remain meaningful and relevant to SUs.

Conclusions

An interpretative phenomenological analysis method was used to explore acute inpatients experience of a mindfulness intervention. This resulted in four main themes. Two unique findings were revealed, the process of self-actualisation and the link to mentalization. In addition the themes of locus of control and cognitive processes linked with current research relating to mindfulness. Healthcare professionals working in acute inpatient settings should utilise the finding to improve services for SUs and further research is needed to expand the knowledge base within this field. The experience of participants within this research indicates some meaningful benefits from mindfulness and therefore it is possible these experiences could be gained for other SUs in a similar situation. This final quote highlights the possible gains from engaging in mindfulness whilst on an acute inpatient ward:

> *'now it's become like a bus journey, it's no longer like a long bus journey , it's like an adventure, because you are aware of the trees and leaves falling, the wind blowing and the smells and it's as if you are more aware of your surroundings and yourself, sounds like a cliché, reborn…retaught' (PETER; 8; 159-164)*

Paper 2 References

Alexander, C.N., Rainforth, M.V., Gelderloos, P. (1991). Transcendental meditation, self-actualization, and psychological health: A conceptual overview and statistical meta-anaylsis. *Journal of Social Behavior & Personality, 6*, 189-248.

Allen, J.G., & Fonagy. P. (Eds.). (2006). *Handbook of Mentalization-Based Treatment*. Chichester: Wiley.

Allen, J.R., Bennett, S., & Kearns, L. (2004). Psychological mindedness: A neglected development line in permissions to think. *Transactional Analysis Journal, 34,* 3-9.

Baer, R.A. (2003). Mindfulness training as a clinical intervention: a conceptual and empirical review. *Clinical Psychology: Science and Practice, 10,* 125-143. http://dx.doi.org/10.1093/clipsy/bpg015.

Bartley, T. (2012). *Mindfulness-Based Cognitive Therapy for Cancer.* Oxford: Wiley-Blackwell.

Bateman, A.W., & Fonagy, P. (2012). *Handbook of Mentalizing in Mental Health Practice*. Arlington: American Psychiatric Publishing.

Beitel, M., Bogus, S., Hutz, A., Green, D., Cecero, J.J., Barry, D.T. (2014). Stillness and motion: An empirical investigation of mindfulness and self-actualization. *Person-Centred & Experiential Psychotherapies*, 13, 187-202. http://dx.doi.org/10.1080/14779757.2013.85513.

Bennett, S., & Nelson, J.K. (2010). *Adult Attachment in Clinical Social Work: Practice, Research, and Policy*. New York: Springer.

British Psychological Society. (2012). *Commissioning and Delivering Clinical Psychology in Acute Adult Mental Health Care: Guidance for Commissioners, Service Managers, Psychology Managers & Practitioners.* London: British Psychological Society.

Brown, C.A., & Jones, A.K. (2013). Psychobiological correlates of improved mental health in patients with musculosketal pain after a mindfulness-based pain management program. *Clinical Journal of Pain, 29,* 233-44. http://dx.doi.org/10.1097/AJP.0b013e31824c5d9f.

Chadwick, P., Hughes, S., Russell, D., Russell, I., & Dagnan, D. (2009). Mindfulness groups for distressing voices and paranoia: A replication and randomized feasibility trial. *Behavioural and Cognitive Psychotherapy, 37,* 403-412. http://dx.doi.ord/10.1017/S1352465809990166.

Chadwick, P., Newman-Taylor, K., & Abba, N. (2005). Mindfulness groups for people with psychosis. *Behavioural and Cognitive Psychotherapy, 33*, 351-359. http://dx.doi.org/10.1017/S1352465805002158.

Chamberlain, K. (2015). Epistemology and qualitative research. In P. Rohleder & A.C. Lyons (Eds.). *Qualitative Research in Clinical and Health Psychology.* (pp.9-28). Hampshire, England: Palgrave MacMillan.

Coon, D., & Mitterer, J.O. (2015). *Introduction to Psychology: Gateways to Mind and Behaviour*. Boston: Cengage Learning.

Cutcliffe, J.R., & McKenna, H.P. (2005). *The Essential Concepts of Nursing: Building Blocks for Practice*. London: Elsevier Ltd.

Davis, M.D., & Hayes, J.A. (2011). What are the benefits of mindfulness? A practice review of psychotherapy-related research. *Psychotherapy, 48*, 198-208. http://dx.doi.org/10/1037/a0022062.

Department of Health (2014). *Closing the Gap: Priorities for Essential Change in Mental Health*. London: Department of Health.

Department of Health (2011). *No Health Without Mental Health: A Cross-government Mental Health Outcomes Strategy for People of All Ages*. London: Department of Health.

Department of Health (2009). *Reference Guide to Consent for Examination or Treatment*. London: Department of Health.

Department of Health (2002). *Mental Health Policy Implementation Guide – Adult Acute Inpatient Care Provision*. London: Department of Health.

Dempster, M. (2011). *A Research Guide for Health and Clinical Psychology.* Hampshire: Palgrave Macmillan.

DeSilva. P. (2014). *An Introduction to Buddhist Psychology and Counselling: Pathways of Mindfulness-Based Therapies*. 5th ed. London: Palgrave Macmillian.

Didonna, F. (2009). *Clinical Handbook of Mindfulness.* New York: Springer Science & Business, Media.

Durrant, C., Clarke, I., Tolland, A., & Wilson, H. (2007). Designing a CBT service for an acute inpatient setting: a pilot evaluation study. *Clinical Psychology and Psychotherapy, 14*, 117-125. 10.1002/cpp.516.

Elliot, R. & Farber, B.A. (2010). Carl Rogers: idealistic pragmatist and psychotherapy research pioneer. In L.G. Castonguay & T. Anderson (Eds.). *Bringing Psychotherapy Research into Life: Understanding Change through the Work of Leading Clinical Researchers.* (pp17-27). Washington: American Psychological Association Press.

Fonagy, P. (1991). Thinking about thinking: Some clinical and theoretical considerations in the treatment of a borderline patient. *International Journal of Psycho-Analysis, 72,* 639-656.

Fonagy, P., Gergely, G., Jurist, E., & Target, M. (2002). *Affect Regulation, Mentlaization, and the development of the Self. New York*: Other Press.

Gehart, D.R. (2012). *Mindfulness and Acceptance in Couple and Family Therapy*. New York: Springer.

Germer, C.K., & Neff, K.D. (2013) Self-compassion in clinical practice. *Journal of Clinical Psychology, 69,* 856-867. 10.1002/jclp.22021.

Germer, C.K., Siegel, R.D., & Fultoin, P.R. (2013). *Mindfulness and Psychotherapy.* New York: Guildford Press.

Goodman, G. (2014). Mentalization an interpersonal approach to mindfulness. In Stewart, H.M., Hayes, S.C., & Sticker, G. (2014). *Mindfulness, Acceptance and the Psychodynamic Evolution: Brining Values into Treatment Planning and Enhancing Psychodynamic Work with Buddhist Psychology* .Oakland, CA: New Harbinger.

Hamarta, E., Ozyesil, Z., Deniz, M., & Dilmac, B. (2013). The prediction level of mindfulness and locus of control on subjective well-being. *International Journal of Academic Research, 4,* 145-150. 10.7813/2075-4124/2013/5-2/B.22.

Hayes, S.C., Strosahl, K.D., & Wilson, K.G. (1999). *Acceptance and Commitment Therapy*, New York: Guildford Press.

Hayes, S.C. (2004). Acceptance and commitment therapy and the new behaviour therapies, mindfulness, acceptance, and relationships. In S.C. Hayes, V.M. Follette & M.M. Linehan (Eds.). *Mindfulness and Acceptance: Expanding the Cognitive Behavioural Tradition (pp.1-29)*. New York: Guildford Press.

Heriot-Maitland, C., Vidal, J.B., Ball, S., & Irons, C. (2014). A compassionate-focused therapy group approach for acute inpatients: Feasibility, initial pilot outcome data, and recommendations. *British Journal of Clinical Psychology, 53*, 78-94. 10.1111/bjc.12040.

Hossein, K., Neda, H., & Foroozan, J. (2012). The impact of mindfulness-based cognitive therapy (MBCT) on mental health and quality of life in a sub-clinically depressed population. *Archives of Psychiatry and Psychotherapy, 14,* 22-28.

Hyland, T. (2011). *Mindfulness and Learning: Celebrating the Affective Dimensions of Education*. Springer Science & Business Media.

Jacobsen, P., Morris, E., Johns, L., & Hodkinson, K. (2010). Mindfulness groups for psychosis: Key Issues for implementation on an inpatient unit. *Behavioural and Cognitive Psychotherapy, 39*, 349-353. http://dx.doi.org/10.1017/S1352465810000639.

Joint Commissioning Panel for Mental Health (2013) *Guideline for Commissioners of Acute Care: Inpatient and Crisis Home Treatment.* London: JCP-MH.

Kabat-Zinn, J. (1990). *Full Catastrophe Living: The Program of the Stress Reduction Clinic at the University of Massachusetts Medical Centre*. New York: Dell.

Kabat-Zinn, J. (1994). *Wherever you go there you are*. New York: Hyperion.

Kabat-Zinn, J. (2003). Mindfulness-based interventions in context: past, present, and future. Clinical Psychology: *Science and Practice, 10,* 144-156. http://dx.doi.org/10.1093/clipsy/bpg016.

Knight, M., Pultinas, D., Collins, S., Sellig, C., Freeman, D.C., Strimaitis, C., Simms, N. & Silver, R.R. (2012). Teaching mindfulness on an inpatient psychiatric unit. *Mindfulness, 4 (3),* 1-9.

Kohler, S., Hoffmann, S., Unger, T., Steinacher, B., Dierstein, N., & Fydrich, T. (2013). Effectiveness of Cognitive-Behavioural Therapy Plus Pharmacotherapy in Inpatient Treatment of Depressive Disorders. *Clinical Psychology and Psychotherapy, 20,* 97-106.

Kuyken, W., Byford, S., Taylor, R.S., Watkins, E., Holden, E., White, K., Barrett, B., Bying, B., Evans, A., Mullan, E., & Teasdale, J.D. (2008). Mindfulness-based cognitive therapy to prevent relapse in recurrent depression. *Journal of Consulting and Clinical Psychology, 76*, 966-978. http://dx.doi.org/10.1037/a0013786.

Ma, H.S. & Teasdale, J. (2004). Mindfulness based cognitive therapy for depression replication and exploration of differential relapse prevention effects. *Journal of Consulting and Clinical Psychology*, 72, 31-40. http://dx.doi.org/10.1037/0022-006x.72.1.31.

Maslow, A.H. (2012). *Towards a Psychology of Being*. USA: Start Publishing LLC.

Maslow, A.H. (1954). *Motivation and Personality*. New York: Harper & Brothers.

McKenzie, S., & Hassed, C. (2012). *Mindfulness for Life*. London: Constable & Robinson Ltd.

Miller, L.J. (2012). *The Oxford Handbook of Psychology and Spirituality*. Oxford: Oxford University Press.

National Institute for Clinical Excellence (2005). *CG26 Post-Traumatic Stress Disorder (PTSD): The Management of PTSD in Adults and Children in Primary and Secondary Care*. London: Author.

National Institute for Clinical Excellence (2006). *CG38 Bipolar Disorder: The Management of Bipolar Disorder in Adults, Children and Adolescents, in Primary and Secondary Care*. London: Author.

National Institute for Clinical Excellence (2009a). *CG78 Borderline Personality Disorder Quick Reference Guide*. London: Author.

National Institute for Clinical Excellence (2009b).*CG90 Depression in adults: The Treatment and Management of Depression in Adults*. London: Author.

National Institute for Clinical Excellence (2010). *Schizophrenia: Core Interventions in the Treatment and Management of Schizophrenia in Adults in Primary and Secondary Care* (update). London: Author.

National Institute for Health Research (2011a). *A Pocket Guide to Good Clinical Practice, Including the Declaration of Helsinki.* Geneva, Switzerland: ICH Secretariat.

National Institute for Health and Clinical Excellence. (2011b). *Service User Experience in Adult Mental Health: Improving the Experience of Care for People Using Adult NHS Mental Health Services*. London: NICE.

Perroud, N., Nicastro, R., Jermann, F., & Huguelet, P. (2012). Mindfulness skills in borderline personality disorder patients during dialectical behaviour therapy: Preliminary results*. International Journal of Psychiatry in Clinical Practice, 16,* 189-196. 10.3109/13651501.2012.674531.

Peterson, C., & Park, N. (2010). What happened to self-actualization? *Perspective on Psychological Science, 5,* 320-322.

Polit, D.E., & Beck, C.T. (2008). *Nursing Research: Generating and Assessing Evidence for Nursing Practice*. Philadelphia, PA: Lippincott Williams & Wilkins.

Raune, D., & Daddi, I. (2011). Pilot study of group cognitive behaviour therapy for heterogeneous acute psychiatric inpatients: treatment in a sole-standalone session allowing patients to choose the therapeutic targets. *Behavioural and Cognitive Psychotherapy, 39*, 359-365. http://dx.doi.org/10.1017/S1352465810000834.

Rogers, C. (1951). *Client-Centred Therapy*. Boston: Houghton Mifflin.

Rogers, C. (1961). *On Becoming a Person: A Therapists View of Psychotherapy.* London: Constable.

Royal College of Psychiatrists. (2011). *Do the Right Thing: How to Judge a Good Ward: Ten Standards for Adult Inpatient Mental Healthcare*. London: Royal College of Psychiatrists.

Rotter, J. (1966). Generalised expectancies for internal versus external control of reinforcement. *Psychological Monoigraphs, 80,* 609. http://dx.doi.org/10.1037/h0092976.

Ryback, D. (2006). Self-determination and the neurology of mindfulness. *Journal of Humanistic Psychology, 46*, 474-493.

Segal, Z.V., Williams, J.M., & Teasdale, J.D. (2002). *Mindfulness-Based Cognitive Therapy for Depression*. Guildford: Wiley.

Smith, J.A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research*. London: Sage Publications.

Willig, C. (2013). *Introducing Qualitative Research in Psychology, 3rd ed.* Berkshire: Open University Press.

Winship, G. (2007). A qualitative study into the experience of individuals involved in a mindfulness group with an acute inpatient mental health unit. *Journal of Psychiatric and Mental Health Nursing, 14*, 603-608.

Veltro, F., Vendittelli, N., Oricchio, I., Addona, F., Avino, C., Figliolia, G., & Morosini, P. (2008). Effectiveness and efficiency of cognitive-behavioral group therapy for inpatients: 4-years follow-up study. *Journal of Psychiatric Practice, 4,* 281-288. http://dx.doi.org/10.1097/01.pra.0000336755.57684.45

York, M. (2007). A qualitative study into the experience of individuals involved in a mindfulness group within an acute inpatient mental health unit. *Journal of Psychiatric and Mental Health Nursing, 14,* 603-608.

Yorston, G. (2001). Mania precipitated by meditation: a case report and literature review. *Mental Health, Religion and Culture, 4,* 209-213.

Paper 3: Reflective paper

A mindful journey through research

Word count: 3,806 (excluding references)

Abstract

This paper provides a reflective account of the completion of a literature review exploring the current psychological interventions on acute inpatient wards. Reflections are also provided on the completion of the empirical research which explored service users' (SUs) experience of a mindfulness intervention on acute inpatient wards. In particular, I reflect upon the research process and the impact of the research, both in terms of the findings from the empirical paper. I am also reflexive throughout the paper and consider the personal and professional meaning of this research topic. Consideration is given to the impact of completing this research upon myself and the learning gained by the reader in order to utilise the findings in response to the participants.

Submission details

The paper is a reflective account to allow the reader to understand the research journey based on paper one and two. For ease of reading and to express the researcher's reflexivity, the paper has been written in the first person and has not been written with publication in mind.

Introduction

I became interested in acute inpatient wards throughout my clinical doctorate training. I had often experienced a dominant medical culture when working on acute inpatient wards. This was a surprise as I had expected the ward context to be psychologically therapeutic. When talking to SUs, they often spoke of being bored and waiting to be discharged from the ward; this suggested to me that SUs had a sense of helplessness in empowering themselves to be involved in their experiences on the inpatient ward. I have experienced staff members who perceive that psychological interventions should take place in the community after SUs have been discharged from the ward. I had limited experience on acute inpatient wards and wondered to what extent psychological interventions were utilised on an inpatient setting. This formed the basis of my literature review, which I hoped would provide useful information for healthcare professionals working on acute inpatient wards. Although there was some literature that answered my literature review question, the research appeared limited and therefore there appeared to be a need for further research in this area. This evidently gave rise to my empirical

paper to explore SUs experience of a mindfulness intervention on acute inpatient wards.

Mindfulness became a key interest of mine when I was travelling in South East Asia several years ago. I travelled to Laos, a country with a predominant Buddhist religion and have a distinct memory of the passing through a village early in the morning; I experienced everyone in the community outside their doors sharing food with those who were less fortunate. There was a sense of contentment and compassion for others that I found inspiring. Returning from travelling, I became interested in how western cultures utilised eastern cultural practices and I therefore engaged in experiential mindfulness based cognitive therapy (MBCT) training and have since self-practiced mindfulness. I have been keen to share my interest in mindfulness throughout my clinical doctorate training providing mindfulness groups for staff members and SUs. With a lack of psychological interventions on the acute inpatient wards I wondered how SUs on these wards would experience mindfulness. I was aware that mindfulness based interventions had been researched to show effectiveness within outpatient settings. However, much less was known about mindfulness interventions on acute inpatient wards. Therefore a qualitative study was most appropriate to understand the meaning and experiences of SUs who have engaged with this intervention on an acute inpatient ward. This paper therefore offers my reflections on the provision of psychological interventions and completing research with SUs on an acute inpatient ward.

Literature review

To thoroughly answer the literature review question, a robust search strategy was required. Therefore several preliminary search strategies were completed (Appendix B) before the final strategy was used to answer the literature review question. Initially, the search terms were too broad, which resulted in medically related results. Redefining the terms resulted in articles that excluded key papers which I had become aware of from scoping searches. Therefore, I made the decision to include therapy specific models as search terms. This required some further alterations, such as the removal of the search term ‘family therapy’ as this produced results that were related to children and adolescents. Although this was a time consuming process, it was

also important so that I could have confidence that I had included all relevant papers within my literature review.

My final search strategy and process for selecting papers resulted in less papers than I had anticipated. I initially thought that I had missed something within my search, however, I checked my search procedure and this was not the case. Reflecting on my initial reaction to the limited literature brought my attention to my belief that this is an area that I feel is deserving of research. I previously worked in a forensic setting for several years. Working with prisoners whose liberty had been deprived holds some similarities for me to SUs on acute inpatient settings. I therefore think that as a healthcare professional and researcher, I have duty to ensure that SUs' voices are heard, as they are vulnerable adults and perhaps would find it more difficult to express their own voices. This is likely to have influenced my attitude towards research and choice of a qualitative research methodology.

Ethical issues

In order to complete the research, ethical approval was sought from both the University's Independent Peer Review committee and the NHS ethics committee. This was quite a time consuming process. However, allowing substantial time in planning my research meant that I had sufficient time for carrying out the research.

Several ethical issues were particularly relevant to research within an acute inpatient ward. Informed consent was particularly important when recruiting participants, as the research participants were on an acute inpatient ward, there was a possibility that they could feel pressure to participate in the research. I was mindful of the importance of giving SUs ample time to consider their decision to take part in the research and ask any questions they had about the research. It was also important they were clear of their sense of self-determination, and aware that they could withdraw from the research at any time. In addition, as some SUs on the ward had been sectioned under the Mental Health Act (1983) it was important that their capacity to participate in the research was assessed by a consultee on the ward. This involved a member of staff with relevant training in order to determine SU's capacity to consent. This decision was made by a member of staff on the ward who met with the SU and made the decision that they had capacity to participate in the research.

Data collection

The research was conducted both on acute inpatient wards and in SUs homes. It is possible that the contextual differences of where the interview was conducted could have an impact on the SUs and what they discussed within the interview. Those on the acute inpatient wards were interviewed in a private room which was quiet and therefore had limited distractions. However, SUs had described the context of the ward to have '*hustle and bustle',* therefore this may have impacted on participants' ability to focus during the interview. Those who were interviewed in their home environment may have been more relaxed and may have felt more able to be open and honest during the interview. For all participants interviewed, some time was spent before the interview to help put them at ease and to build a rapport. I was mindful throughout the interview of a possible power dynamic, particularly given the context of an acute inpatient ward. During the interviews, there were occasions when participants asked me questions such as '*what do you think?*' It was important to maintain a rapport whilst also refraining from providing personal views that could influence the participant's responses, therefore, I remained curious about their experience rather than my own. In addition, two participants appeared to seek reassurance throughout the interview asking '*is that okay?*' I addressed this by further explaining that there was no right or wrong answer and that their unique experience was of interest. However, on reflection it is possible that the participants may have only wanted to provide positive responses, which could explain the lack of negative themes within the data.

A further factor that may have impacted on SUs ability to focus during the interview, is that the majority of participants were prescribed psychotropic medication. This may have impacted on the clarity of the answers that were given. One of the participants appeared to have difficulty focusing on the questions that were asked and it was unclear at times, if they were referring to their experience on the mindfulness group or other groups that they had attended. This may have also been related to one of the participants appearing to have some learning difficulties, therefore having difficulties comprehending the questions. It was important to include these participants' responses within the analysis. However, the data included was limited in order to ensure the focus was on the research question.

At times during the data collection, I was aware of my own mind wandering particularly when I noticed links between what participants were describing. The use of mindfulness was helpful in allowing me to notice that my mind had wandered and bracket this experience to some extent, and then I was able to return to the participant and engage in the interview in a deeper and meaningful way. Throughout the interviews, I also found it helpful to keep a note of key words used by the participant so that I could further explore these within the interview. However, I am mindful that my identification of a 'key word' is influenced by my epistemological stance. I would affiliate with a critical realist position and therefore I identified words which I believed to hold further meaning, which may possibly be related to the participant's cultural and societal experiences, this may therefore have impacted on the direction of the interview. I attempted to ensure that the interview was as open as possible both in my phrasing of questions and also asking towards the end of the interview if there was anything else that they wanted to share that we had not discussed.

During the interviews, I attempted to encourage participants to consider and reflect on their response. I attempted to do this by slowing the pace of the interview, although this did not appear to successful for all participants as some spoke at a rapid pace. It is possible that this might have reflected their anxiety within the interview. When I noticed this, I attempted to put them at further ease using non-verbal communication such as smiling and nodding. During the interviews, it appeared to me that one participant may have been upset, although this was not overtly expressed. I was mindful not to probe too deeply when this occurred so to ensure that she was not distressed by the content that was discussed during the interview. Although ethically this appeared to be the correct decision, this may have limited the data by avoiding further exploration. Following the interview, I highlighted the appropriate avenues that she could contact if she required any further support.

Participants were recruited once they had attended a minimum of two mindfulness sessions and then were interviewed a minimum of three weeks following the third mindfulness session. Although this research design was created to ensure that participants had sufficient time to reflect on their experience, this may also have been a limitation for some SU's who had been discharged from the ward within this timeframe. A SU who expressed an interest in the research, when contacted, could no longer remember her

experience on the ward. If she had been recruited sooner, she might have been able to contribute to the research. Finally regarding the data collection, several participants expressed their enjoyment taking part in the interviews. This was particularly expressed by those who resided on the inpatient ward and one participant said *'it was good to be able to think in such detail and it's not something I do that often'.* Although it was explicitly described in the participant information pack that no personal benefits could be gained from taking part in the research, I was glad that participants had been able to gain some personal benefits.

Analysis

An interpretative phenomenological analysis (IPA) method was used to analysis the data. It was an important that sufficient time was provided for the analysis as this was a time consuming process, which required reviewing the data several times. During the coding stage, it was important to be aware of my own attitudes and beliefs that could impact on the analysis of the data. As previously stated, I have a personal interest in mindfulness and I personally find it a useful way to live my life. It was therefore important for me to 'bracket' my own beliefs as far as possible as I was aware how this could influence how I saw the participants' data. Staying close to the data helped me to ensure that emergent themes were directly linked to participants, which enhanced confirmability of the findings (Treharne & Riggs, 2015). I also attended and contributed to an IPA peer group which helped to verify the links between the data and the emergent themes and aided credibility in the findings. The interpretative aspect of the IPA highlights some ethical issues, as this element of coding moves away from the raw data which could result in losing the participant's voice (Willig, 2013). I was mindful to ensure that the participants' voices were maintained within the research. Therefore, when developing the emergent themes I would ensure there was a direct link back to the raw data. This was facilitated by the use of a table which incorporated the emergent themes and direct quotes by participants (Appendix V). Although it is not possible to completely bracket one's own views from the data, the use of a research journal was helpful to increase my insight in which I was able to write down my own reflections and comments. In addition, it was helpful to have breaks from the data. This allowed me to look at the data in a 'new light'.

The interpretative coding involved the process of double hermeneutics in that I was attempting to make sense of the participant making sense of their experience. This process appeared to hold some similarities to psychodynamic theory by understanding the deeper meaning, perhaps at the unconscious level, in which the participants are not able to access the underlying structures of their experiences (Willig, 2012). This resonates for me as I am currently learning a psychodynamic theory on an elective clinical placement and am also engaged in personal therapy with a psychoanalyst. Therefore, I have recognised that there can be deeper meaning to what we express, that is not always clear at a superficial level. The process of double hermeneutics in IPA appears to link to some extent to the participant's experience of mentalizing. The participants were more able to become aware of their own state of mind and notice the state of mind of others. In a similar way, I was attempting to understand the participant's experience of how they made sense of their experience of mindfulness.

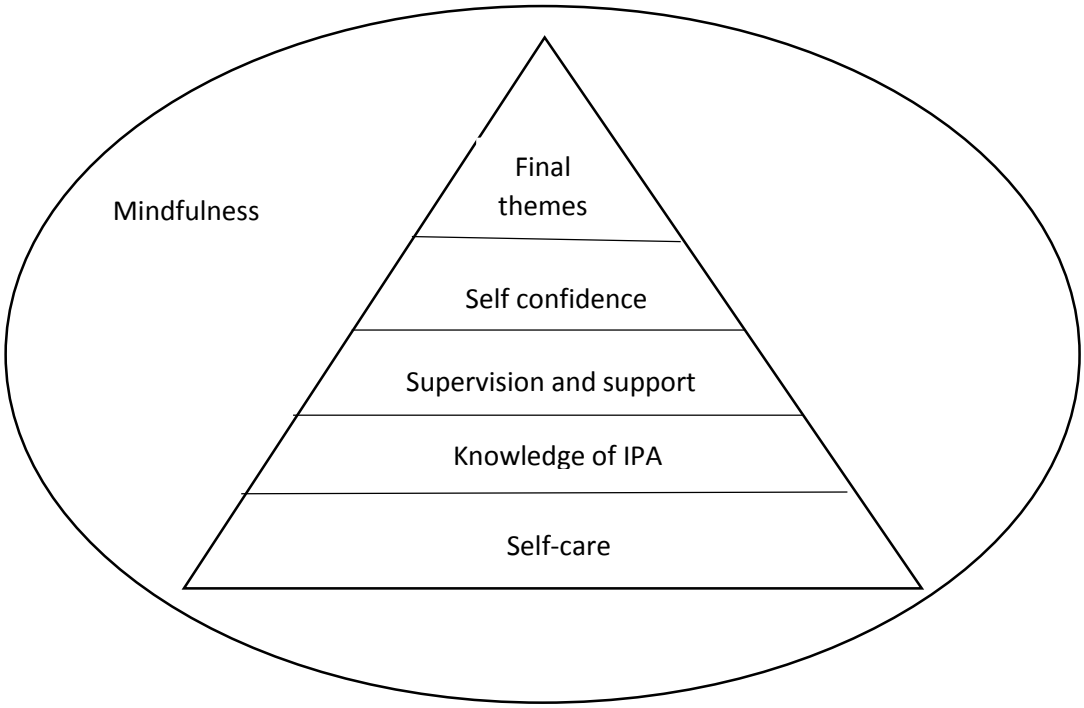
Use of visual representations were helpful when identifying superordinate codes from the individual participant's data (Appendix U) and from across all the participants' data (Appendix W). The process of arriving at the final superordinate themes was challenging, and required coming back to the data every few days. Gradually, I was able to synthesis the data which resulted in the emergence in four main superordinate themes. This process appeared to take some time as I was mindful that I did not want to lose the individual's experience from reducing the data into the final themes. The self-practice of mindfulness was a useful aid in completing the data analysis as it allowed me to have a clarity when looking at the data each time and therefore reducing the 'clutter' within my mind.

Process towards self-actualisation in research

Throughout the data analysis there was a process which resulted in the emergence of the final superordinate themes. There are some similarities to the process towards self-actualisation described by participants within the empirical paper. The process towards the final superordinate themes evolved through a number of stages. First, the basic need of self-care was met by providing myself with sleep, food and drink. This then allowed for the next level to be achieved of acquiring learning which involved attending IPA workshops and

reading relevant literature; this provided a sense of safety within the research in that I had a theoretical understanding. With a knowledge of IPA, I was then supported through supervision and consulted with other professionals with specialist IPA knowledge. This then led to developing my own confidence within the approach, which resulted in a reduced need to seek reassurance from my supervisor as I began to become more confident in own ability. When this was achieved, I was able to allow the final superordinate themes to emerge (figure 1). To some extent this has similarities to self-actualisation; as when the themes emerged, I had a positive feeling and felt that it made sense. As a trainee psychologist and a researcher, it is meaningful to make sense of human experiences and, by doing so, I have moments of feeling self-actualised. Throughout this process, the use of mindfulness helped facilitate my journey through IPA, in which I was able to take a reflective stance that enabled me to make informed decisions. I particularly found the use of mindfulness helpful towards the final stage of analysis in which I had vast amounts of data that needed to be assimilated. This was initially overwhelming, but rather than get absorbed into the emotions and thoughts about this, I was able to notice this and create some distance so that I was able to focus and pay detailed attention to the analysis.

Figure1: Process of arriving at superordinate themes in IPA



Therapeutic context

The findings of the empirical paper revealed that participants experienced a '*sharp transition'* between engaging in mindfulness sessions and being back on the ward. Participants described being back on the ward and noticing people rushing about and the '*hustle and bustle'*. This impacted on participants' ability to feel able to engage with mindfulness on the ward. I wondered what was contributing to context of the acute wards, in which there was a difference between mindfulness practice and the experience on the acute inpatient ward. My initial expectation was that it would be a place where SUs could have the opportunity to engage in psychological interventions such as mindfulness. The Joint Commissioning Panel for Mental Health (2013) highlights that acute inpatient wards should be welcoming to SUs and their families. However, it appeared from the descriptions from participants that there was a sense of agitation and restlessness whilst on the ward. Participants have described that they find it helpful to talk, but notice that the ward staff are busy so do not always do this. Throughout my experience working on acute inpatient wards, the staff have a desire to spend more time with SUs but often feel overwhelmed with tasks that are often administrative, impacting on the amount of time they interact with SUs. The Department of Health (2013) recommends that staff have the skills and time to care for SUs. However, it seems that time is consumed by multiple demands, which may impact on both the staff members and SUs' wellbeing. Within the empirical paper, it was recommended that mindfulness is incorporated on the ward as a general strategy and it is possible that using mindfulness as a ward milieu would have a beneficial impact for both SUs and the staff team.

Impact of findings

One of the key findings from the empirical paper was the link between mindfulness and mentalization. Mentalization is the process in which the person can recognise their own emotional states and the emotional states of others (Allen & Fonagy, 2006). It has also been linked to psychological mindedness, in which the person is able to self-reflect, understand themselves and others and be motivated by internal states (Allen, Bennett & Kearns, 2004). Locally within Community Mental Health Team's (CMHT's) it is often a requirement that the SU is psychologically minded so that they are able to

engage in psychological therapy. This can create difficulties for SUs who do not have this capacity, resulting in a delay in their access to psychological therapies within the community. In some cases, this can result in SUs having repeated admission to the acute inpatient wards, which is likely to be disempowering for the SU and reduce their hope for recovery. Providing mindfulness on an acute inpatient ward may help SUs to develop skills such as mentalization and possibly psychological mindedness which would then help to achieve a more fluid continuation for their mental health care needs. This remains to be a hypothesis and requires future research.

Finally, the use of mindfulness within my experience of completing research has helped me manage stress and be more compassionate towards myself. I wonder how the use of mindfulness could be used for staff on acute inpatient wards. I have attempted to run reflective practice groups for staff on an acute inpatient ward but with little success. Staff members often describe how valuable they believe it would be but say they have no time. This has the potential to be a dangerous trap in which the staff members become increasingly busy without being able to notice the impact of their stress. The use of mindfulness within reflective practice could be helpful to allow staff to be able to take an observing stance so they are more able to make informed choices about their intended actions.

Conclusion

Using an IPA approach has given me the opportunity to research an area that has had limited research attention. It has given me to chance to give voices to SUs on acute inpatient wards and express their experience of engaging with the psychological intervention of mindfulness. It has been a powerful experience to be immersed within the SUs worlds, whilst also noticing my own motivations and values and how this becomes entwined in understanding their experiences. It has motivated my passion to pursue a career in which I can contribute psychologically to those with complex mental health difficulties on acute inpatient wards. I hope that other healthcare professionals and I can utilise the findings of both the literature review and the empirical paper so that SUs can have a more direct influence on their care provision within acute inpatient wards.

Paper 3 References

Allen, J.R., Bennett, A., & Kearns, L. (2004). Psychologically Mindedness: A Neglected Developmental Line in Permissions to Think. *Transactional Analysis Journal,* 34, 3-9.

Allen, J.G., & Fonagy, P. (Eds.). (2006). *Handbook of Mentalization-Based Treatment*. Chichester, England: Wiley.

Department of Health (2013). *Treating patients and service users with respect, dignity and compassion*. England: DoH.

Department of Health (2008). *Code of Practice: Mental Health Act 1983*. London: TSO.

Joint Commissioning Panel for Mental Health. (2013). *Guidance for Commissioners of Acute Care – Inpatient and Crisis Home Treatment.* London: JCP-MH.

Treharne, G.J., & Riggs, D.W. (2015). Ensuring quality in qualitative research. In Rohleder, P., & Lyons, A.C. (2015). *Qualitative Research in Clinical and Health Psychology*. Hampshire: Palgrave Macmillan.

Willig, C. (2013). *Introducing Qualitative Research in Psychology, 3rd Ed*. Berkshire: Open University Press.

Willig, C. (2012). Perspectives on the epistemological bases for qualitative research. In, Cooper, H., P. Camic., Long, D.L., Panter, A.T., Rindskopf. D., Sher, K.J. (Ed.). (2012). *APA Handbook of Research Methods in Psychology, Vol1: Foundations, Planning, Measures and Psychometrics.* (pp.5-21). Washington, DC: American Psychological Association.

Appendix A: Journal Submission Guidelines for paper one and paper two- Journal of Psychotherapy Research

Disclaimer

Paper 1 has been written for publication in *Psychotherapy Research.* General submission guidelines for the target journal have been followed, however for the purposes of thesis submission Ariel font size 12 has been used to adhere to University submission guidelines, and for ease of accessibility.

Additional content included for the purposes of thesis review will be removed prior to manuscript submission to the target journal.

Relevant general guidelines

- APA referencing
- Font Times New Roman, 12 point. Use margins of at least 2.5 cm
- Titles: Use bold for article title, with initial capital letter after a colon
- Give names of all contributing authors on the tile page
- List the affiliation of each author
- Provide an institutional email address and postal address for corresponding author
- Write funding agency out in full and include grant number
- Ensure your identity and that your co-authors is not revealed in the text of your article
- Provide 5-6 keywords
- Indicate in the text where tables and figures should appear
- Use numerals for 10 and above and words for numbers below 10
- No word count
- Please supply all details required by any funding and grant-awarding bodies as an acknowledgement
- Abstracts of 100-200 words
- Section headings should be concise
- Authors must also incorporate a Disclosure Statement which will acknowledge any financial interest or benefit they have arising from the direct applications of their research
- For all manuscripts non-discriminatory language is mandatory

- Authors must adhere to SI units. Units are not italicised.
- When using a word which is or is asserted to be a proprietary term or trade mark, authors must use the symbol ® or TM.

Appendix B: Preliminary review searches

Searches: Four preliminary searches were completed. From each of the searches the outcomes are provided and an explanation for the change in the search strategy.

Screening process guide:

A. Titles from articles were screened using the following key:

   1 = Yes (the information in the title suggests relevance relating to the inclusion criteria and also meets the exclusion criteria). Include for abstract screening.

   2= Maybe (information in the title is unclear as the whether it meets the inclusion criteria or if it meets the exclusion criteria). Include for abstract screening.

   3= No (information in the title does not meet the inclusion criteria and does meet the exclusion criteria). Excluded from the review.

B. The abstract from the articles identified in 1 and 2 were screened for further coding:

   1 = Yes (the information in the abstract suggests relevance relating to the inclusion criteria and also meets the exclusion criteria). Include for full paper screening.

   2= Maybe (information in the abstract is unclear as the whether it meets the inclusion criteria or if it meets the exclusion criteria). Include for full paper screening.

   3= No (information in the abstract does not meet the inclusion criteria and does meet the exclusion criteria). Excluded from the review.

C. All papers from both 1 and 2 at stage B were read in full and given a final code.

   1 = Yes (the information in the paper suggests relevance relating to the inclusion criteria and also meets the exclusion criteria). Include for full paper within the review.

   3= No (information in the abstract does not meet the inclusion criteria and does meet the exclusion criteria). Excluded from the review

Search 1

Terms: (Group n3 psychotherapy OR group n3 therap* OR psycholog* n3 therap* OR psycholog** n3 treatment$ OR psycholog** n3 intervention$ OR psychotherapeutic n3 technique$) AND (Inpatient$ OR in-patient$ OR psychiatric resident$ OR psychiatric patient$)

Search Results:

Limiters:	Age 18 years +; Date range 1980-2014; peer reviewed journal articles.
Search Results:	9,994
Process:	Screening stage A conducted by PI
Inclusion Criteria:	1. Participants are adults
	2. Participants are inpatients in a mental health hospital and not a forensic inpatient unit or an general hospital.
	3. The study took place in an inpatient unit in the UK.
	4. Related to psychological treatments (group and individual) and not medical or physical treatment.
Exclusion criteria:	1. Not as above
	2. outpatient services
	3. Eating disorder services, mother and baby units, forensic services as in the UK there are separate inpatient units for these patients and psychological interventions will differ.
	4. Relates to intellectual disability services

Comments: A large number of results was produced with a large percentage relating to medical procedures. The papers were not clearly related to a psychological intervention. Needs refinement due to differences in healthcare systems across different countries. Search words need to be more specific, therefore removal and adaptation of ‘wildcard’ symbols required. Also, removal of “psychiatric resident” and “psychiatric patient” as these terms related to medical interventions and not acute inpatient services.

Search 2

Terms: (English OR England Or Britain Or “great Britain” OR Scottish OR Scotland OR Wales OR Welsh OR “northern Ireland” OR Irish OR NHS OR “united kingdom”) AND (AB ”group psychotherapy*” OR AB “psychotherapy group*” OR AB psychotherapy OR AB “individual psychotherapy” OR AB

“psychological treatment*” OR AB “psychological intervention*” OR AB “cognitive behaviour* therapy” OR AB “dialectical behaviour* therapy” OR AB psychodynamic OR mindfulness OR AB “systemic therapy” OR AB “family therapy” OR AB “cognitive analytic therapy” OR AB “compassionate focused therapy”) AND (AB “inpatient” OR AB inpatient OR AB “acute inpatient”) AND (AB psychiatric OR AB “mental health”)

Limiters:	Date range 2004-2014; peer reviewed journal articles
Search Results:	250
Process:	Screening stage A conducted by PI and research supervisor (95% overlap in 1 and 2s).
Inclusion Criteria:	1. Participants are adults 2. Participants are inpatients in a mental health hospital and not a forensic inpatient unit or an general hospital. 3. The study took place in an inpatient unit in the UK 4. Related to psychological treatments (group and individual) and not medical or physical treatment.
Exclusion criteria:	1. Not as above 2. outpatient services 3. Eating disorder services, mother and baby units, forensic services as in the UK there are separate inpatient units for these patients and psychological interventions will differ. 4. Relates to intellectual disability services
Comments:	Change of date based on a recent policy that related to psychological provisions in acute inpatient settings. Inclusion of specific psychological interventions. This increased the number of papers that were related to psychological interventions, but also included papers relating to interventions for children this was particularly relevant for ‘family therapy’. Also added search term “acute inpatient”.

Search 3

Terms: (AB ”group psychotherapy*” OR AB “psychotherapy group*” OR AB psychotherapy OR AB “individual psychotherapy” OR AB “psychological treatment*” OR AB “psychological intervention*” OR AB “cognitive behaviour* therapy” OR AB “dialectical behaviour* therapy” OR AB psychodynamic OR mindfulness OR AB “systemic therapy” OR AB “cognitive analytic therapy” OR AB “compassionate focused therapy” OR “acceptance and commitment therapy”) AND (AB “inpatient” OR AB inpatient) AND (AB psychiatric OR AB “mental health”)

Limiters:	Date range 2004-2014; peer reviewed journal articles.
Search Results:	567
Process:	Screening stage A, B and C conducted by PI due to high percentage of overlap in screening articles in search 1.
Inclusion Criteria:	1. Participants are adults 2. Participants are inpatients in a mental health hospital and not a forensic inpatient unit or an general hospital. 3. The study took place in an inpatient unit in countries with a universal health care system. 4. Related to psychological treatments (group and individual) and not medical or physical treatment.
Exclusion criteria:	1. Not as above 2. outpatient services 3. Eating disorder services, mother and baby units, forensic services as in the UK there are separate inpatient units for these patients and psychological interventions will differ. 4. Relates to intellectual disability services

Comments: Removal of “family therapy” also previous search results related to children and adolescents not adults. Removal of “acute inpatient” and did not result in any additional articles. Removal of search words relating to geographical region of the UK as the results were too limited and on reflection the UK has similar healthcare system to countries with a universal healthcare system, therefore these countries will also be included in the review. Majority of articles not related to acute inpatient wards.

Search 4

Terms: (AB ”group psychotherapy*” OR AB “psychotherapy group*” OR AB psychotherapy OR AB “individual psychotherapy” OR AB “psychological treatment*” OR AB “psychological intervention*” OR AB “cognitive behavioural therapy” OR AB “dialectical behavioural therapy” OR AB psychodynamic OR mindfulness OR AB “systemic therapy” OR AB “cognitive analytic therapy” OR AB “compassionate focused therapy” OR “acceptance and commitment therapy”) AND (ti “inpatient” OR ti inpatient) AND (AB psychiatric OR AB “mental health”)

Limiters:	Date range 2004-2014; peer reviewed journal articles.
Search Results:	378 (removal of duplicates = 329)
Process:	Screening stage A, B and C conducted by PI.
Inclusion Criteria:	1. Participants are adults
	2. Participants are inpatients in a mental health hospital and not a forensic inpatient unit or an general hospital.
	3. The study took place in an inpatient unit in countries with a universal health care system.
	4. Related to psychological treatments (group and individual) and not medical or physical treatment.
Exclusion criteria:	1. Not as above
	2. outpatient services
	3. Eating disorder services, mother and baby units, forensic services as in the UK there are separate inpatient units for these patients and psychological interventions will differ.
	4. Relates to intellectual disability services

Comments: Some key papers were not included, therefore a change was made to the search term “cognitive behaviour* therapy” to “cognitive behavioural therapy” and from dialectical behaviour* therapy” to “dialectical behavioural therapy”. Due to the majority of papers not being related to acute inpatient wards ‘inpatient’ and ‘in-patient’ were search terms within the title. The output was cross referenced with the previous search to ensure that relevant papers were not excluded.

Articles	Included/ Excluded	Comments
Alves et al. The Effects of Guided Imagery on Comfort, Depression, Anxiety, and Stress of Psychiatric Inpatients with Depressive Disorders	Include	Guided imagery intervention that took place in Portugal
Bauer et al. Personality disorders after inpatient psychodynamic psychotherapy	Exclude	Not available in English
Beutel et al. Psychodynamic focal group treatment for psychosomatic inpatients - with an emphasis on work-related conflicts	Exclude	Referral to the hospital made by pension and health insurance companies not the remit of an acute ward
Beutel et al. Inpatient psychosomatic treatment of anxiety disorders: Comorbidities, predictors, and outcomes	Exclude	Psychosomatic clinics, not acute inpatient wards
Blais et al. Exploring Therapeutic Alliance in Brief Inpatient Psychotherapy: A Preliminary Study	Exclude	Focus on therapeutic alliance rather than psychological intervention. Study took place in the USA
Blom & Colijn An inpatient version of mentalisation-based treatment for patients with cluster A personality disorders].	Exclude	Not available in English
Brakemeier et al. Feasibility and Outcome of Cognitive Behavioral Analysis System of Psychotherapy (CBASP) for Chronically Depressed Inpatients: A Pilot Study	Exclude	Only letter to editor available not full text
Buccheri et al. Comprehensive evidence-based program teaching self-management of auditory hallucinations on inpatient psychiatric units.	Exclude	USA (US military)
Crowe & Porter Inpatient treatment for mania: A review and rationale for adjunctive interventions	Exclude	Literature review
Durrant et al. Designing a CBT service for an acute inpatient setting: A pilot evaluation study	Include	CBT, Acute inpatient, UK

Emond & Rasmussen The Status of Psychiatric Inpatient Group Therapy: Past, Present, and Future	Exclude	USA based. Unable to obtain a full text copy
Forsyth et al. Implementing cognitive behaviour therapy skills in adult acute inpatient settings	Exclude	UK, focus on staff training on CBT on the wards
Fowler et al. Personality and Symptom Change in Treatment-Refractory Inpatients: Evaluation of the Phase Model of Change Using Rorschach, TAT, and DSM-IV Axis V	Exclude	Study took place in the USA
Gaudiano & Herbert Acute treatment of inpatients with psychotic symptoms using Acceptance and Commitment Therapy: Pilot results	Exclude	USA,
Heriot-Maitland et al. A compassionate-focused therapy group approach for acute inpatients: Feasibility, initial pilot outcome data, and recommendations	Include	Compassionate focused therapy, UK, acute inpatient ward
Herrmann & Huber The influence of patient- and treatment-related factors on the success of inpatient psychotherapy	Exclude	Not available in English
Huffman et al. Feasibility and utility of positive psychology exercises for suicidal inpatients	Exclude	Based in the USA
Iqbal & Bassett Evaluation of perceived usefulness of activity scheduling in an inpatient depression group	Include	Activity scheduling, UK, acute inpatients
Oestrich et al. The Feasibility of a Cognitive Behavioural Intervention for Low Self-Esteem within a Dual Diagnosis Inpatient Population	Exclude	Unclear if study took place in USA or Denmark. Unclear if an acute inpatient ward. Specific for dual-diagnosis inpatients
Kech et al. Interpersonal Psychotherapy for inpatients with depression. Effects on social adjustment and interpersonal problems	Exclude	Not available in English
Kirchmann et al. Effects of adult inpatient group psychotherapy on attachment characteristics: An observational study comparing routine care to an untreated comparison group	Exclude	Based in psychotherapy inpatient wards, not acute wards in Germany

Knight et al. Teaching mindfulness on an inpatient psychiatric unit	Exclude	USA
Köhler et al. Effectiveness of Cognitive-Behavioural Therapy Plus Pharmacotherapy in Inpatient Treatment of Depressive Disorders	Include	Psychiatric unit in Berlin
Lampe et al. Treatment outcome of Psychodynamic Trauma Therapy in an inpatient setting	Exclude	Not available in English
Leweke et al. Alexithymia as a predictor of outcome of psychodynamically oriented inpatient treatment	Exclude	Based in Germany. Includes long term psychodynamic therapy for inpatients, not specifically for acute inpatients
Lynch et al. A group-oriented inpatient CBT programme: a pilot study	Exclude	USA
McCann & Bowers Training in cognitive behavioural interventions on acute psychiatric inpatient wards	Exclude	Focus on training ward staff
Mehl-Madrona Introducing narrative practices in a locked, inpatient psychiatric unit.	Exclude	Based in USA
Meyer et al. Self-help groups as part of in-patient psychotherapeutic treatment	Exclude	Not available in English
Newbold et al. Staff and patient experience of improving access to psychological therapy group interventions for anxiety and depression	Exclude	Based in an IPAT service not acute wards, UK
Nurenberg,et al. Equine-facilitated group psychotherapy with chronic psychiatric inpatients: two controlled studies	Exclude	Not clear if the study took place on an acute inpatient ward
O'Donovan & O'Mahony Service users' experiences of a therapeutic group programme in an acute psychiatric inpatient unit	Include	Ireland. Acute psychiatric inpatient service
Prunetti et al. Three-week inpatient Cognitive Evolutionary Therapy (CET) for patients with personality disorders: Evidence of effectiveness in symptoms reduction and improved treatment adherence	Exclude	Not an acute inpatient service
Quartier Psychiatry and psychoanalysis: psychopathology among inpatients.	Exclude	Not available in English

Rabovsky & Stoppe The role of psychoeducation in the treatment of psychiatric inpatients	Exclude	Not available in English
Raune & Daddi Pilot Study of Group Cognitive Behaviour Therapy for Heterogeneous Acute Psychiatric Inpatients: Treatment in a Sole-Standalone Session Allowing Patients to Choose the Therapeutic Target	Include	Uk, Psychological intervention, acute inpatient ward
Reiss et al. Treatment Satisfaction of Patients with Borderline Personality Disorder in Inpatient Schema Therapy	Exclude	Not available in English
Rosner et al. Effectiveness of an inpatient group therapy for comorbid complicated grief disorder	Exclude	Focus on complicated grief. Germany
Rudolf et al. Results of psychodynamic inpatient psychotherapy in relation to diagnosis	Exclude	Not available in English
Sachsse et al. Results of psychodynamically oriented trauma-focused inpatient treatment for women with complex posttraumatic stress disorder (PTSD) and borderline personality disorder (BPD)	Include	Germany
Schramm et al. Efficacy and therapeutic factors of interpersonal psychotherapy for depressed inpatients - Results of a pilot study	Exclude	Not available in English
Schramm et al. An intensive treatment program of interpersonal psychotherapy plus pharmacotherapy for depressed inpatients: Acute and long-term results	Include	
Silverman Effects of a Single-Session Assertiveness Music Therapy Role Playing Protocol for Psychiatric Inpatients	Exclude	USA
Singh et al. Enhancing Treatment Team Process Through Mindfulness-Based Mentoring in an Inpatient Psychiatric Hospital	Exclude	USA, staffs perspectives
Spivack Subgrouping with psychiatric inpatients in group psychotherapy: Linking dependency and counter dependency	Exclude	USA

Stingl et al. Effects of inpatient psychotherapy on the stability of alexithymia characteristics	Exclude	Inclusion of longer term therapy, not relevant to acute inpatient wards
Summ et al. Psychoeducation for In-Patient Anxiety - The Evaluation of the Cognitive Behavioural Group Programme "PAsta"	Exclude	Not available in English
Veltro et al. Effectiveness of cognitive-behavioural group therapy for inpatients	Include	Italy, psychiatric inpatient unit
Veltro et al. Effectiveness and efficiency of cognitive-behavioural group therapy for inpatients: 4-year follow-up study	Include	Italy, psychiatric inpatient unit
Ward et al. A Naturalistic Psychodynamic Psychotherapy Study: Evaluating Outcome with a Patient Perspective	Exclude	UK, not acute inpatient. In a psychotherapy service
YORK A qualitative study into the experience of individuals involved in a mindfulness group within an acute inpatient mental health unit	Include	

Appendix D: Qualitative paper screening tool

1. Was there a clear statement of the aims of the research?

   What was the research question?

   Was it clearly stated?

2. Does the research state where it fits within relevant literature?

3. Is a qualitative methodology appropriate?

4. Was the research design appropriate to address the aims of the research?

   Was the method justified?

   Would a different design have been more appropriate?

5. Was the recruitment strategy appropriate to the aims of the research?

   Are the participants described in terms of their life circumstances?

6. Has the relationship between researcher and participants been adequately considered?

7. Have ethical issues been taken into consideration?

   Was informed consent/ confidentially sought/ maintained?

   Was approval sought from an ethics committee?

   Does the study show respect towards the participants?

8. Is the procedure for collecting the data clear?

   Was the data collected in a way that addressed the research issue?

   Was there saturation of the data?

   Is the setting for data collection justified?

   Are specific questions posed to participants included?

9. Was the data analysis sufficiently rigorous?

   Is it clear how categories themes were arrived?

   Did the researchers critical examination of their own role?

10. Where a general understanding of a phenomenon is intended, it is based on an appropriate range of instances?

11. Are there credibility checks? (triangulation, respondent validation etc.)

12. Has the author specified their theoretical orientation and personal anticipations?

   Are limitations acknowledged?

14. Is the data appropriately presented?

   Are examples of data given to illustrate the analytical procedures?

Can the themes be understood from the data?

Was contradictory data considered?

15. Does the study resonant with the reader, does it represent accurately the subject matter?

16. How valuable is the research?

Are the finding transferable?

Do the findings contribute to the existing knowledge?

Was the relating literature critically evaluated?

Appendix E: Quantitative paper screening tool

1. Did the study address a clearly focused issue?

   Was the population well defined?

   Was the intervention given?

   Were outcomes considered?

2. Are the main outcomes to be measured clearly described in the introduction or methods section?

3. Was the choice of design appropriate?

   Was it appropriate to the aims?

4. Were ethical issues considered?

5. Where the participants recruited in acceptable way?

   Do the participants represent a defined population?

   Was everyone included who should have been included?

6. Are the characteristics of the participants clearly defined?

7. Are the interventions of interest clearly described?

8. Was an attempt made to blind participants to the intervention they received?

9. Are the measurements used appropriate?

   Did they use subjective or objective measurements?

   Have the measurements been validated and are they reliable?

   Was the outcome accurately measured to minimise bias?

   Was the assessor blinded (if not does this matter)?

10. Has the author identified all important confounding variables?

    Have they taken confounding variables into account in the design/ analysis?

11. Did the study have enough participants to minimise play of chance?

    Is there a power calculation?

12. Where applicable, were participants allocated appropriately to invention and control groups?

    Were they recruited from the same population?

13. Was there a follow up?

    Was this complete enough?

    Was this long enough?

14. What are the results of the study?

    What are the bottom line results?

Were all participants accounted for within the results?

15. How precise are the results?

What is the confidence intervals?

Have actual probability values been reported?

Was the effect size report?

16. Were the statistical test used appropriate?

Non parametric should be used for small sample sizes

17. Do you believe the results?

What is the effect size?

Are their flaws in the design or method that makes the results unreliable?

18. Can the results of the study be generalised?

Do the participants represent the population from which they were recruited?

Consider outcomes from the point of view of the:

- Individual
- Policy maker
- Family/carers
- Wider community

Do the benefits outweigh the costs?

19. Do the results of the study fit with other available evidence?

What does this add to current knowledge?

20. What are the implications of this study for practice?

Can the findings be applied?

Were there any follow ups?

Appendix F: Certificate of indemnity

ZURICH MUNICIPAL

To Whom It May Concern

Our ref: SB/IND

16 July, 2013

Zurich Municipal Customer: Staffordshire University

This is to confirm that Staffordshire University have in force with this Company until the policy expiry on 31 July 2014 Insurance incorporating the following essential features:

Policy Number: NHE-02CA03-0013

Limit of Indemnity:

Public Liability:	£ 25,000,000	any one event
Products Liability:	£ 25,000,000	for all claims in the aggregate during any one period of insurance
Pollution:		
Employers' Liability:	£ 25,000,000	any one event inclusive of costs

Excess:

Public Liability/Products Liability/Pollution:	£ 1,000 any one event
Employers' Liability:	Nil any one claim

Indemnity to Principals:
Covers include a standard Indemnity to Principals Clause in respect of contractual obligations.

Full Policy:
The policy documents should be referred to for details of full cover.

Yours faithfully

Underwriting Services
Zurich Municipal
Farnborough

Zurich Municipal
Zurich House
2 Gladiator Way
Farnborough
Hampshire
GU14 6GB

Telephone 0870 2418050
Direct Phone: 01252 387852
Direct Fax: 01252 375893
E-mail
helen.atwal@uk.zurich.com

Communications will be monitored regularly to improve our service and for security and regulatory purposes

Zurich Municipal is a trading name of Zurich Insurance plc

A public limited company incorporated in Ireland. Registration No. 13460
Registered Office: Zurich House, Ballsbridge Park, Dublin 4, Ireland.

UK branch registered in England and Wales Registration No. BR7985.
UK Branch Head Office: The Zurich Centre, 3000 Parkway, Whiteley, Fareham, Hampshire PO15 7JZ

Authorised by the Central Bank of Ireland and subject to limited regulation by the Financial Services Authority. Details about the extent of our regulation by the Financial Services Authority are available from us on request

ZURICH MUNICIPAL

Certificate of Employers' Liability Insurance(a)

(Where required by regulation 5 of the Employers' Liability (Compulsory Insurance) Regulations 2008 (the Regulations), a copy of this certificate must be displayed at all places where you employ persons covered by the policy or an electronic copy of the certificate must be retained and be reasonably accessible to each employee to whom it relates).

Policy No.	NHE-02CA03-0013
1. Name of policyholder	Staffordshire University
2. Date of commencement of insurance policy	01 August 2013
3. Date of expiry of insurance policy	31 July 2014

We hereby certify that subject to paragraph 2:

1. The policy to which this certificate relates satisfies the requirements of the relevant law applicable in Great Britain, Northern Ireland, the Isle of Man, the Island of Jersey, the Island of Guernsey and the Island of Alderney **(b)**

2. **(a)** the minimum amount of cover provided by this policy is no less than £5 million **(c)**

Signed on behalf of Zurich Insurance plc (Authorised Insurer).

Signature

S. Lewis

Stephen Lewis

Chief Executive Officer, Zurich Insurance plc (UK Branch)

Zurich Municipal is a trading name of Zurich Insurance plc
A public limited company incorporated in Ireland
Registration No.13460
Registered Office Zurich House, Ballsbridge Park ,Dublin 4 Ireland.
UK branch registered in England and Wales Registration No. . BR 7985
UK Branch Head Office
The Zurich Centre, 3000 Parkway,
Whiteley, Fareham, Hampshire PO15 7JZ

Authorised by the Central Bank of Ireland and subject to limited regulation by the Financial Services Authority. Details about the extent of our regulation by the Financial Services Authority are available

Notes

(a) Where the employer is a company to which regulation 3(2) of the Regulations applies, the certificate shall state in a prominent place, either that the policy covers the holding company and all its subsidiaries, or that the policy covers the holding company and all its subsidiaries except any specifically excluded by name, or that the policy covers the holding company and only the named subsidiaries.

(b) Specify applicable law as provided for in regulation 4(6) of the Regulations.

(c) See regulation 3(1) of the Regulations and delete whichever of paragraphs 2(a) or 2(b) does not apply. Where 2(b) is applicable, specify the amount of cover provided by the relevant policy.

Appendix G: Independent peer review approval

STAFFORDSHIRE UNIVERSITY

Faculty of Health Sciences

The Science Centre

Staffordshire University
Leek Road
Stoke-on-Trent ST4 2DF
United Kingdom

+44 (0) 1782 294000 (enquiries)
+44 (0) 1782 294643 (direct)

www.staffs.ac.uk

Date: 05 February 2014

To whom it may concern

Application for Independent Peer Review Approval

Researcher: **Ann Fausset**

Study Title: How do in-patients with acute mental health difficulties experience a mindfulness intervention on a hospital ward?

I can confirm that Staffordshire University supports this research project proposal being put forward by the above research project applicant, and that the University is willing to act as sponsor of the project if it received LREC approval.

Our support for this project takes account of the outcome of an independent peer review of its scientific merit undertaking within the University.

I can also confirm that the University has generic indemnity/insurance arrangements in place as stated on the attachment to this letter, that arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed, that arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts and that the duties of sponsors set out in the NHS Research Governance Framework for Health and Social Care will be undertaken in relation to this research.

Professor Nachi Chockalingam
Chair,
University Academic Ethics Sub-Committee

Appendix H: NHS proportionate review favourable opinion

NRES Committee East Midlands - Nottingham 1
The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Telephone: 0115 8839390

14 May 2014

Miss Ann Fausset
Trainee Clinical Psychologist
South Staffordshire and Shropshire NHS Foundation Trust
Mellor house, St.Georges Hospital
Corporation Street
Stafford
ST16 3DR

Dear Miss Fausset

Study title:	**How do in-patients with acute mental health difficulties experience a mindfulness intervention on a hospital ward?**
REC reference:	**14/EM/0207**
Protocol number:	**n/a**
IRAS project ID:	**139655**

The Proportionate Review Sub-committee of the NRES Committee East Midlands - Nottingham 1 reviewed the above application on 13 May 2014.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the REC Manager Ms Helen Wakefield, NRESCommittee.EastMidlands-Nottingham1@nhs.net.

Ethical opinion

- The sub-committee commented this study investigates in-patients with acute mental health issues perceptions of mindfulness.
- The sub-committee noted this is a study being carried out by a student as part fulfilment of a PhD in clinical psychology.
- The sub-committee commented the reasoning for conducting the study is because there has been limited research conducted in the area of use of mindfulness on a mental health in-patient ward, but the sub-committee also commented the study reads more like a service evaluation.

- The sub-committee noted that participants will be recruited from two different sites.
- The sub-committee noted ward staff at the study sites will be on hand to offer support to participants should this be needed.
- The sub-committee commented the Participant Information Sheet is adequate and acceptable.
- The sub-committee commented upon the box and statement on the Research Reply Form; 'I am not willing to take part' and commented this should not be on the form.
- The sub-committee commented the boxes on the Consent Form are misaligned and as a result obscure some of the text on the forms.
- The sub-committee confirmed that this study has no material ethical issues.

On behalf of the Committee, the sub-committee gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

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

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

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

Sponsors are not required to notify the Committee of approvals from host organisations.

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

1. The tick box and statement 'No I am not willing to take part in the study should be removed from the Research Reply Slip.

2. The boxes on the Consent Forms should be realigned in order not to obscure textual information.

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

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

Approved documents

The documents reviewed and approved were:

Document	*Version*	*Date*
Covering Letter		17 February 2014
Evidence of insurance or indemnity		16 July 2013
GP/Consultant Information Sheets	Capacity to Consent Form	17 February 2014
Interview Schedules/Topic Guides	1	17 February 2014
Investigator CV	Ann Fausset	
Investigator CV	Dr Ken McFadyen	17 February 2014

Letter from Sponsor		05 February 2014
Letter of invitation to participant	1 (Participants on the Ward)	17 February 2014
Letter of invitation to participant	Participants Discharged from the Ward	17 February 2014
Other: Peer Review		05 February 2014
Participant Consent Form	1	17 February 2014
Participant Consent Form: Participants Reply Slip	1	17 February 2014
Participant Information Sheet	1	17 February 2014
Protocol	1	17 February 2014
REC application		17 February 2014

Membership of the Proportionate Review Sub-Committee

The members of the Sub-Committee who took part in the review are listed on the attached sheet.

Statement of compliance

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

After ethical review

Reporting requirements

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

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.
information is available at National Research Ethics Service website > After Review

14/EM/0207 **Please quote this number on all correspondence**

We are pleased to welcome researchers and R & D staff at our NRES committee members'

training days – see details at http://www.hra.nhs.uk/hra-training/

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

Yours sincerely

pp C Hallwell

Reverend Keith Lackenby
Vice Chair

Email: NRESCommittee.EastMidlands-Nottingham1@nhs.net

Enclosures:	*List of names and professions of members who took part in the review*
	"After ethical review – guidance for researchers"
Copy to:	*Dr Liz Boath* *Ms Audrey Bright, South Staffordshire and Shropshire NHS Trust*

NRES Committee East Midlands - Nottingham 1

Attendance at PRS Sub-Committee of the REC meeting on 13 May 2014

Committee Members:

Name	*Profession*	*Present*	*Notes*
Reverend Keith Lackenby (Vice Chair)	Lay member	Yes	
Mr Jon Merrills	Barrister/Pharmacist	Yes	
Mr Robert Oldroyd	Lay member	Yes	

Also in attendance:

Name	*Position (or reason for attending)*
Ms Carolyn Halliwell	REC Assistant
Tad Jones	REC Assistant

NHS
Health Research Authority

NRES Committee East Midlands - Nottingham 1
The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Telephone: 0115 8839695

16 May 2014

Miss Ann Fausset
Trainee Clinical Psychologist
South Staffordshire and Shropshire NHS Foundation Trust
Mellor house, St.Georges Hospital
Corporation Street
Stafford
ST16 3DR

Dear Miss Fausset

Study title:	**How do in-patients with acute mental health difficulties experience a mindfulness intervention on a hospital ward?**
REC reference:	**14/EM/0207**
IRAS project ID:	**139655**

Thank you for your email of 16 May 2014. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 14 May 2014

Documents received

The documents received were as follows:

Document	*Version*	*Date*
Covering Letter		15 May 2014
Participant Consent Form	2	15 May 2014
Participant Consent Form: Participant Consent Form - Reply Slip	2	15 May 2014

Approved documents

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

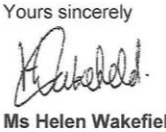
Document	*Version*	*Date*
Covering Letter		17 February 2014
Evidence of insurance or indemnity		16 July 2013

GP/Consultant Information Sheets	Capacity to Consent Form	17 February 2014
Interview Schedules/Topic Guides	1	17 February 2014
Investigator CV	Ann Fausset	
Investigator CV	Dr Ken McFadyen	17 February 2014
Letter from Sponsor		05 February 2014
Letter of invitation to participant	1 (Participants on the Ward)	17 February 2014
Letter of invitation to participant	Participants Discharged from the Ward	17 February 2014
Other: Peer Review		05 February 2014
Participant Consent Form	2	15 May 2014
Participant Consent Form: Participant Consent Form - Reply Slip	2	15 May 2014
Participant Information Sheet	1	17 February 2014
Protocol	1	17 February 2014
REC application		17 February 2014

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

14/EM/0207 **Please quote this number on all correspondence**

Yours sincerely



Ms Helen Wakefield
REC Manager

E-mail: nrescommittee.eastmidlands-nottingham1@nhs.net

Copy to: *Dr Liz Boath,*
Ms Audrey Bright, South Staffordshire and Shropshire NHS Trust

Appendix I: Local trust research and development approval

South Staffordshire and Shropshire Healthcare NHS
NHS Foundation Trust

A Keele University Teaching Trust

R&D Department
Block 7
St George's Hospital
Corporation Street
STAFFORD ST16 3AG

Telephone: 01785 221168

Our Ref: AB/R277

1 July 2014

Ms Ann Fausset
Trainee Clinical Psychologist
Trust HQ
Stafford ST16 3AG

Dear Ann

Study title: How do in-patients experience a mindfulness-based intervention?

We have considered your application for access to patients and staff from within this Trust in connection with the above study.

On behalf of the Trust and the Responsible Care Professionals within the Psychology Directorate have now satisfied themselves that the requirements for Research Governance, both Nationally and Locally, have been met and are happy to give approval for this study to take place in the Trust, with the following provisos:

- That all researchers coming into the Trust have been issued with either a letter of access or honorary contract by ourselves
- That you conform to the requirements laid out in the letters from the REC dated 14th and 16th May 2014, which prohibits any changes to the agreed protocol
- That you keep the Trust informed about the progress of the project at 6 monthly intervals
- If at any time details relating to the research project or researcher change, the R&D department must be informed.

Your research has been entered into the Trust database and will appear on the Trust website.

As part of the Research Governance framework it is important that the Trust are notified as to the outcome of your research and as such we will request feedback once the research has finished along with details of dissemination of your findings. You will be asked to provide a copy of the final report and receive an invitation to present final feedback via our research seminar series. To aid dissemination of findings, copies of final reports are placed on our Trust Website. To this end, please contact me towards the completion of the project to discuss the dissemination of findings across the Trust and a possible implementation plan.

If I can help in any other way please do not hesitate to contact me.

Yours sincerely

Ruth Lambley-Burke
R&D Manager

Cc: Dr Rachel Lucas, Director of Psychological Services, Trust HQ, Stafford

Appendix J: Coventry and Warwickshire research and development approval

Coventry and Warwickshire NHS Partnership Trust

National Institute for Health Research Clinical Research Network: West Midlands
Fourth Floor, Rotunda (ADA40014)
University Hospitals Coventry & Warwickshire NHS Trust
University Hospital
Clifford Bridge Road
Coventry
CV2 2DX

19 August 2014

Miss A Fausset
Trainee Clinical Psychologist
South Staffordshire and Shropshire NHS Trust
Mellor House
St Georges Hospital
Corporation Street
Stafford
ST16 3SR

Dear Miss Fausset

Project Title: How do in-patients experience a mindfulness-based intervention?
R&D Ref: PAR240614
REC Ref: 14/EM/0207

I am pleased to inform you that the R&D review of the above project is complete, and NHS permission has been granted for the study at Coventry and Warwickshire Partnership NHS Trust. The details of your study have now been entered onto the Trust's database.

The permission has been granted on the basis described in the application form, protocol and supporting documentation. The documents reviewed were:

Document	Version	Date
Research Protocol	2.0	11.08.2014
GP Letter: Capacity to Consent	1.0	17.02.2014
Interview Questions	1.0	17.02.2014
Letter of Invitation to Participants discharged from the ward	1.0	17.02.2014
Letter of Invitation to Participants on the ward	1.0	17.02.2014
Participant Consent Form: Reply Slip	2.0	15.05.2014
Participant Consent Form	4.0	18.08.2014
Participant Information Sheet	1.0	17.02.2014
Cover Letter	1.0	14.08.2014
R & D Form	139655/620392/14/957	04.06.2014

Appendix K: Participant information sheet

South Staffordshire and Shropshire Healthcare NHS
NHS Foundation Trust
A Keele University Teaching Trust

PARTICIPANT INFORMATION SHEET

Title of Project: The experience of in-patients following a mindfulness intervention

Name of Researcher: **Ann Fausset**

I would like to invite you to take part in this research study. Before you decide, I would like you to understand why the research is being done and what it would involve for you. **I will go through the information sheet with you and answer any questions you have.** I would suggest this should take about 15 minutes. Please talk to others about the study if you wish. Ask me if there is anything that is not clear.

The purpose of the study

Mindfulness has been a focus of research in the field of health care for the last few decades and has been found to be a useful exercise for people with both mental and physical difficulties. However currently little research has been conducted within an in-patient setting. It is the aim of this research to explore the experience of in-patients following a mindfulness-based sessions. It is hoped that the findings of this study will add to the current literature in the field.

Why have I been invited to participate?

You have been invited to participate in this study as you have either chosen to take part in the mindfulness-based group on the ward or individual mindfulness sessions on the ward. All patients who are taking part in the mindfulness-based interventions on the ward will be invited to take part in this research.

Do I have to take part?

It is up to you to decide whether to join the research. I will describe the research and go through this information sheet. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. This would not affect the standard of care you receive. However, following data analysis it will not be possible to withdraw.

What will happen to me if I take part?

Following the mindfulness-based sessions, you will attend an interview with the researcher, this will last approximately one hour. The interview will take place approximately 3 weeks after you have attended the mindfulness sessions. If you are on the ward at this time the interview will take place in a private room on the ward or if you have been discharged at a suitable location within the community. The interview will be audio-taped. This tape will be transcribed and used in the data analysis.

Research method

The research is interested in participants' experience of mindfulness, therefore a research method will be used that allows the interviews of the participants' to be analysed. This will allow for an understanding of the experiences of the group of participants.

What are the possible risks of taking part?

Mindfulness is about connecting with your current experiences without judgment through moment-by-moment awareness. This process may cause some discomforting feelings. If you experience any feelings of distress you can speak to your allocated support worker. Also if you feel you need further support the group facilitator will be available to speak to on the ward.

What are the possible benefits of taking part?

I cannot promise the study will help you but the information we get from the study will hopefully contribute to the literature in the field and may help people with acute mental health difficulties manage their distress.

What are the arrangements after the study has completed?

Following your participation in the study, you are able to continue to attend Mindfulness sessions on the ward if you choose to.

Will my taking part in the study be kept confidential?

Yes. Ethical and legal practice will be followed and all information about you will be handled in confidence. The details are included in Part 2.

Part 2

What if relevant new information becomes available?

If the study is stopped for any reason, you will be told and your continuing care will be arranged.

What will happen if I don't want to carry on with the study?

You can withdraw from the study and your data will be destroyed and not used in the research. This is possible up until the data analysis which is expected to take place July 2014, at this time your data will still need to be used in the research.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions (tel: 01782 295785 or email f027426b@student.staffs.ac.uk). If you remain unhappy and wish to complain formally, you can do this through the NHS complaints procedure.

Will my taking part in this study be kept confidential?

The procedures for handling, processing, storing and destroying your data match the Caldecott principles and appropriate legislation.

- Your data will be collected during an interview using an audio recorder
- Your data will be stored securely on an encrypted memory stick and/or encrypted and password protected laptop.
- You will be given a unique participant number once the consent forms have been completed and from then on your name will not be used in the research
- Personal information will be on your consent form. This will be stored in a locked cabinet on the ward which only the researcher and research supervisor will have access to. Subsequently this form will be stored in a locked cabinet at Staffordshire University, which may be viewed by regulatory authorities for audit purposes.
- Following the University of Staffordshire policies, your data will be stored securely for 10 years, after which your data will be destroyed.
- It is however possible if you attend an interview on the ward that other participants on the ward may see you go to your interview.

What will happen to the results of the research study?

The results of the study are intended to be published in a journal. You will not be identified in any report and/or publication. You will also be given a summary of the findings. Please include an address on the consent form of where you would like this information to be sent.

Who will review the study?

All research in the NHS is looked at by an independent group of individuals, called a Research Ethics Committee, to protect your interests. This study has been reviewed and approved by Staffordshire University peer review panel.

Further information and contact details

For general information about the research you can contact the Clinical Psychologist available on the ward.

For specific information about the research you can contact the researcher, Ann Fausset, telephone: 01782 295785 or email f027426b@student.staffs.ac.uk

For advice as to whether you should participate you can speak to your personal support worker, who is available on the ward.

If you are unhappy with the study you can contact the researcher Ann Fausset, Dr Rachel Lucas or the Patient Advice and Liaison Service (PALS) on 01785 221469.

Appendix L: Capacity to consent

South Staffordshire and Shropshire Healthcare NHS
NHS Foundation Trust
A Keele University Teaching Trust

Confirmation of capacity to consent to the research

Study title: The experience of in-patients following a mindfulness intervention

Researcher: Ann Fausset

I have assessed the following patient

_____ and can confirm that they do have capacity to take part in the research.

_____ _____

Consultee's name and staff grade Date

_____

Consultee's signature

Appendix M: Reply slip

South Staffordshire and Shropshire Healthcare NHS
NHS Foundation Trust
A Keele University Teaching Trust

Research reply slip

Study title: The experience of in-patients following a mindfulness intervention

Researcher: Ann Fausset

I have read the information contained in the letter and information sheet about the above study, and:

☐ Yes I am willing to take part in the study

_____ _____

Participant's name Date

_____

Participant's signature

Please contact me on at the below address

_____

_____

_____

_____

My contact telephone number is

_____

Appendix N: Consent form

South Staffordshire and Shropshire Healthcare NHS
NHS Foundation Trust

A Keele University Teaching Trust

Patient Identification Number for this trial:

CONSENT FORM

Title of Project: The experience of in-patients following a mindfulness intervention

Name of Researcher: **Ann Fausset**

Please initial all boxes

1. I confirm that I have read and understand the information sheet dated **15/05/2014** (version **2**) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

3. I understand that relevant sections of my medical notes and data collected during the study, may be looked at by the researcher, from the NHS Trust, where it is relevant to my taking part in this research. I give permission for this individual to have access to my records.

4. I agree to the interview being audio recorded and for the data to be transcribed by the researcher.

5. I agree to take part in the above study.

If you wish to be sent a summary of the research findings please leave either a contact postal address or an email address in the space provided below:

_____
_____
_____

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person	Date	Signature

Appendix O: Letter to Participant discharged from the ward

South Staffordshire and Shropshire Healthcare NHS
NHS Foundation Trust

A Keele University Teaching Trust

Mellor House
St.Georges Hospital
Corporation Street
Stafford
ST16 3SR

Letter of invitation to participants discharged from the ward

Study title: The experience of in-patients following a mindfulness intervention

Dear _____

My name is Ann Fausset. I am a clinical psychology doctorate student at the University of Staffordshire. I am conducting this research as a requirement of my course and I would like you to participate.

I am studying in-patients' experience of a mindfulness-based sessions. If you decide to participate you will be asked to attend an interview about your experiences of the mindfulness sessions that you attended whilst you were on the in-patient ward. The interview will take place in the community at a suitable location such as an NHS site or your home address. The interview should last about 60 minutes. The interview will be audio taped so that I can accurately reflect what we discuss. The tapes will only be reviewed by the research team who will transcribe and analyses them. Following this, the data will be securely stored for a period of 10 years and then destroyed.

Participation is confidential. The study information will be kept in a secure cabinet on the ward, whilst the study is taking place. Following completion of the study the information will be secured at Stafford University. The results of the study may be published or presented at professional meetings; however your identity will remain confidential.

Taking part in the study is your decision. You do not have to take part in the study if you do not want to. You may also leave the study at any time.

I am happy to answer any questions you may have about the study. You may contact me on tel: 01782 295785 or email: f027426b@student.staffs.ac.uk

Thank you for your time. If you would like to participate please also read the information sheet and then complete the reply slip below and return it using the pre-paid envelope enclosed. I will then contact you in due course to discuss your participation.

With kind regards

Ann Fausset
Trainee Clinical Psychologist
Lead researcher
Email: f027426b@student.staffs.ac.uk

Appendix O: Capacity to consent form

Appendix P: Letter to Participant on the ward

South Staffordshire and Shropshire Healthcare NHS
NHS Foundation Trust

A Keele University Teaching Trust

Mellor House
St. Georges Hospital
Corporation Street
Stafford
ST16 3SR

Letter of invitation to participants on the ward

Study title: The experience of in-patients following a mindfulness intervention

Dear _____

My name is Ann Fausset. I am a clinical psychology doctorate student at the University of Staffordshire. I am conducting this research as a requirement of my course and I would like you to participate.

I am studying in-patients' experience of a mindfulness-based sessions. If you decide to participate you will be asked to attend an interview about your experiences following the mindfulness sessions that you have attended. The interview will take place either on the ward in a private room or in the community at a suitable location, should you have been discharged. The interview should last about 60 minutes. The interview will be audio taped so that I can accurately reflect what we discuss. The tapes will only be reviewed by the research team who will transcribe and analyses them. Following this, the data will be securely stored for a period of 10 years and then destroyed.

Participation is confidential; however it is possible that other participants might see you going to the interview if this takes place on the ward. The study information will be kept in a secure cabinet on the ward, whilst the study is taking place. Following completion of the study the information will be secured at Stafford University. The results of the study may be published or presented at professional meetings; however your identity will remain confidential.

Taking part in the study is your decision. You do not have to take part in the study if you do not want to. You may also leave the study at any time.

I am happy to answer any questions you may have about the study. You may contact me on tel: 01782 295785 or email: f027426b@student.staffs.ac.uk

Thank you for your time. If you would like to participate please also read the information sheet and then complete the reply slip below and either post it in the reply box on the ward or give it to your mindfulness practitioner if you are attending individual mindfulness sessions.

With kind regards

Ann Fausset
Trainee Clinical Psychologist, Lead researcher
Email: f027426b@student.staffs.ac.uk

Appendix Q: Minor amendment

NHS
Health Research Authority

NRES Committee East Midlands - Nottingham 1
Royal Standard Place
Nottingham
NG1 6FS
Tel: 0115 8839425

18 August 2014

Miss Ann Fausset
Trainee Clinical Psychologist
South Staffordshire and Shropshire NHS Foundation Trust
Mellor house, St.Georges Hospital
Corporation Street
Stafford
ST16 3DR

Dear Miss Fausset

Study title:	**How do in-patients with acute mental health difficulties experience a mindfulness intervention on a hospital ward?**
REC reference:	**14/EM/0207**
Protocol number:	**n/a**
Amendment number:	**Minor Amendment 18.08.2014**
Amendment date:	**17 August 2014**
IRAS project ID:	**139655**

Thank you for your letter of 17 August 2014, notifying the Committee of the above amendment.

The Committee does not consider this to be a "substantial amendment" as defined in the Standard Operating Procedures for Research Ethics Committees. The amendment does not therefore require an ethical opinion from the Committee and may be implemented immediately, provided that it does not affect the approval for the research given by the R&D office for the relevant NHS care organisation.

Documents received

The documents received were as follows:

Document	*Version*	*Date*
Notice of Minor Amendment [Email from Ann Fausset]		17 August 2014
Other [Cover letter]	1	14 August 2014
Participant consent form	3	14 August 2014
Research protocol or project proposal	2	11 August 2014

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for

Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

14/EM/0207:	Please quote this number on all correspondence

Yours sincerely

Ms Penelope Gregory
REC Manager

E-mail: NRESCommittee.EastMidlands-Nottingham1@nhs.net

Copy to: *Ms Audrey Bright, South Staffordshire and Shropshire NHS Trust*
Dr Liz Boath

Appendix R: Cover letter

Coventry and Warwickshire NHS Partnership Trust

Caludon Centre
Clifford Bridge Road
Walsgrove
Coventry
West Midlands
CV2 2TE

Cover letter

Study title: The experience of in-patients following a mindfulness intervention

Dear _____

I am writing to you as you recently you attended some mindfulness based sessions that took place at the Caludon centre, Coventry. Research is currently taking place that is interested in understanding people's experience of mindfulness whilst they have been an inpatient. I have enclosed an invitation letter, an information sheet and a reply slip from the researcher Ann Fausset, Trainee clinical psychologist. Should you wish to take part following reading the information, please complete and return the reply slip in the pre-paid envelope enclosed. If you would like to discuss the research further, please contact the researcher Ann Fausset on the contact details within the invitation letter.

With kind regards,

John Homer
Cognitive Behavioural Therapist
Caludon Centre, Coventry
Tel: 024 7696 8100

Appendix S: Interview schedule

Interview Questions

1. What led you to take part in the mindfulness group?

(What brought this about? Can you tell me how you felt about mindfulness at that time?)

2. What was the mindfulness group like?

(Probe: What were some of the exercises like? There was an exercise on *focusing on an object* what was that like? What was your experience of the exercises whilst you were on the ward?)

3. What was it like engaging in mindfulness as part of a group/ within individual sessions?

4. Tell me about a time when you have used mindfulness since the group.

(Probe: what made you think of using that? What was it like to use it? What did it mean to you?)

5. What has experiencing mindfulness meant to you?

(Probe: what has it been like for you?)

6. How did things compare on the ward after you engaged with the mindfulness sessions?

(Probe: Did you notice any differences on the ward once you started the mindfulness sessions?)

7. Has mindfulness affected the way you think and/or feel?

(Probe: Do you think about things any differently now compared to before you experienced mindfulness?)

8. What is it like now having mindfulness in your life?

(Probe: How did that affect you? What did you notice? How does it compare now?)

9. How do you see mindfulness in your future?

(Probe: What do you imagine things to be like with mindfulness in your life? How might mindfulness impact on your mental health in the future?)

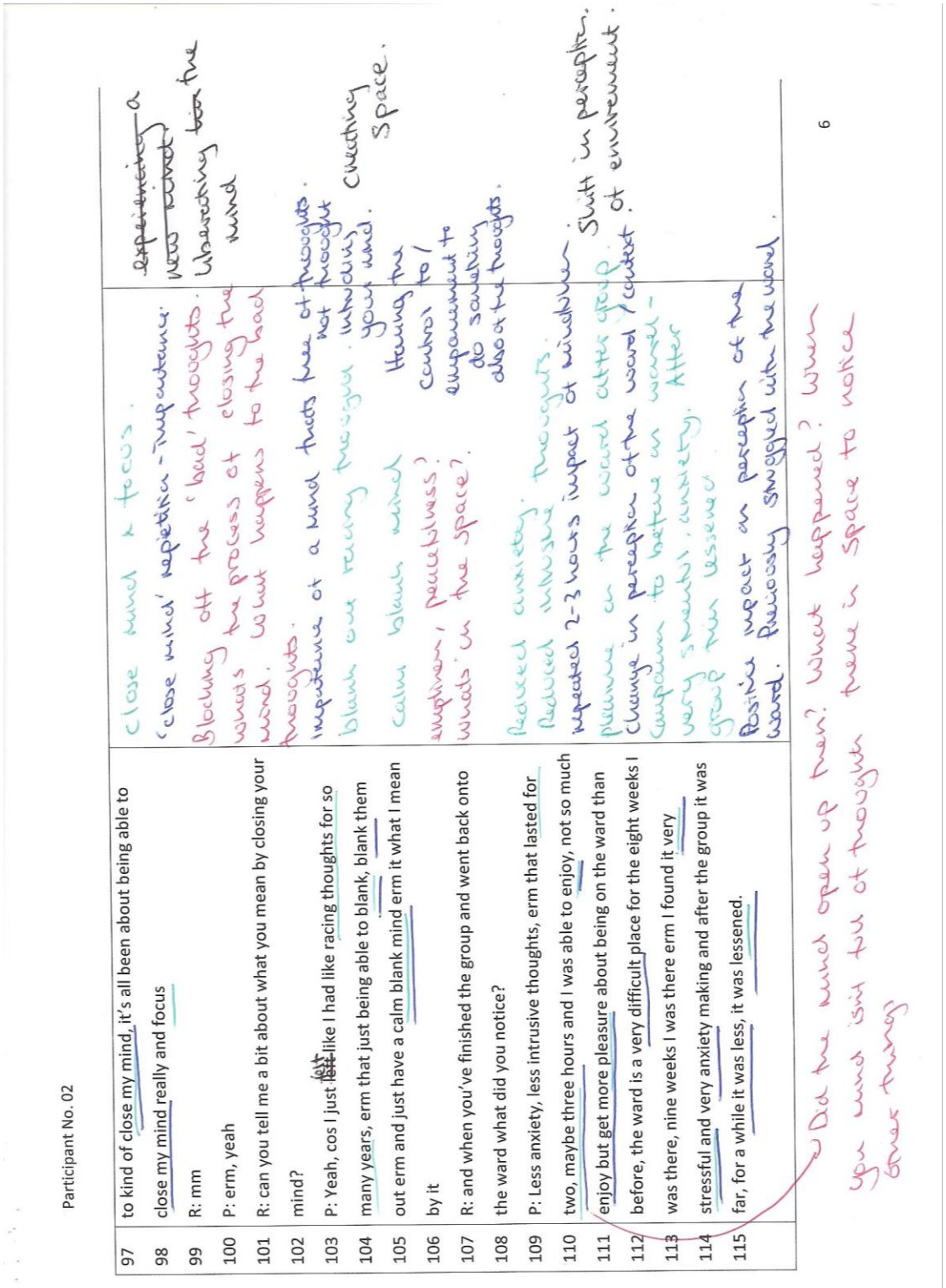
10. Is there anything else you would like to tell me about mindfulness that we haven't discussed so far?

Note: These questions may change based on the responses from participants

Appendix T: Guidelines for conducting IPA (Smith et al. 2009)

Step 1	Reading and re-reading the transcripts whilst listening to the audio recording and noting any reflections in the research journal.
Step 2	Line by line coding was completed with a three colour system for descriptive, linguistic and conceptual codes written in the second column.
Step 3	Emergent themes were then developed by identifying connections and patterns between the exploratory codes and written in the third column.
Step 4	Emergent themes were drawn together. This involved bringing the themes together visually into categories using a process of abstraction, subsumption, polarization, contextualization, numeration and function (Smith et al. 2009). Following this, superordinate themes were provided for each category of themes and the data was entered into a table in which the themes were linked back to the original data.
Step 5	The above process was repeated for each subsequent transcript.
Step 6	Patterns and connections were identified across the cases in which each table of themes were explored and synthesis and reorganisation of the themes lead to superordinate themes that were presented in a master table.

Appendix U: Examples of line by line coding



Participant No. 02

97	to kind of close my mind, it's all been about being able to	close mind & focus.	~~experiencing~~ a ~~new mind~~
98	close my mind really and focus	'close mind' repetition - importance.	
99	R: mm	Blocking off the 'bad' thoughts.	Liberating ~~the~~ the mind
100	P: erm, yeah	whats the process of closing the	
101	R: can you tell me a bit about what you mean by closing your	mind. What happens to the bad	
102	mind?	thoughts.	
103	P: Yeah, cos I just ~~left~~ felt like I had like racing thoughts for so	importance of a mind thats free of thoughts.	
104	many years, erm that just being able to blank, blank them	blank out racing thoughts. not thought intruding your mind.	Creating space.
105	out erm and just have a calm blank mind erm it what I mean	calm blank mind	Having the
106	by it	emptiness, peacefulness?	control to /
107	R: and when you've finished the group and went back onto	whats in the space?	empowerment to do something
108	the ward what did you notice?		also of the thoughts.
109	P: Less anxiety, less intrusive thoughts, erm that lasted for	Reduced anxiety.	
110	two, maybe three hours and I was able to enjoy, not so much	Reduced intrusive thoughts.	
111	enjoy but get more pleasure about being on the ward than	repeated 2-3 hours impact of mindfulness.	Shift in perception.
112	before, the ward is a very difficult place for the eight weeks I	pleasure on the ward after group.	of environment.
113	was there, nine weeks I was there erm I found it very	Change in perception of the ward / context.	
114	stressful and very anxiety making and after the group it was	Comparison to before on ward -	
115	far, for a while it was less, it was lessened.	very stressful, anxiety. After group this lessened	
		Positive impact on perception of the ward. Previously struggled with the ward.	

Did the mind open up then? What happened? When you mind isn't full of thoughts there is space to notice other things

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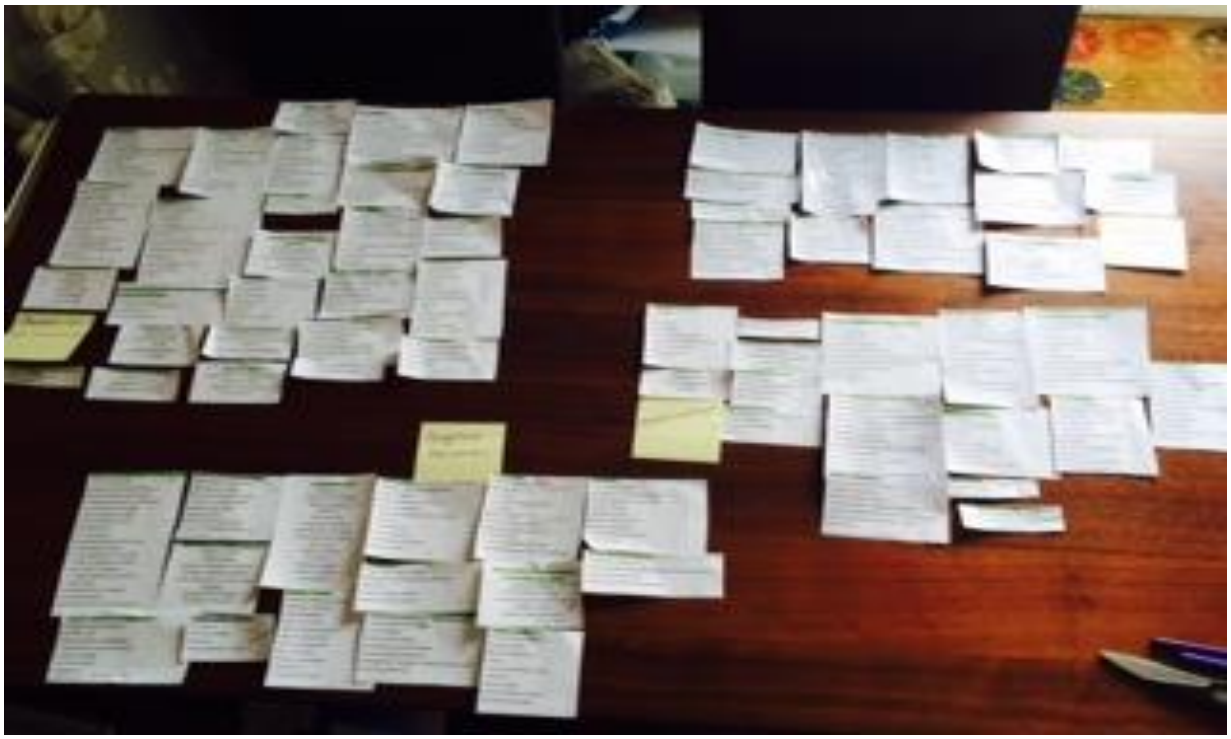
Appendix V: Examples of analysis of cases

Table of superordinate themes for participant two

Themes	Page/ line	Key words
Dichotomous		
Habitual behaviour	12/213	History of drink and drugs
Value of change	13/245	means the world to me
Process of change	5/96	then by the third week
stability	5/92	anchor your thoughts
Suffering		
Fear of leaving comfort zone	4/60	I'd be dealing with it since I was 17
Relentless experience of distress	13/246	I was just fighting it
Self-criticism	8/141	Beating myself up
Mentalisation		
Emotional state	1/16	Anxiety was always lower after the group
Emotional awareness	7/123	Created this very high anxiety
relaxation	8/135	More relaxed
Cognitive flexibility		
Attention shifting	10/186	Bring your thoughts to the… breath
Differentiating	13/235	What's the medication and what's not
Change in perception of thoughts	2/36	Thoughts were less intrusive
Change in relation to thoughts	9/156	Let them go sometimes
Shift in perception of environment	6/111	More pleasure on the ward than before
Flexibility	16/301	Can use it in public or…by yourself
Struggling with thoughts	9/159	Found it very difficult… thought I'd be blamed

Self-enhancement		
Determination in continual practice	3/43	Couldn't focus…finding it easier
Developing skills	11/203	Better…more I use them
Developing understanding	12/227	Become more attuned
Acquiring skills	3/54	Realising that I was learning
Future oriented	4/72	Able to plan
Self-compassion	8/144	With compassion
Attachment		
Developing a bond with the group	12/219	Remember the group fondly
Group engagement	15/274	Group work was good
Group dynamics	16/292	Not in tune with me
Bonding	14/272	Being in a group…in a circle
familiarising	14/269	Stressful begin…final session…calming
Empowerment		
Liberating	4/74	Without being stuck on something
Reflecting	3/40	I remember
creating space	6/105	Calm blank mind
focus the mind	6/98	Close my mind…focus
Accessibility	16/300	Can use it anywhere
Empowerment	11/197	I can use to help me
Locus of control		
External focus	2/30	Like drug therapy
External locus of control	7/127	They would under medicate me
Process of internal focus	3/42	Close our eyes…focus
Disempowerment on the ward	7/124	I got sectioned

Appendix X: Example of diagrammatic analysis across cases