Implementing a flexible psychotherapeutic approach (Method of Levels) in an

acute inpatient setting: feasibility and acceptability

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Thesis declaration form

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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Overview

There has been a call for greater psychological provision for people with complex mental health problems, reflected in government initiatives and access and waiting time standards. It is, however, difficult to implement treatment according to research protocols and standards within the realities of NHS service delivery.

Part 1 is a review of the treatment characteristics of studies investigating the effectiveness of Cognitive Behavioural Therapy for psychosis (CBTp), for the purpose of answering whether National Institute for Health and Care Excellence (NICE) guidelines can be delivered. Nine studies were reviewed; there was no uniformity in the number, frequency, length of sessions, duration of treatment, or where and by whom CBTp was delivered. No studies implemented their intended number of sessions, highlighting the difficulty of implementing structured treatment protocols. The quality of reporting within studies, limitations of the review and clinical implications are discussed alongside suggested avenues for further research.

Part 2 is a mixed methods study investigating the feasibility of sessional therapists implementing a flexible psychotherapeutic approach (Method of Levels) in an acute inpatient mental health setting. Feasibility was assessed through attendance patterns of participants, usage of therapeutic resources offered by therapists, and the ability of therapists to adhere to the Method of Levels (MOL) approach following training and with ongoing supervision. Acceptability was explored qualitatively through interviews with patients who had attended MOL session(s) and by recording attendance patterns of participants. The data indicated that it is feasible to implement a flexible, possibly

standalone approach in an inpatient setting, but that using sessional therapists would be an inefficient use of resources. Qualitative analysis indicated that thirteen of fifteen participants had a satisfactory experience of help that was humanising. It is difficult to tell whether participant experience would have been different with another therapeutic model. Results are used to make recommendations for service delivery and to highlight research opportunities.

Part 3 is a reflective discussion regarding the influence of the researchers' background, values and beliefs throughout the research process. The discussion focuses on the implementation stage and the analysis stage. It concludes with suggestions for areas of future research.

Impact statement

Part 1 of this thesis calls into question the blanket recommendation for sixteen sessions of CBT for psychosis (CBTp) as recommended by the National Institute of Health and Care Excellence (NICE). The review highlights that there is poor reporting within randomised controlled trials (RCTs) investigating the effectiveness of individual CBTp, and great variation in the focus, desired outcomes and treatment characteristics within the literature. In addition, it questions whether reviewed studies who claim to be investigating 'effectiveness' are actually investigating efficacy. It highlights the difficulty in implementing a structured treatment protocol in NHS settings and indicates that the NICE guidelines are simplistic and not feasible to implement.

At an academic level, this review indicates that studies need to employ clearer reporting of treatment characteristics before conclusions regarding the feasibility and effectiveness of the treatment can be made. If there were clearer reports, meta-analyses could follow on from this research investigating whether treatment characteristics impact on effectiveness, and contribute to the literature regarding CBTp. At a public health level, the review encourages NICE guideline authors to include more up-to-date research on treatments for psychosis and to take into account the complexities of psychosis when considering whether a blanket recommendation across settings is feasible and indeed optimal. This could have wider implications for the care patients receive in different settings, and the standards to which services are held, which has further implications for funding. The review contributes to the literature regarding treatments for psychosis and could, with further research, result in a more beneficial treatment protocol.

Part 2 of this study investigates the implementation of a flexible psychotherapeutic approach (MOL) by sessional therapists in acute inpatient care. The study indicated that the approach was feasible and acceptable, but that using sessional therapists would not be a financially advisable recommendation. Larger scale research is required to build on the evidence base behind MOL, and comparison to other therapeutic input would help to elucidate what of the participants experience was down solely to the approach. The research showed that some participants had a worthwhile and humanising experience of therapy and adds to previous literature regarding the NHS and the importance of compassionate care.

The implications of the research could reach individuals locally through clinical practice, in dissemination of the findings to the hospital in which the research took place, but could be disseminated nationally and with particular focus in educating commissioners and policy makers. If funding was allocated for the therapeutic approach to be adopted more widely, more patients could have a satisfactory experience of care and a positive experience of therapy. Though implementation was on a small scale in this project, and continuity across inpatient and outpatient care was not always possible, future implementation designs could take into account this important factor. Collaboration with academics could build on the literature behind the Method of Levels and inpatient psychological input.

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Part 1: Literature Review

Under what conditions can the NICE guidelines Cognitive Behavioural Therapy for

Psychosis be implemented?

Abstract

Aims: This review examined the treatment characteristics of randomised controlled trials (RCTs) investigating the effectiveness of individual Cognitive Behavioural Therapy for psychosis (CBTp). This was for the purpose of understanding if it possible to deliver National Institute for Health and Care Excellence (NICE) recommendations.

Method: Nine studies were identified from three electronic databases (CINHAL, MEDLINE, and PsycINFO), from Cochrane reviews, and from meta-analyses. Studies satisfied inclusion criteria relating to: i) research design (RCT), ii) population (United Kingdom), iii) problem (psychosis), iv) intervention characteristics (individual CBTp) and v) outcome (psychosis-related).

Results: There is great variation in the focus of studies, desired outcomes, and mode of delivery of the intervention. The treatment characteristics breakdown demonstrates no uniformity in terms of number, frequency, or length of sessions, nor duration of treatment. The setting and by whom CBTp was delivered varied across studies. No studies succeeded in delivering the intended number of sessions.

Conclusions: The review found variation in treatment characteristics and, due to limited reporting, it is difficult to draw conclusions regarding the best way to implement CBTp. The review highlighted the difficulty in implementing a structured treatment protocol in NHS settings, and indicated that a blanket recommendation of sixteen sessions of CBTp is simplistic, failing to address both the complexities of psychosis, and the realities of service delivery in the NHS. Further research looking at the feasibility of implementing treatments for psychosis is needed, with clearer reporting of treatment characteristics.

Introduction

Psychosis and NICE guidelines

The most recent statistics reported by Public Health England state that over 170,000 people in England had a diagnosis of psychosis in 2015, with approximately 91,000 of those under the care of specialist mental health teams (Public Health England, 2016). The treatment recommended by the National Institute for Health and Care Excellence (NICE, 2014) for psychosis is to offer those with first episode psychosis oral medication in conjunction with psychological interventions (family interventions and individual cognitive behavioural therapy). NHS England set the access and waiting time standard at 50 per cent of people experiencing their first episode of psychosis to be assessed and engaged in a NICE-recommended treatment package within two weeks (DOH & NHS England, 2014).

CBTp is recommended by NICE (2014) to be delivered on a one-to-one basis, over at least sixteen planned sessions following a treatment manual. The treatment manual must enable patients to establish links between their thoughts, feelings, actions and symptoms, and to re-evaluate their perceptions or reasoning as they relate to their symptoms. Additionally, the manual must include at least one of the following components: i) monitoring of own thoughts, feelings, behaviours with respect to symptoms; ii) promoting alternative ways of coping with the target symptom; iii) reducing distress; and/or iv) improving functioning.

CBT for psychosis evidence base

Much worldwide research has been conducted into the efficacy of CBT for psychosis, with mixed results. As it is a NICE-recommended individualised treatment, one would assume that there is a robust evidence base behind the recommendation. A number of meta-analyses have been undertaken, analysing studies from as early as 1978. Many of these meta-analyses support the efficacy of CBT in reducing the symptoms of psychosis (Sarin, Wallin & Winderlov, 2011; Turner, van der Gaag, Karyotaki & Cuijpers, 2014; Wykes, Steel, Everitt & Tarrier, 2008). However, in more recent meta-analyses, doubt has been cast on the methodological rigour of earlier studies. Velthorst et al. (2015) put forward that successes reported in older, lower quality studies into CBTp, were not replicated in more recent studies. Jauhar et al. (2014) comment that as so few meta-analyses and reviews have taken into account quality ratings for the studies, unreliable conclusions have been drawn. Lynch, Laws and McKenna (2010) put forward that when stricter methodological rigour was applied to their meta-analysis, CBTp was not found to be efficacious in reducing symptoms or preventing relapse. Wykes et al. (2008) put forward that studies without masked group allocation are likely to have inflated effect sizes. Lynch et al. (2010) make the interesting point that when reviewed studies approximate a methodology more comparable to drug treatment trials, namely using double-blind placebo controlled trials, the findings are not in line with the favourable conclusions of meta-analyses, editorials, reviews and government documents.

Availability of therapy in United Kingdom (UK)

Regardless of the conflicting evidence base, availability of therapy for people

with severe mental health problems is limited. In the National Audit of Schizophrenia (2014), it was found that just 39 per cent of service users with psychosis had ever been offered CBT, and only 19 per cent had ever been offered family intervention (HCIP and The Royal College of Psychiatrists, 2014). Mind (2013) conducted focus groups and carried out a survey of more than 1,600 people with mental health problems who had used psychological therapies. They reported that of people with a diagnosis of schizophrenia, bipolar disorder or personality disorder, less than 30 per cent who were referred to psychological therapies accessed these within three months, and only around 33 per cent of patients who had accessed therapy felt they had had as many sessions as they needed. In a survey of over 1,800 UK therapists, 65 per cent felt that their service did not provide appropriate access to psychological therapies for people with severe mental health problems (Mind, 2013).

In conjunction with limited service offerings, there are practical barriers to delivering sixteen sessions of CBTp. Inpatient hospital stays are often less than sixteen weeks - in 2016 the average length of stay on an acute adult ward was 33 days (NHS Benchmarking Network, 2016). Psychological provision within mental health hospitals is so stretched that multiple therapy sessions per person per week are unlikely to be feasible, and may not be acceptable to patients. The Improving Access to Psychological Therapies (IAPT) programme was originally funded to free up specialist resources for secondary care. In reality however, IAPT services have replaced rather than added to existing services. There have been cuts to non-IAPT therapy funding resulting in greater difficulty for people with complex problems to get psychological treatment (IAPT, 2012, cited in Mind, 2013) and even some Early Intervention in Psychosis (EIP) teams cannot

provide CBTp. The Royal College of Psychiatrists audited the provision of psychological therapies offered by EIP services nationally in 2016 (HQIP & The Royal College of Psychiatrists, 2016). The audit considered CBTp to be 'offered' only if the service had the capacity to deliver sixteen sessions with appropriately trained and supervised therapists and offer therapy within the first six months of being put on EIP teams' caseload. Of the 2,465 patients accepted onto an EIP caseload, just 41 per cent were offered CBTp. Forty-three per cent of those not offered CBTp were in services where sixteen sessions of CBTp was unavailable to them. Even in services where CBTp was available, 49 per cent of patients were offered CBTp (HQIP & The Royal College of Psychiatrists, 2016). Even IAPT services specifically intended for people with severe mental illness (IAPT-SMI) have reported difficulties in delivering NICE recommendations and have reported therapy as 'completed' if participants attend just five sessions (Jolley et al. 2015). The realities of psychological provision in the NHS suggests that recommending sixteen sessions of treatment to 50 per cent of people diagnosed with psychosis is not feasible for patients or services under current funding and service design.

NICE treatment guidelines

A key aspect for implementing the NICE recommendations, and a focus for this review, is the recommendation for sixteen sessions of CBTp. In the NICE guidelines for treatment and management (National Collaborating Centre for Mental Health, 2014), the authors conducted a meta-analysis of the clinical effectiveness of CBTp studies of varying lengths and formats (group and individual). They concluded that individual, but not group, CBTp when added to standard care reduces the rate of future hospitalisation

of patients with schizophrenia. They conducted an economic analysis of the cost of delivering CBT, taking into account the cost of re-hospitalisation. As group CBTp was found to be ineffective, when said economic analysis was undertaken to determine the cost of CBT, an estimate of 'resource use' across the studies looking at individual CBTp was used. This was based on the average resource use reported in just five studies (Gumley, O'Grady, McNay, Reilly, Power & Norrie, 2003; Lewis et al., 2002; Tarrier, Yusupoff, Kinney, McCarthy, Gledhill, Haddock & Morris, 1998; Turkington, Kingdon & Turner 2002), one of which was a non-UK population (Bach & Hayes, 2002). This average was sixteen individually-delivered, 60 minute sessions.

The conclusion of this economic analysis was that the average 'resource use' of sixteen, hourly sessions of individual CBTp was considered economically beneficial when authors considered the cost of implementing sixteen sessions of CBT compared with the cost of the additional future hospitalisation of patients with psychosis without CBT. Thus, this became the recommended treatment by NICE in conjunction with oral anti-psychotic medication.

The focus of the review

As the justification for sixteen sessions of CBTp was based on an economic analysis, an important question raised is whether sixteen sessions of individual CBTp is the optimal intervention for treating psychosis. Feasibility, as defined by Peters, Adam, Alonge, Agyepong & Tran (2013) is the extent to which an intervention can be carried out in a particular setting or organisation. The feasibility of implementing sixteen sessions of CBTp was not a focus of the studies analysed by the National Collaborating

Centre for Mental Health (2014) and it is questionable whether services should be held accountable to delivering this standard considering how different service delivery is across the NHS.

As a result, the current review will focus on treatment characteristics of the interventions delivered in randomised controlled trials (RCTs) in the UK so as to address whether the studies would indicate that sixteen sessions are possible. These 'treatment characteristics' include what was delivered, how many sessions were taken up, how often, by whom, session duration, treatment duration and in what setting. Due to the complexities of psychosis and broad nature in which CBT can be implemented, many studies focus on specialist groups (such as those with treatment-resistant psychosis), or use CBT with patients with psychosis, but not in order to specifically target psychotic symptoms. The purpose of this review was to investigate the literature exclusively with regards individual CBTp and the most representative cross-section of the psychosis population.

Previous reviews

Previous Cochrane reviews have focused on the use of CBT in comparison to other treatments for psychosis. These consist of CBT versus pharmacological treatments for schizophrenia (Jones, Cormac, Campbell, Meaden & Hacker, 2009); CBT versus standard care for schizophrenia (Jones, Campbell, Cormac, Hacker & Meaden, 2009); CBT versus other psychosocial treatments for schizophrenia (Jones, Hacker, Cormac, Campbell, Meaden & Irving, 2011, 2012); and CBT (brief versus standard duration) for schizophrenia (Naeem, Farooq & Kingson, 2015). All reviews looked at treatments,

where they defined the CBT treatment components, any 'other' psychosocial intervention (where appropriate) and listed the outcome measures used. Also defined in the reviews, a sensitivity analysis was performed between studies which employed both qualified and unqualified CBT therapists.

None of the reviews looked in detail at the intervention characteristics in terms of how many sessions were delivered, how often, by whom, session duration, treatment duration, or in what setting, when making comparisons to other treatments. The current review is novel in its focus on treatment characteristics.

Aims of the review

This review aims to examine the treatment characteristics of RCTs investigating the effects of individual CBTp in order to answer whether CBTp can be delivered as per NICE guidelines (2014). These characteristics will be broken down into:

1. The CBT delivered.

2. Intensity and duration of treatment (the number, length, and frequency of sessions taken up and over what time-frame these sessions occurred).

3. Who delivered the intervention.

4. Where the intervention was delivered.

Method

A systematic literature review with a narrative synthesis was used. This approach was used due the suitability of adopting a textual approach to address the specific review question (Centre for Reviews and Dissemination, 2008).

Search methods for identification of studies

A computer-assisted search of PsycINFO, MEDLINE and CINAHL was undertaken. Both thesaurus and text word searches were carried out, conducted with the following search terms.

Title/abstract search: Schizo* OR Schizophrenia OR exp SCHIZOPHRENIA OR Schizoaffective OR psychosis OR exp PSYCHOSIS

AND Title/abstract search: cognitive therapy OR cbt OR cognitive behavior therapy OR cognitive behavio*ral therapy OR exp Cognitive Therapy

AND Title/abstract search: random OR randomi*ed control trial OR clinical trial OR exp Clinical Trials.

The search in October 2017 yielded a total of 765 hits across the three databases. Alternative searching methods included looking at reference lists in relevant meta-analyses and examining Cochrane reviews which garnered another 104 studies. After duplicates were removed from all searches, the remainder were screened at title and/or abstract for relevance to the review questions. Thirty papers remained for full text screening; nine remained for narrative synthesis after the inclusion/exclusion criteria was applied. The screening process is described in more detail below.

Inclusion and exclusion criteria

Inclusion criteria

Studies chosen for review were selected on the basis of research design, population, problem, intervention characteristics and outcome (PICO; Richardson, Wilson, Nishikawa & Hayward, 1995). In this review, only the following were included:

- Papers written in English
- RCTs which included:
  - Adult participants with psychosis
  - UK population
  - Individual CBTp delivered by professionals trained in CBTp compared to treatment as usual (TAU) or any other type of therapy
  - Outcomes related to psychosis, such as psychotic symptom change or reduction in relapse or re-hospitalisation

Only RCTs were included as the review sought to focus on high quality studies with methodological rigor. Only studies carried out with a UK population and written in English were included as the review was in the context of the NICE guidelines applied in the NHS.

Exclusion criteria

The review sought to focus on the most representative cross-section of the psychosis population to whom the NICE guidelines would apply, rather than those needing more specialist treatment. Therefore, the following were excluded:

- Studies with participants requiring more specialist treatments, such as the resistant-to-treatment population

- Studies focussing on participants at high risk of developing psychosis

Studies focussing on participants at high risk of developing psychosis were excluded as the treatment reviewed is intended for patients already diagnosed. NHS services do not routinely provide help to people at risk and so treatment for this population would not reflect NICE guidelines implemented in the NHS.

Studies were also excluded on the following basis:

- Studies where the primary focus of the CBT treatment was not psychosis

- Group CBTp, or treatments that integrated individual CBTp with another established treatment as the main treatment (for example, CBT and Acceptance and Commitment Therapy)

- Studies which did not use CBTp specifically, despite a focus on psychosis (for example, CBT for worry in patients with psychosis)

Studies where individual CBTp was not delivered were excluded as the review sought to investigate the most representative use of the intervention in the NHS as recommended by NICE.

There was no exclusion based on setting or when the study was published.

Screening

In total, 869 studies were found. Figure 1 outlines the exclusion process using Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA; Moher, Liberati, Tetzlaff, Altman (2009).

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│ Database searching:     │   │ Alternative searching:  │
│ 106 psychinfo           │   │ 104 meta-analyses and   │
│ 323 medline             │   │ Cochrane reviews        │
│ 336 cinahl              │   │                         │
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        │ 25                       │      │ 9 non-UK pop             │
        │                          │      │ 4 not generic CBT        │
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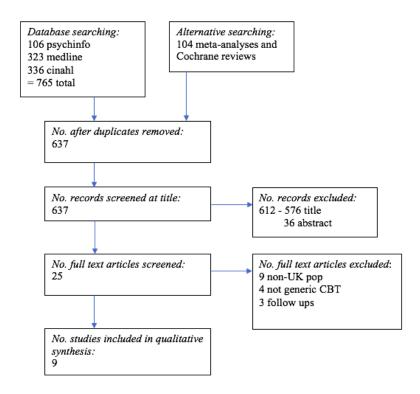
Figure 1. Process of study selection

After duplicates were removed from all searches, 637 studies remained to be screened at title and/or abstract for relevance. 612 studies were excluded at title and abstract screening, leaving a remaining twenty-five reports which potentially met the inclusion criteria.

Each paper was read in full and considered for inclusion by the author and the

supervisor; disagreement was resolved through discussion. Following application of the inclusion/exclusion criteria sixteen papers were removed: nine were found not to be based on UK populations; one did not assess CBT; one used cognitive therapy for command hallucinations which they described in the text as different from previous and generic types and models of CBT for psychosis; one was a pilot study that adapted the therapy used to focus on experience of developing psychosis and of hospitalisation, therefore making it more specialist; one used group CBT in their study; three were follow-up studies of those already included in the synthesis. This left a total of nine studies identified for selection, all of which were RCTs. Table 1 details the studies selected for review.

Analysis

The Clinical Trials Assessment Test (CTAM; Tarrier & Wykes, 2004) was used to assess the quality of studies reviewed. Scores for six of the studies were taken from the Wykes et al. (2008) meta-analysis. In 18 studies, independent ratings by 2 of the Wykes et al. authors showed good blind inter-rater agreement of 0.96. The scale showed adequate internal consistency (Cronbach a = .697). Three studies published subsequent to the Wykes review were scored by the reviewer, and the six studies taken from Wykes et al. (2008) re-rated to check for consistency. Good inter-rater agreement of 0.83 was found for the six studies. The maximum score for the CTAM is 100; in this sample of studies the mean score was 74.6 (range 53-100) indicating good overall study quality.

Table 1

Reviewed studies

Garety, Fowler, Freeman, Bebbington, Dunn & Kuipers (2008)	*Cognitive–behavioural therapy and family intervention for relapse prevention and symptom reduction in psychosis: randomised controlled trial.*
Gumley, O'Grady, McNay, Reilly, Power & Norrie (2003)	*Early intervention for relapse in schizrenia: results of a 12-month randomized controlled trial of cognitive behavioural therapy.*
Haddock, Tarrier, Morrison, Hopkins, Drake & Lewis (1999)	*A pilot study evaluating the effectiveness of individual inpatient cognitive-behavioural therapy in early psychosis.*
Haddock, Barrowclough, Shaw, Dunn, Novaco & Tarrier (2009)	*Cognitive–behavioural therapy v. social activity therapy for people with psychosis and a history of violence: randomised controlled trial*
Lewis, Tarrier, Haddock, Bentall, Kinderman, Kingdon, Siddle, Drake, Everitt, Leadley, Benn, Grazebrook, Haley, Akhtar, Davies, Palmer, Faragher & Dunn (2002)	*Randomised, controlled trial of cognitive-behaviour therapy in early schizophrenia: acute phase outcomes.*
Morrison, Turkington, Pyle, Spencer, Brabban, Dunn, Christodoulides, Dudley, Chapman, Callcott, Grace, Lumley, Drage, Tully, Irving, Cummings, Byrne, Davies & Hutton (2014)	*Cognitive therapy for people with schizophrenia spectrum disorders not taking antipsychotic drugs: a single-blind randomised controlled trial.*
Startup, Jackson, Evans & Bendix (2005)	*North Wales randomized controlled trial of cognitive behaviour therapy for acute schizophrenia spectrum disorders: two-year follow-up and economic evaluation.*
Tarrier, Yusupoff, Kinney, McCarthy, Gledhill, Haddock & Morris (1998)	*Randomised controlled trial of intensive cognitive behavioural therapy for patients with chronic schizophrenia.*
Turkington, Kingdon &Turner (2002)	*Effectiveness of a brief cognitive-behavioural therapy intervention in the treatment of schizophrenia.*

Results

Nine studies met the inclusion criteria. Four of these were included in the five studies selected by NICE in their economic analysis for CBTp (Gumley et al., 2003; Lewis et al., 2002; Tarrier et al., 1998; Turkington et al., 2002). The fifth study in the economic analysis was based on a non-UK population and so did not meet the inclusion criteria. Table 2 outlines the demographic and clinical details of each study. Four studies delivered interventions in outpatient settings, one in inpatient settings, and four in both. All studies included participants with diagnoses of schizophrenia and other psychosis-related diagnoses. Sample sizes ranged from 21 to 422 participants. All studies included both male and female participants. Mean ages ranged between 27 and 40 years old. Two studies involved carers who were offered interventions as part of the study. All studies included a CBTp intervention but studies varied in the comparison intervention, ranging from treatment as usual (TAU) to supportive counselling, family intervention, psychoeducation, social activity therapy, all used as an adjunct to TAU except in one study. Between the nine studies, there was variation in the focus of the studies and the outcomes being measured. All studies included improvement in psychotic symptoms as either a primary or secondary outcome of their research. All but one study described their study as investigating or making conclusions regarding the 'effectiveness' of CBTp. Tarrier et al. (1998) does not make a statement about whether the study investigates effectiveness or efficacy. As the reporting was so poor regarding what was delivered, it is not possible for the reviewer to determine whether the study demonstrated efficacy or effectiveness.

Five studies examined rates of relapse and days spent in hospital, measuring the

Table 2

Demographic and clinical features and outcomes of included studies

Study	Design	Setting	Participants incl. diagnosis, mean age range, gender, history, sample size, effect size	Outcome
Garety et al. (2008)	RCT: Two pathways: Without carers: CBT+TAU vs. TAU With carers: CBT+TAU vs Family intervention + TAU vs TAU	Inpatient and outpatient	Diagnosis: Schizophrenia, schizoaffective disorder, delusional disorder Sex: Male and female Age: Mean 37 History: Recently relapsed Sample size: 384 (CBT=133, FI = 28, TAU=140)	No beneficial effect of CBTp or family intervention on relapse and re-admission rates or improvement of symptoms.
Gumley et al. (2003)	RCT: CBT+ TAU vs TAU	Outpatient	Diagnosis: Schizophrenia, Schizoaffective, Schizophreniform, Delusional disorder, Psychotic disorder NOS. Sex: Male and female Age: Mean 35.8 (CBT), 36.7 (TAU) History: Relapse and admission (or neither). Sample size: 144 (72 per condition)	Significantly lower number CBT group relapsed during the 12 months compared to TAU. No difference for number of hospital admissions. Significantly greater improvements in symptoms and global functioning at 12-month follow up in the CBT group compared to TAU. No effect sizes reported.
Haddock et al. (1999)	RCT: CBT + TAU vs Supportive counselling/ Psychoeducation + TAU	Inpatient	Diagnosis: Schizophrenia or schizoaffective disorder (DSM-IV). Sex: Male and female Age: ~29. History: First treatment for schizophrenia less than 5 years ago, currently admitted to acute ward for onset or relapse of psychotic symptoms. Sample size: 21 (11= SC, 10 = CBT).	No significant difference between the groups on the Brief Psychiatric Rating Scale following treatment and no difference in time to discharge. At 2-year follow up, there was no difference between groups.

Haddock et al. (2009)	RCT: CBT + TAU vs social activity therapy (SAT) + TAU	Inpatient and outpatient	Diagnosis: Schizophrenia, schizoaffective disorder, psychotic illness NOS Sex: Male and female Age: Mean CBT=35.7 years; SAT=33.9 years History: Violent behaviour Sample size: 77 (CBT=38, SC=39)	Severity of delusions, violence and risk reduced in CBT at end of intervention but not follow up. Effect size not reported.
Lewis et al. (2002)	RCT: CBT + TAU vs supportive counselling + TAU vs TAU	Inpatients and outpatients – early psychosis	Diagnosis: Schizophrenia, schizophreniform, schizoaffective, or delusional. Sex: Male and Female. Age: Median 27.4. History: First or second episode admissions, positive psychotic symptoms for 4 weeks or more, moderate or severe score (4 or more) on PANSS target item for delusions or hallucinations. Sample size: 309 (CBT=101, SC=106, TAU=102)	CBT showed some advantages in speed to remission over SC and TAU at 4 weeks. Effect size not reported.
Morrison et al. (2014)	RCT: CT + TAU vs TAU	Outpatient – no medication	Diagnosis: Schizophrenia, schizoaffective, delusional disorder or met criteria for EIP service. Sex: Male and female Age: Mean 32.95 (CT plus TAU), 29.7 (TAU) History: Not in receipt of anti-psychotic medication Sample size: 74 (CBT=37, TAU=37)	CT significantly improved personal and social functioning and some dimensions of delusional beliefs (cognitive) and voice hearing (cognitive and physical) compared to TAU (d = 0.46). Did not significantly affect the level of distress, levels of depression, social anxiety, or self-rated recovery.
Startup et al. (2005)	RCT: CBT + TAU vs TAU	Inpatient and outpatient	Diagnosis: Schizophrenia, schizoaffective, schizophreniform Sex: Male and female Age: Mean CBT=30.5 years, TAU=31.3 years. History: Age at onset 23-25; inpatients acutely unwell Sample size: 90 (CBT=47, TAU= 43)	Negative symptoms (d=0.33) and social functioning (d=0.4) were significantly better for CBT group than control group at 2 years. CBT group showed improvement in positive symptoms at 1 year (d=0.65) but not 2-year follow up. No significant effect of CBT on relapse

				and days spent in hospital.
Tarrier et al. (1998)	RCT: CBT + TAU vs Supportive Counselling + TAU vs TAU	Outpatient	Diagnosis: Schizophrenia, schizoaffective psychosis, delusional disorder (DSM III R). Age: Mean 39. Sex: Male and female. History: Median duration of illness 11 years, persistent positive symptoms. Sample size: 87 (CBT=33, SC=26, TAU=28)	CBT group showed significantly less psychotic symptoms compared to TAU, but not to SC. No significant effect on time to relapse in either therapy group in comparison to TAU. No effect size reported.
Turkington et al. (2002)	RCT: Brief CBT (with/without carer) vs TAU	Outpatient secondary care	Diagnosis: Schizophrenia (ICD-10). Age: Mean 40.47 years. Sex: Male and female History: Previous hospital admissions Sample size: 422 (CBT=275, TAU=165).	CBT showed statistically significant overall improvements in symptomatology, mood and insight, with clinically significant improvements in insight. At the end of the treatment, there was no significant difference in psychotic symptoms between groups. Effect sizes not reported.

*Est = estimate

success of their interventions primarily in terms of reduction of relapse and re-hospitalisation (Garety et al., 2008; Haddock et al., 1999; Tarrier et al., 1998; Gumley et al., 2003; Startup et al., 2005). Haddock et al. (2009) focused on the effect of CBTp on aggression and violence in addition to psychotic symptoms.

Treatment characteristics

This review focused on the variation in treatment characteristics implemented in studies which form the basis of the evidence for using CBTp. Table 3 outlines treatment characteristics. All studies specified the intervention they implemented was 'CBT for psychosis' but there were variations in some aspects of the interventions, who delivered the interventions, the setting, intensity, and duration. The following sections describe treatment characteristics in more detail and the variation between studies, focusing on what was taken up.

The CBT delivered

Studies varied in whether they delivered generic CBTp, modified generic CBTp or phased CBTp. Three studies used generic CBTp as described in the NICE guidelines (2014; Lewis et al., 2002; Morrison et al., 2014; Startup et al., 2004); using an individualised, problem-oriented approach incorporating a manualised process of assessment and formulation. This approach involves the evaluation and normalisation of the appraisals people make, testing such appraisals with behavioural experiments, and helping individuals to identify and modify unhelpful cognitive and behavioural responses. Two studies modified generic CBTp: the focus of the work in the Garety et al. (2008) study was developing a shared formulation of relapse by exploring people's

understanding of triggers and their risks of relapse. Therapists would then attempt to target the key problems associated with vulnerability to relapse, as identified by a personal formulation. Haddock et al. (2009) modified CBTp to include strategies to reduce the severity of anger linked to aggression and violence. It described the adaptation as including motivational interviewing and strategies to improve the potential for engagement in CBTp.

Gumley et al. (2003) had two phases of CBTp: one phase was an engagement phase in which therapists delivered psychoeducation around psychosis and relapse, and developed an individualised case formulation with participants. A targeted intensive phase commenced at the sign of an individual's early warning signs for relapse. This involved assessment of the evidence for and against emerging relapse, eliciting beliefs concerning relapse and the development of alternative beliefs about relapse as a controllable process. Strategies to prevent relapse were then emphasised to counteract negative beliefs and use of unhelpful coping strategies.

Haddock et al. (1999) delivered a manual-based CBT, and then booster sessions which involved reviewing and consolidating strategies used during inpatient settings following discharge. Tarrier et al. (1998) delivered three components of CBTp (coping strategy enhancement, problem solving, and relapse prevention strategies) and then booster sessions, which they do not describe. Turkington et al. (2002) used an intervention based on generic CBTp, adapted to be delivered as a brief approach. It had a series of ten supplementary educational booklets for patients and carers, specifically developed for the study.

Table 3

Treatment characteristics of included studies

Study	Setting	Sample Size	Therapy characteristics	No. and length of sessions	Frequency of sessions	Duration of treatment	CBT therapists	CTAM
Garety et al. (2008)	Inpatient and outpatient	N = 384 (CBT=133, FI = 28, TAU=140)	Adapted generic CBT to target relapse	Planned: 12 -20 sessions 1 hourly CBT taken up: Mean 14.3 sessions, on average 1 hour.	Planned: No intended frequency reported. CBT taken up: Frequency not reported.	Planned: 9 months CBT taken up: 9 months	Five lead trial therapists (all clinical psychologists) and mixture of doctoral clinical psychologists and nurses.	83
Gumley et al. (2003)	Outpatient	N = 144 (72 per condition)	Two phases: engagement, then intensive targeted phase	Planned: 5-session engagement phase. 2-3 sessions per week intensive phase at sign of relapse. No planned session length reported. CBT taken up: Median (range) of 5 (0-6) engagement sessions between week 1-12. Median (range) of 5 (2–16) targeted sessions. Session length not reported.	Planned: Up to 5 sessions in up to 12 weeks. 2-3 sessions per week during intensive phase. CBT taken up: Frequency not reported.	Planned: Engagement phase between entry and 12 weeks. Intensive targeted phase not reported. CBT taken up: Not reported.	One clinical psychologist (author).	53

Haddock et al. (1999)	Inpatient	N = 21 (SC =11, CBT = 10).	Two phases: CBT then booster sessions	Planned: Amount nor length reported. CBT taken up: Mean no. sessions = 10.2 over up to 5 weeks, with 1.67 booster sessions. Session length not reported.	Planned: Not explicitly reported CBT taken up: Frequency not reported.	Planned: 5 weeks of CBT; booster sessions over 4 months post-discharge CBT taken up: Not reported	Therapists: two clinical psychologists (authors).	56
Haddock et al. (2009)	Inpatient and outpatient	N = 77 (CBT=38, SC=39)	Generic CBT with strategies to reduce severity of anger.	Planned: 25 sessions CBT taken up: Mean no. sessions attended = 17. Session length not reported.	Planned: Weekly CBT taken up: Frequency not reported.	Planned: 6 months CBT taken up: 6 months.	Therapists trained in CBT – number not reported.	60
Lewis et al. (2002)	Inpatients and outpatients – early psychosis	N = 309 (CBT=101, SC=106, TAU=102)	Generic CBT for psychosis	Planned: 15-20 hours within 5-week, up to 4 booster sessions. Length not reported. CBT taken up: Mean no. sessions attended = 16.1 sessions (mean hours 8.6). Does not discriminate between sessions attended in 5 weeks or booster. Session length not reported.	Planned: Treatment 'envelope' not reported. At 2 weeks, 1, 2 and 3 months post treatment. CBT taken up: Frequency not reported.	Planned: In 5-week treatment envelope; booster sessions at a further 2 weeks, and 1, 2, 3 months CBT taken up: Mean duration not reported.	One therapist trained in CBT in psychosis independent of the services.	100

Morrison et al. (2014)	Outpatient – no medication	N = 74 (CBT=37, TAU=37)	Generic CBT for psychosis	Planned: 26 sessions offered, plus up to four booster sessions CBT taken up: Mean sessions attended = 13.3, each session lasting roughly 1 hour.	Planned: Roughly weekly CBT taken up: Frequency not reported.	Planned: 26 sessions, maximum of 9 months; then booster sessions in the subsequent 9 months CBT taken up: Not reported.	Eight therapists: five clinical psychologists, two nurses with specialist qualification in cognitive therapy, and one consultant psychiatrist with specialist training in cognitive therapy.	83
Startup et al. (2004)	Inpatient and outpatient	N = 90 (CBT=47, TAU= 43)	Generic CBT for psychosis	Planned: 25 sessions, max 90 minute sessions CBT taken up: Mean sessions = 12.9. Session length not reported.	Planned: Weekly, delivered flexibly CBT taken up: Frequency not reported.	Planned: Presumably 25 weeks CBT taken up: Not reported.	CBT was provided by three clinical psychologists: two authors; one therapist with specialist training.	64
Tarrier et al. (1998)	Outpatient	N = 87 (CBT=33, SC=26, TAU=28)	Intensive CBT	Planned: 20 sessions total, 1 hour sessions. 4 booster sessions. CBT taken up: Mean sessions not reported. Session length not reported.	Planned: Twice a week. Booster sessions once a month for 4 months. CBT taken up: Frequency not reported.	Planned: 10 weeks; booster for 4 months. CBT taken up: Not reported.	Three experienced clinical psychologists.	96
Turkington et al. (2002)	Outpatient secondary care	N = 422 (CBT=275, TAU=165).	Brief CBT for psychosis	Planned: 6 hour-long sessions for participant. Total of 3 sessions for carer if wanted. CBT taken up: Mean sessions not reported. Session length not reported.	Planned: Not reported. CBT taken up: Frequency not reported.	Planned: 2-3 months. CBT taken up: 2-3 months.	Community Psychiatric Nurses who received 10 days of intensive training in the use of CBT. At least 6, one for each site.	77

Frequency, amount, duration of sessions

None of the studies reviewed intended to deliver the NICE guideline recommendation of sixteen sessions. None of the studies that stated an intended number of CBTp sessions to deliver actually achieved their intention. Only two studies (Lewis et al., 2002; Haddock et al., 2009) reported delivering sixteen sessions of CBTp. As there is such poor reporting of the mean number of sessions, the frequency and the duration of treatment delivered in studies, the picture regarding what was delivered is unclear. There was variation in the intensity of delivery of CBTp across studies and settings, and so without meta-analytic methods, it is difficult to say what is an optimal treatment in a particular setting. What can be inferred however, is that planned treatments do not translate to delivered treatments, which should be considered when NHS services are held to similar standards of delivery.

Who delivered the intervention

Most of the studies used clinical psychologists trained to doctoral level as therapists delivering CBTp, with some studies using other professionals trained in CBTp (Turkington et al., 2002; Morrison et al., 2014). CBTp for four of the studies were delivered by the authors (Garety et al., 2008; Gumley et al., 2003; Haddock et al., 1999; Startup et al., 2004) and one used a clinical psychologist independent of the service to deliver all required CBTp to all of those in the CBT group (Lewis et al., 2002). Haddock et al. (2009) used therapists trained in CBT but did not report the number or whether these were researchers.

There is enormous variation in the number of therapists to the number of participants. The sample sizes for CBT groups range from 33 to 275, with no pattern

of more therapists for larger sample sizes, no pattern in the number of therapists to setting, nor number of therapists to better outcomes. It is possible that in the case of Lewis et al. (2002), having a therapist independent to the service made delivery of sixteen sessions possible. It is however, reasonable to assume that the Lewis et al. (2002) therapist to sample size ratio (one therapist for 101 participants) is an unrepresentative demonstration of what is possible to deliver in NHS settings, particularly considering that the role of a clinical psychologist is broader than the implementation of NICE recommendations. Haddock et al. (2009) does not report how many therapists delivered the intervention, or whether they were connected to the services, limiting information about how sixteen sessions were possible in the study.

As most studies are lacking in their descriptions of frequency and length of sessions, it is difficult to draw any conclusions as to whether the profession of the therapist made a difference to the feasibility of delivering the intervention to the intended protocol. The studies suggest that psychologists are the main facilitators of CBTp, but with the multi-faceted nature of a psychologists' role and the mixture in outcomes achieved in the reviewed studies, feasibility is still unclear.

Setting of the intervention

There was no uniformity in settings of delivery within the literature. Both Haddock et al. (2009) and Lewis et al. (2002), who successfully delivered sixteen sessions, did so in inpatient and outpatient settings. However, neither reported over what time span these sessions occurred, the session length, or the frequency. Poor reporting within these studies limits information about why it was feasible to implement these sixteen sessions and what time period necessitates this treatment

recommendation. There is no indication from the data that certain settings allowed for more or less sessions to be implemented.

Discussion

The literature reviewed reflects the complexity and multi-faceted nature of psychosis treatment, in spite of tight inclusion/exclusion criteria. The studies included considered outcomes at an individual level, in trying to improve symptoms, lessen distress and improve functioning; at a systemic level, in trying to decrease burden of care to carers and relatives; and at a healthcare level, in trying to deliver an economically beneficial yet feasible intervention in inpatient and outpatient settings in order to reduce admissions to hospital.

The purpose of this review was to examine whether the RCTs contributing to the evidence base indicate that it is possible to deliver sixteen sessions of CBTp and therefore if it is a feasible treatment recommendation. This discussion will seek to reflect on the findings, in the context of answering the review question and make further comments on the clinical and research implications, with recommendations for future research.

Can NICE guidelines for CBTp be delivered?

When examining treatment characteristics of these studies, and keeping in mind the NICE guidelines, studies have not used a sixteen-session manual as a target. The studies reviewed delivered between five and seventeen sessions, with only two studies having achieved delivery of sixteen sessions of CBTp, though this was not their stated intention. Due to poor reporting, it is not possible to say how many therapists, with what frequency and over what time span the sessions need to

be delivered to achieve the standard to which NHS services are held (DOH & NHS England, 2014). The findings indicate that it was not possible for the reviewed RCTs to implement CBTp in accordance with the NICE treatment guidelines.

In terms of the conditions under which CBTp can be delivered, it is hard to draw conclusions about the best way to deliver CBTp and in what setting due to the heterogeneity between the studies that have researched individual CBTp. All studies except one spoke about their results in terms of effectiveness; the reviewer would question whether the conditions under which CBTp was implemented in all of these studies reflected 'real' NHS settings. The variety in focus of studies, the variation in settings and delivery, the nuances and differing severity of presentations of psychosis, and the variation in preferred outcomes speak to the multi-faceted nature of psychosis, again calling into question the recommendation by NICE (2014) across mental health services.

Clinical and research implications

Considering the above, this review would question the clinical justification for sixteen sessions of CBT for psychosis as a NICE guideline. As put forward in the introduction, the sixteen-session recommendation by NICE was based on an average of five studies in an economic analysis of cost of CBTp versus cost of re-hospitalisation of patients. These studies did not overwhelmingly support CBTp and the most recent study was published in 2003. Despite an update in 2014, and a review of evidence in 2017 by NICE, more recent literature has not been incorporated into a review. It would be a positive step forward to see guideline authors reviewing more up-to-date literature and taking into account more than these five studies when considering recommended treatment in the future. An

acknowledgment of the inability of RCTs to implement the NICE guidelines could prompt a push towards considering other interventions for psychosis.

Other interventions for psychosis

The review demonstrates that too little is known about the specifics of treatments being delivered under the description of CBTp. Further research is needed to examine the different modes of delivery or indeed, different combinations of therapy which could not only forge a way towards a treatment pathway to better address the difficulties faced by people with psychosis, but also a treatment pathway that could be feasibly implemented in a struggling NHS. Though the evidence suggests that group CBTp is ineffective (National Collaborating Centre for Mental Health, 2014), there is some evidence to suggest that both individual and group Acceptance and Commitment Therapy (ACT) can reduce the risk of rehospitalisation of inpatients with psychosis (Gaudiano & Herbert, 2006; Tyberg, Carlbring & Lundgren, 2017). Haddock et al. (2009) and Lewis et al. (2002) succeeded in delivering sixteen sessions of CBTp across inpatient and outpatient hospitals, though it is unclear whether it was due to these settings that implementation was possible. It is possible that feasibly implemented interventions in hospitals help to have an earlier impact, perhaps increases the likelihood of patient engagement in outpatient services and resulting in higher uptake of offered sessions of CBTp. Further research is needed.

The review highlights a difference in desired outcomes across reviewed studies, reflecting the number of difficulties people who live with psychosis face. NICE guideline authors focused on rates of rehospitalisation, yet reviewed studies focused on other outcomes of CBTp. Whilst reducing rates of rehospitalisation is

important, people with psychosis suffer in many ways and distress can be caused by other aspects of the experience. More recent studies have focused on the nuances of psychosis and where treatment could be more specifically targeted to improve the experience of people with psychosis. The Better Sleep Trial (Freeman et al., 2015) tailored CBTp to focus on insomnia, a common experience of those with psychosis. Birchwood et al. (2014) focused on harmful compliance with hallucinations using a cognitive therapy grounded in social rank theory. Freeman et al. (2015) reported significant improvements in insomnia; Birchwood et al. (2014) reported clinically meaningful (but not statistically significant change). Whilst delivering an economically viable treatment is important, consideration should be given by the NICE guideline authors to the nuances of patient experience and what is most distressing for the individual. These more specific interventions may or may not have resulted in greater personal outcomes for participants, and impacted future use of services even if they did not focus on reducing rehospitalisation. Research is required to investigate the feasibility of implementing financially viable treatment recommendations, but those that allow flexibility in choice and focus of treatment.

Poor reporting within studies

A salient finding of the review is the poor quality of reporting of treatment characteristics in reviewed studies. The Clinical Treatment Assessment Measure (Tarrier & Wykes, 2004) assesses reporting of sample, allocation and analysis within studies and the ratings of the reviewed studies indicated good overall quality. Despite quality in respect of these aspects, the reviewed studies failed to produce a useful portrayal of what treatment was delivered. Good reporting is possible, as demonstrated by Allot, Killackey, Sun, Brewer & Velligan (2018) in their

description of cognitive-adaption training in first-episode psychosis. With respect to the literature on CBTp however, poor reporting has limited the conclusions that can be made regarding the feasibility of implementing a blanket recommendation. Future RCTs looking at treatments for psychosis require better reporting, in order to help elucidate whether guidelines are possible and therefore if services should be held to particular standards.

Limitations of the review

The current review has limitations that should be taken into consideration. Firstly, the review excluded non-UK studies. Though this was to focus on the feasibility of implementing a structured intervention in the NHS, information could be gleaned from foreign studies regarding feasible implementation protocols.

Secondly, the review was limited to studies investigating only individual CBTp. As is discussed above, there are a number of studies investigating variations of CBT with people with psychosis. A number of studies were excluded from the review because they investigated CBTp in conjunction with other treatment approaches. Though the review focused on individual CBTp because of the NICE recommendations, information on the treatment characteristics of other studies might have garnered useful information about the feasibility of implementing structured treatment protocols in general. As questions have been raised about the methodological rigour of older individual CBTp studies, and doubt about the intervention has been cast, it would be prudent to examine whether modified CBTp or indeed a different treatment for psychosis is more effective and feasible to implement.

Conclusions

The review found that only two studies achieved delivery of sixteen sessions of CBTp, though this was not their stated intention. All studies with an intended 'dose' of treatment failed to deliver that dose, indicating that it is not feasible to adhere to a sixteen-session model, or perhaps not feasible to adhere to a structured treatment protocol. This infeasibility reflects the realities of the challenges of service delivery in the NHS, and raises questions as to why services are being held to standards which cannot be achieved (HQIP & The Royal College of Psychiatrists, 2016).

It is hard to draw conclusions about the best way to deliver CBTp and in what setting due to the heterogeneity between the studies that have researched individual CBTp. Due to poor reporting, it is not possible to say how many therapists, with what frequency and over what time span the sessions need to be delivered to achieve the standard to which NHS services are held (DOH & NHS England, 2014). The review concludes that a blanket recommendation of sixteen sessions of CBTp is simplistic and does not address the multi-faceted nature of psychosis nor the complexities of service delivery across the NHS.

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Part 2: Empirical Paper

Implementing a flexible psychotherapeutic approach (Method of Levels) in an

acute inpatient setting: feasibility and acceptability

Abstract

Aims: This study sought to investigate the feasibility and acceptability of sessional therapists implementing a flexible psychotherapeutic approach (the Method of Levels - MOL) on an acute mental health inpatient ward.

Method: Mixed methods was used. Quantitative analysis assessed the feasibility of implementation by investigating the attendance patterns of participants, usage of therapeutic resources offered by therapists, and the ability of therapists to adhere to the MOL approach following training and ongoing supervision. Acceptability of MOL was explored using a thematic analysis (Braun & Clarke, 2006) of participant interviews and by recording attendance patterns of participants.

Results: The data indicates that it was feasible to implement an MOL intervention when sessional therapists attended the ward one day a week. Quantitative data indicates that therapists are able to learn, use and adhere to an MOL approach in an acute setting. Thematic analysis of participant experience of the therapy generated domains which spoke to participants' experience of being in the NHS, participants having spent meaningful time with the therapist, and having gained something from the session.

Conclusions: The data indicates that the delivery model is feasible to implement and was acceptable to most participants when therapists were adequately trained and supervised. Using sessional therapists would not be a financially viable recommendation when compared to routine psychological input. Qualitative analysis indicates that overall, there was a shared, humanising experience of therapy, but it is unclear whether this was due to MOL specifically. A randomised control trial is required to compare MOL to other therapies and build on findings.

<center>**Introduction**</center>

Acute inpatient units

The state of inpatient mental health services in England and Wales has been highly criticised for overcrowding, lack of therapeutic activities, high staff turnover and impoverished environments (Joint Commissioning Panel for Mental Health, 2013; Mind, 2013). Bed occupancy has risen year on year (The Mental Health Taskforce, 2016), yet many acute wards are reported to be unsafe, not therapeutic and not conducive to recovery. With the reduction in provision of mental health inpatient beds, there has been an increase in involuntary admissions, something Keown, Weich, Bhui & Scott (2011) attribute to planned admissions or necessary admissions being delayed, resulting in mental health crises. In order to be admitted, service users need to present with higher levels of risk, more complex needs and more severe mental health problems. It also means that patients are more readily discharged once they 'stabilise', often when they are still experiencing difficult social circumstances and psychological problems. This can sometimes result in 'revolving door syndrome' where patients quickly relapse following a shorter hospital stay, something that has become more noticeable in the advent of trying to provide more outpatient treatment rather than treating during longer periods of hospitalisation (Smyth & Hoult, 2000).

Psychological provision

The National Institute for Health and Care Excellence (NICE) recommends that service users should be able to access evidence-based treatments to facilitate recovery. Cognitive Behavioural Therapy (CBT) is recommended for diagnoses common on acute inpatient wards (British Psychological Society, 2012), specifically

to those diagnosed with psychosis and schizophrenia (NICE, updated 2014), post-traumatic stress disorder (NICE, 2005) bipolar disorder (NICE, updated 2018), and antisocial personality disorder (NICE, updated 2013). In "Improving acute inpatient psychiatric care for adults in England" (The Commission, 2015), patients and carers called for a wider range of treatments to be made available to inpatients, including positive ward activities and psychological therapies.

Despite justifiable calls for improved therapeutic provision, there are many barriers to the delivery of even NICE-recommended psychological interventions in inpatient care. As discussed above, the pressure of new admissions and the impact of short-term stays can impede intervention (Clarke & Wilson, 2009). For example, 16 sessions of CBT for psychosis (CBTp) is the NICE recommended treatment for psychosis but the average length of stay on an acute adult ward in 2016 was 33 days (NHS Benchmarking Network, 2016). Part 1 of this thesis suggested that it is not feasible to implement a structured protocol as per NICE guidelines; just two of nine reviewed studies succeeded in implementing sixteen sessions of CBTp (Haddock et al., 2009; Lewis et al., 2002). Both studies' interventions spanned inpatient and outpatient settings however, and one study used a psychologist independent of the service, factors which might have made implementation easier. The skills of ward psychologists include the provision of consultation, supervision and reflective practice to inform the psychological thinking of the multi-disciplinary team, not solely individual therapeutic input (Nicholson & Carradice, 2002). This range of tasks coupled with the lack of additional, therapeutically-trained staff makes it difficult for clinical psychologists alone to deliver structured treatment protocols to patients who typically present with the above diagnoses.

Patients' level of acuity and co-morbid mental health problems can complicate delivering CBT treatments with disorder-specific models. People diagnosed with schizophrenia have an increased likelihood of being diagnosed with panic disorder (15% of cases), post-traumatic stress disorder (29%), obsessive compulsive disorder (23%), and depressive disorders (50%) (Buckley, Miller, Lehrer & Castle, 2009). Rush & Koegl (2008) found that specialist hospital inpatient services had the highest level of co-morbidity (28%) when compared to specialist hospital outpatient services and community mental health services. Therefore, whilst using a disorder-specific therapeutic approach has been found to be efficacious (Hofmann & Smits, 2008; James, Soler, & Weatherall, 2009), the realities of complex mental health care limit the opportunity to implement therapies according to trial protocols.

Method of Levels – a flexible psychotherapeutic intervention

Method of Levels (MOL) is an intervention designed to be delivered flexibly, transdiagnostically, and with the option of either one or multiple sessions. Based on the principles of Perceptual Control Theory (PCT; Powers, 1973, 2005, 2008), MOL is designed to help people to reduce the psychological distress which occurs when people are unable to control experiences that are important to them (Carey & Mullen, 2008). It is based on the idea that distress arises when people feel unable to control their experiences as they would like, due to conflicting goals. For example, to achieve sense of safety by simultaneously avoiding people whilst also wanting to seek support. MOL uses the ability that people possess to be aware of both the content of what they are describing, but also of background thoughts or commentaries about what they are saying (Carey & Mullen, 2008). MOL aims to

help the individual gain greater awareness of their goals and a new perspective on their problems, and to encourage a change in priorities so that their higher-level goals can be realised (Mansell, Carey & Tai, 2013). Unlike approaches such as solution focused therapy (De Shazer, 1976) or motivational interviewing (Rollnick & Miller, 1995), the discrepancy between the client's current situation or experience and desired situation or experience is not directly reflected upon or elicited by the therapist. Though clients are asked to notice their thoughts, unlike in mindfulness practice (Langer, 1989), they are asked to analyse the background commentaries around those thoughts rather than simply noticing them. The role of the therapist is not to offer advice, or provide the patient with solutions to their distress, but as Carey & Mullen (2008) describe, to assist them in shifting their perspective on their difficulties, in the hope the patient generates their own solutions to their conflicts, termed 'reorganisation', explained in more detail below.

MOL has an emerging evidence base in primary care services; Carey and Mullen (2008) noted large effect sizes when looking at improvements in depression, anxiety and stress in participants (using the Depression Anxiety Stress Scale; Lovibond & Lovibond, 1995) when MOL sessions were made available in an urban GP practice for six months. A patient-led appointments system was in place, whereby patients booked sessions as and when they deemed they required one. Carey, Carey, Mullan, Spratt & Spratt (2009) reported similar improvements (but did not report effect sizes) when patient-led appointments were available for twelve months in three NHS primary care services and one NHS secondary care service.

MOL in practice

MOL has been described in three manuals (Carey, 2006; 2008; Mansell et al. 2012). It is intended to be used only when a person is feeling distressed, as it assumes the reason for distress is due to conflict. It assumes only the individual can identify what aspect of their experience is not 'normal' for them. For that reason, MOL can be used singularly in just one session, or could be used with the same client multiple times, focusing on the same conflict or different conflicts. It depends entirely on what the client 'brings' that session. The ethos behind MOL is very much client-led. The client decides if they would like to talk, leads in terms of content, decides for how long they would like to talk, and whether they would like to have further sessions (Carey, 2008).

MOL has two main components in practice. The task of the therapist delivering MOL is to 1) facilitate focus what it is that is preoccupying the client and ask questions to sustain awareness on that topic and; 2) to notice, comment and ask about 'disruptions' – moments where the client has become distracted, looked away or moved in a way that suggests they are thinking about something else. When people pause, gesture or look away, Carey (2006b) puts forward that it indicates that there could be a commentary in a person's mind at the time that has stopped them from continuing to speak. By noticing and being curious about these 'disruptions', it facilitates the client becoming more aware of what they are thinking or feeling about what they are saying. The aim of both of these tasks is to push clients' awareness further and further up in order to achieve a higher level of awareness about conflicts that might be occurring in their life.

Carey (2008) puts forward that a hierarchy of three levels exists at which

conflicts can occur, described in more detail by Alsawy, Mansell, Carey, McEvoy &
Tai (2014). At the first level are the symptoms the person is aware of, for example
feeling anxious and behaving in a way to reduce the anxiety. The middle level is an
awareness of a conflicting desires, goals and experiences, for example a person
wanting to tackle their anxiety but the thought of doing that triggering anxiety. At the
highest level of awareness, higher-arching conflicts exist. For example, the person
may realise that they behave in a certain way to reduce their anxiety in order to feel
safe, but also want to be 'normal' and not to behave in this way. Shifting perspective
up to this higher level of awareness is thought by proponents of MOL to enable
'reorganisation'. Reorganisation happens when a person becomes aware of a gap or
conflict between what they want and what they are experiencing, which may lead
them to develop solutions to this conflict. It is the process by which the systems that
are maintaining control (for example, by behaving in a certain way to reduce anxiety)
change in order to restore and enhance control. In the example above, awareness of
the higher-level conflict of wanting to feel safe, but wanting to behave 'normally'
leads the person to become aware of why they feel distressed. Realising this conflict
is thought to lead the person to develop their own solutions. Alsawy et al. (2014)
gives the example of the person finding new ways to feel safe to reduce their anxiety.
Reorganisation can happen during a session or any time afterwards and is understood
to happen within a person such that, though others may observe the consequences to
reorganisation, they cannot see the person's control systems reorganising. The
concept of within-person experience and change forms the foundation on which
MOL is based. It drives the reason for client-led decision making and a move away
from the traditional methods of formulating and developing solutions.

Given that this is a relatively new and innovative way of working, further details and

case examples are given in appendix A.

The application of MOL in an acute setting

MOL has the potential to be ideally suited to working with individuals in an inpatient setting. As it has a transdiagnostic focus on reducing distress rather than reducing symptomatology, it could overcome barriers such as co-morbidity and the high levels of distress observed in those in acute inpatient settings (Rush & Koegl, 2008). Due to its focus on present-moment distress, patients may have just one, or multiple MOL sessions. Some patients may require only one or two sessions to gain a new perspective on their difficulties and their solutions. Others may require more sessions to reach this point. This allows the therapy to be scheduled flexibly or 'as needed', something which could work well in inpatient settings with variable lengths of stay. In this way of working, the patient makes the decision whether or not therapy is warranted.

Carey (2016) encourages a delivery of care that puts patient-perspective first rather than privileging therapists' opinions about session length or focus. MOL sessions puts the scheduling, the focus and the content of the session firmly in patients' hands, allowing them to decide on the amount of treatment they would like and what they would like to focus on (Carey, Tai & Stiles, 2013). Using an MOL approach where there is no pre-prescribed number of sessions or a particular sequence of sessions to be followed could reduce the concept of 'wasted' therapeutic resources (Saini, Brownlee, Eslshaug, Glasziou, Heath, 2017) and could work well with the unpredictable course that psychological change typically follows (Carey et al., 2013). Mansell et al. (2013) put forward that the uncertainty of length of

admissions and quickly-arranged discharges could be irrelevant to the single-session format in which MOL can be implemented.

Context of the study

There is a scant amount of literature on implementing therapy in inpatient settings, and very little on the topic of MOL. More research is needed to attend to the question of how individual psychological therapy can be implemented in inpatient units contending with staff shortages, competing demands and unpredictable lengths of stay. MOL could be ideally suited to overcoming some of these challenges but there remains a lack of research regarding the use of transdiagnostic approaches in inpatient settings, especially regarding the acceptability to patients (Newby, McKinnon, Kuyken, Gilbody & Dalgleish, 2015). This study will focus on contributing to this research base. Before a large-scale study explores the use of MOL in inpatient settings, it is necessary to first establish whether it is feasible to implement therapy flexibly, possibly in a 'standalone' format and without a lengthy treatment protocol in inpatient settings. A question complimentary to this, which can also build on the MOL literature, is whether the approach is acceptable to patients.

The purpose of the study

In order to address the questions above, this study focused on the implementation of MOL on acute inpatient wards. Two therapists trained in MOL worked on acute wards for one day per week, acting as additional 'sessional' therapists, available to patients for MOL sessions should they wish to discuss anything that was distressing them. Ward psychologists would refer patients they thought might be suitable for MOL or who had requested psychology sessions, but who had not had routine psychological input yet.

Peters, Adam, Alonge, Agypeong and Tran (2013) describe various implementation outcome variables that can serve as indicators of the success of implementation: acceptability, adoption, appropriateness, feasibility, fidelity, implementation cost, coverage, and sustainability of the implemented intervention. Due to the preliminary nature of this study and the limitations of a DClinPsy research project, only a limited number of the Peters et al. (2013) implementation outcome variables were included. These were: the feasibility of the intervention - the extent to which sessional therapists could carry out a flexible, possibly standalone therapy in an inpatient setting and the degree to which the intervention could be adhered to as intended following training and supervision; the experience of the intervention – how acceptable it was to patients. These are operationalised below.

Aims

Feasibility

The study aimed to ascertain whether it is feasible for sessional therapists to implement therapy flexibly, possibly in a 'standalone' format and without a lengthy treatment protocol in an acute inpatient setting. This feasibility was considered in terms of:

1. Take up of referrals. This was assessed by recording the number of referrals made and how many of these referrals were seen, declined or were unable to be seen.

2. Attendance patterns of patients. As MOL sessions can be standalone, the number of sessions attended does not in itself indicate whether the intervention was feasible. The attendance patterns of patients were used to inform whether it is possible to implement a varying number of sessions.

3. The ability of therapists to use and adhere to an MOL approach in an acute setting.

Acceptability

1. Attendance patterns of patients. This was used to demonstrate whether the approach was acceptable to participants. Coupled with qualitative data, this would provide information as to whether the intervention could be implemented without adverse events relating to the therapy, such as increased distress.

2. Participant experience. The question of patient experience of MOL therapy sessions was addressed by interviewing participants, specifically asking about the context and impact of their contact with therapists.

Method

Design

This study used mixed methods to explore feasibility and experience of implementing an MOL approach in an acute inpatient mental health setting. Feasibility of implementation was assessed using attendance patterns of patients, usage of therapeutic resources offered by therapists and the ability of therapists to adhere to the MOL approach following training and with ongoing supervision. Experience of MOL was explored using a thematic analysis of qualitative interviews (Braun & Clarke, 2006).

A mixed methods approach was chosen as qualitative measures would enable detailed understanding of the experience of receiving a novel, patient-led and open-ended intervention. Thematic analysis allows for the identification of themes across

rich, individual accounts of experience (Braun & Clarke, 2006) and quantitative measures would complement the qualitative data gathered. For example, recording of attendance patterns could provide information about the acceptability of the approach in terms of how patients respond to follow up invitations for additional therapy sessions.

The researcher used an essentialist epistemological position, assuming that the language interviewees use reflected their experience and the meaning they give to that (Braun & Clarke, 2006). See data analysis section below for more detailed information regarding this method of analysis.

Setting

The study took place in two adult acute inpatient units (one female, one male) at a large psychiatric hospital in London. Each ward had 0.4 full time equivalent (FTE) days of dedicated input from a qualified psychologist, and 1.0 FTE days of input from an assistant psychologist. All patients are offered group sessions conducted by assistant psychologists which focus on psychoeducation or offer low-intensity interventions such as mindfulness. The focus of the qualified psychologist is assessment and formulation to determine suitability of an individual for therapy interventions in the community. The qualified psychologist would see a maximum of three patients per day for one-to-one sessions depending on meetings and other duties.

Implementation strategy

Two therapists, one qualified clinical psychologist (therapist one – T1), one trainee clinical psychologist (therapist two – T2), offered 0.2 FTE weekly 'clinical

sessions' each on a separate ward, using the Method of Levels approach for thirty weeks over a period of thirty-nine weeks. Between weeks 1-12, T1 attended one ward once a week; T2 had not started her honorary contract. Between weeks 12 and 16, T1 was unavailable. T2 spent this time practising and becoming familiar with the approach. Thus, sessions conducted during this period were excluded from the study. From week 17 to week 39, both therapists offered sessions on separate wards once a week.

T1 had attended biannual training events for the previous four years. He received regular supervision sessions with the therapy developers Tim Carey and Sara Tai. T2 undertook three-days of training in MOL and was subsequently supervised by therapist one. Supervision involved discussing therapy session evaluations using the MOL evaluation form (see description below; Mansell, Carey & Tai, 2013). T1 was the chair of the Control Theory Special Interest Group for the British Association for Behavioural & Cognitive Psychotherapies (BABCP) and supervised T2. T2 was the researcher. A Masters student interviewed six of the fifteen participants whose data was used in this study; the trainee researcher interviewed six; the research supervisor interviewed three. The therapists provided input in additional to regular psychological provision by ward psychologists. They were available for half- and full-day availability, with no fixed appointment slots unless arranged by a patient at the end of a previous session.

Implementation research requires sufficient flexibility to allow for changes and adaptations that may be needed as a result of difficulties in examining something newly introduced to an existing system (Moore et al., 2015). This need for flexibility and change arose early in the study. Initially the aim was to allow patients to opt-in

by signing themselves up for sessions advertised on noticeboards, highlighted during ward community meetings, and encouraged by clinicians. However, in practice this approach failed because patients were often discharged so quickly as to be unaware that sessions would be offered at some point. It was therefore decided by researchers, in consultation with ward psychologists, that ward psychologists and the multi-disciplinary team would refer suitable patients. In order to maximise psychological provision on the wards, referrals were usually patients who had not yet had individual psychological input. Patients were offered a session, which they could accept or decline. As the ethos of MOL is patient-led, patients had control over how long sessions lasted and whether or not they booked another. Therapists left the ending open asking patients if they were happy to be approached in the future and offered a session. Outpatient appointments were offered to patients if they were due to be discharged, unless patients already had an onward referral to a psychological service in place.

Ethical approval

Ethical approval was obtained from an NHS Research Ethics Committee (Ref: 15em/02/63 The East Midlands Research Ethics Committee). All participants gave written consent to take part. One participant declined to give consent to report their demographic information. See Appendix B for information and consent forms and Appendix C for confirmation of ethical approval.

Participants

Inclusion and exclusion criteria

Service users were eligible to be interviewed if they:

1. Had received at least one individual MOL therapy session.

2. Had sufficient grasp of English to provide consent and participate in an interview.

3. Were deemed well enough to participate and consent by a member of the clinical care team

4. Were well enough to engage in the research and their ability to focus and engage in 1:1 work had not been impeded by marked side effects of medication.

One participant was excluded at the analysis stage for reason 2.

Given the transdiagnostic nature of MOL (Higginson, Mansell & Wood, 2011; Carey, Carey, Mansell, Spratt & Spratt, 2009), individuals were eligible to receive MOL regardless of diagnosis, age, or intellectual ability. Where the patient risk had escalated to a level where staff members considered the patient unsafe, the individual was not offered the intervention. This occurred in one instance following advice from the ward psychologist.

Recruitment

The ward psychologists referred patients for therapy. If deemed appropriate for the study, patients were given information about the study and asked to consider taking part. Of the 28 patients who consented to take part in the research, 12 were discharged and lost to follow up and one later declined to interview. Fifteen participants were interviewed. Nine participants were interviewed on their respective wards, three were interviewed in the outpatient meeting rooms and three were interviewed at their homes. All participants were given a supermarket voucher to the value of £15 in exchange for their time.

Participant characteristics

The 15 participants (7 men, 8 women) ranged in age from 25-58 years (mean: 42 years); six described themselves as White British, one as White Eastern European, three as Black African and four as Asian British. One participant did not consent for their demographic information to be reported. Primary diagnoses obtained from the Trust patient information-recording database were: personality disorder (N=2), paranoid schizophrenia (N=1), schizoaffective disorder (N=5), bipolar disorder (N=6), alcohol dependence (N=1), depression (N=2). Length of stay on the ward ranged from six days to 141 days (mean: 47.6 days; 6.8 weeks). Table 1 details demographic information. See results section for information regarding attendance patterns.

Table 1

Demographic information

P	Sex	Ethnicity	Primary Diagnosis	Length of Stay	Length of therapy
1	M	White British	Bipolar disorder	13 days	1 session
2	DNC*	DNC	DNC	DNC	3 sessions
3	M	Asian British	Schizoaffective disorder	96 days	2 sessions
4	M	Asian British	Schizoaffective disorder	141 days	2 sessions
5	M	Asian British	Paranoid Schizophrenia	32 days	1 session
6	M	Black African	Bipolar disorder	33 days	1 session
7	F	Asian British	EUPD**; alcohol dependence	6 days	1 session
8	F	White British	Recurrent depression	12 days	9 sessions
9	F	White British	Bipolar disorder	32 days	1 session
10	F	White Eastern European	Schizoaffective disorder	82 days	2 sessions
11	M	Black African	Schizoaffective disorder	63 days	2 sessions
12	F	White British	Bipolar disorder	20 days	1 session
13	F	Black African	Schizoaffective disorder	12 days	2 sessions
14	F	White British	Depression; EUPD	106 days	1 session
15	F	White British	Bipolar disorder	19 days	1 session

Note. P = participant; *DNC = participant did not consent to demographic information being reported **EUPD = Emotionally Unstable Personality Disorder.

Quantitative data collection

Quantitative measures were used to explore the feasibility of implementing the intervention and to explore participant experience.

1. *Attendance patterns.*

Feasibility of implementation was assessed by recording the frequency and number of sessions attended; the number of referred patients seen per 'clinical session' by

therapists and the availability of patients referred to therapists during a working day (for example, whether the patient was on leave, sleeping, or at other appointments).

2. *MOL Session Evaluation Forms - Self.*

The feasibility of implementing an MOL approach was assessed using MOL session evaluation forms (Mansell, Carey & Tai, 2013). Some sessions were recorded and adherence to the MOL approach was self-evaluated by the therapist. See Appendix D for an example of the rating scale. It has eight questions relating to aspects of an MOL approach: how much the content was generated by the patient; how much the therapist questioned rather than advised; how much the therapist asked about disruptions; how much the therapist asked detailed and specific questions; how much the therapist questioned rather than assumed; how much the therapist asked about the patient's immediate experience; how much the therapist followed rather than led; how well the therapist facilitated sustaining a focus on one or more areas.

At present, there are no reliability or validity checks for MOL evaluation scales. Some session recordings were made by therapists with the intention of using MOL Session Evaluation Forms - Other (Mansell, Carey & Tai, 2013) for therapists' supervisors to co-rate. However, only a very small number of participants had their sessions recorded and recordings made by therapist two were primarily of training sessions and not a true reflection of the approach. For this reason, recordings were not used in analysis to compliment other data gathered as it was considered too limited. See the discussion for further comment on this.

3. *Routine Outcome Measures.*

The Outcome Rating Scale (ORS; Miller & Duncan, 2000) and the Session Rating Scale (SRS; Johnson, Miller & Duncan, 2002) were administered with the intention of using routine clinical information to record pre-session functioning and post-session assessment of the patient's view of the therapeutic relationship. Unfortunately, many participants declined to complete the forms pre- and post-session and so this data was considered too limited to use in analysis.

Quantitative analysis

Average ratings by therapists on the session evaluation forms were compared using a repeated measures Analysis of Variance with Bonferroni post-hoc comparisons to ascertain whether there were significant differences in self-ratings on each dimension of the scale. Ratings above 5 were considered acceptable adherence for the purpose of this research, decided by the researcher and research supervisor.

Interviews

A semi-structured interview schedule was developed for the study with a view to use thematic analysis (Braun and Clarke, 2006) as a means of analysing the data collected on participant's experience of MOL sessions. The interview was developed in collaboration with the MOL treatment developers. It was developed in line with the Elliott (2012) change interview but to reflect the MOL intervention specifically. Questions in the interview explored the general experience of the therapy sessions, what was helpful and unhelpful about the way of working, and perceived changes the therapy had or had not made to the way the service user thought and felt about their difficulties and the future. Questions focused specifically on the experience and impact of MOL sessions compared to previous experiences of therapy. Finally, there was also a focus on service users' experience of booking

therapy sessions due to the different way MOL therapists were providing therapeutic input.

Interviews were conducted by a Masters student, the trainee researcher and research supervisor. Consistency was monitored by discussion in supervision to ensure coverage was equivalent, follow up questions were asked, and that participants were given an equal amount of space to talk. The interviews used open and non-directive questions as much as possible, with follow-up questions and prompts when necessary to gather more information or clarify meanings. If participants were predominantly positive or negative about their experience, interviewers made efforts to explore contradictions or alternative experiences to broaden the picture provided. As the trainee researcher and research supervisor were the psychologists implementing therapy, interviews were always carried out by someone independent to the therapist, to allow interviewees to speak more freely and openly.

The interviews with service users were conducted within three weeks of being invited to participate. The time between the last session and interview varied between four hours and three weeks. Interviews lasted between ten and 57 minutes. All interviews were audio-recorded and transcribed verbatim by the Masters student and the trainee researcher. Transcription rules were used by both transcribers so as to maintain fidelity to the protocol. See Appendix G for interview schedule and Appendix H for transcription rules.

Data analysis

The Braun and Clarke (2006) method of thematic analysis was used to identify patterns across the data set. The researcher used an inductive approach

whereby latent themes were identified, strongly linked with the data. An essentialist stance was used; the researcher accepted that what the participants said reflected their actual experiences and ways of making sense of what they had experienced (Dyson & Brown, 2006).

Researchers' background

The researcher HJ is a trainee clinical psychologist. She had no prior affiliations with the hospital in which the research was conducted, nor affiliations with the BABCP Control Theory Special Interest Group or the developers of MOL. She chose to undertake the research due to an interest in inpatient mental health settings and the quality of care delivered in the NHS. Her preferred therapeutic approach is a Post-Milan systemic approach (Cecchin, 1987; Burnham, 1992), integrating aspects of narrative therapy (Coombs & Freedman, 2012) and social constructionism into clinical practice (Ekdawi, Gibbons, Bennett & Hughes, 2000).

The Masters student was, at the time, working as a psychological therapist in primary care. He had no prior affiliations with the hospital in which the research was conducted, and had no prior experience of the MOL approach. He used the data from the six interviews for his MSc research project. The researcher did not have access to his dissertation at any point during analysis or write up.

The internal research supervisor (and qualified psychologist who provided the therapy) is the chair of the BABCP Control Theory Special Interest Group. He has a long-standing interest in Method of Levels, corresponds and collaborates regularly with treatment developers and had been using the approach for approximately two years before the research started.

The external research supervisor is a consultant clinical psychologist and professional lead for the inpatient and acute psychology service in which the study took place. She has a long-standing interest in psychological involvement and therapy in such settings.

Phases of analysis

The six recommended phases of the Braun and Clarke (2006) method of thematic analysis were used. Firstly, all transcripts were read several times enabling the researcher to familiarise herself with the data and note initial ideas. The second step entailed coding features of the data that appeared interesting and relevant to the researcher considering the research question (see Appendix I for an example of step two). All transcripts were systematically coded and data relevant to the codes generated recorded across the data set. The third step entailed collating codes into subthemes and gathering all relevant data to each potential theme (see Appendix J for example of extracts related to one subtheme). The researcher combined steps four and five, reviewing subthemes, tentatively naming themes, and reviewing and checking if they made sense in relation to the coded extracts, and the entire data set. When the researcher completed step six - producing the written report - themes were further refined and clear names for themes and subthemes were generated. Selected extracts were used to reflect the themes generated and the overall story of the analysis. In order to ensure that themes were grounded in the data and not in the researcher's preconceptions and prior assumptions of the researcher, raw data were repeatedly revisited and subthemes revised if appropriate (Flick, 2006).

Credibility checks

To further enhance credibility and validity in accordance with good practice

guidelines suggested by Stiles (1999), one participant reviewed themes and subthemes generated throughout the data. This was achieved by the researcher emailing a table of domains, themes and subthemes, which was later explained and discussed via telephone. The participant was asked to comment on the validity of subthemes, whether she wished to change the emphasis placed on subthemes and whether she wished to comment further on subthemes, her experience of their session(s) or the interview process. The participant responded that her views were fully captured in the subthemes and that the grouping of themes into domains made sense from her point of view. She endorsed further subthemes that came from other participants, which were then included in the analysis write-up.

To avoid individual researcher bias influencing the analysis, as suggested by Flick (2006), one interview was cross-coded by an independent researcher. The researcher was another trainee psychologist undertaking doctoral research relating to chronic obstructive pulmonary disease. She had never worked in an inpatient mental health unit, nor had she ever worked using an MOL approach. As the internal research supervisor had a significant interest in the MOL approach, he was involved in analysis only at the point at which main themes had been drawn, to discuss the development of themes and subthemes. The internal supervisor made some suggestions for amendments when subthemes seemed unclear. Once the researcher had completed a draft of step six, the internal supervisor and another independent researcher reviewed the results of the thematic analysis. Reviews of the thematic analysis were triangulated between the researcher, internal supervisor and independent researcher. This was to avoid any pre-existing beliefs about the experience of MOL biasing analysis. As with all research, it is impossible to completely 'bracket' assumptions (Tufford & Newman, 2010) but efforts were taken

to notice where pre-existing assumptions about the experience of care in the NHS, of MOL and of therapy in general might have influenced coding. Revisions were made following discussions and suggestions, until the final thematic structure was created. See Appendix K for trail of analysis.

Results

Feasibility of implementing MOL

Resources used

One 'clinical session' was one day (0.2 FTE) of attendance to one ward by one psychologist to meet with patients. Therefore, on a week when both therapists attended the wards, 0.4 FTE of psychological input was offered. See Table 2 for referrals over the 30 weeks of implementation, broken down by those seen, those declined, and those unable to be seen. Table 2 illustrates that a total of 75 patients were referred over the course of the 30 weeks. Of these, 38 patients (50%) accepted the first invitation to a session; 18 declined the invitation (25%); and 19 patients were unable to be seen (25%). Referred patients were unable to be invited to a session for a variety of reasons: the patient being asleep; patient on leave; patient at other appointments; for safety reasons; language barriers; patient preparing for discharge; patient having family visits; patient at work.

During clinical sessions, therapists offered appointments to new referrals and followed up with patients who had consented to be approached again. See Table 3 for average resource breakdown per clinical session. Table 3 shows that the number of patients to be seen per clinical session ranged between one and five and that there was some variation in how many of these were seen per clinical session, on average between one and two patients.

Table 2

Resource breakdown over 30 weeks

Over 30 weeks implementation	Total number
Patients referred	75
Referred patients accepted first invitation	38
Referred patients declined invitation	18
Referred patients unable to be seen	19

Table 3

Resource breakdown per clinical session

Per clinical session	Average number (range)
Patients to be seen (referrals and follow up)	2.86 (1-5)
Patients seen	1.59 (0-4)
Patients who declined	0.51 (0-2)
Patients who were unable to be seen	0.76 (0-3)

On average, one participant declined therapy during a clinical session and one was unable to be seen. The data indicates that it was feasible for therapists to see referrals and follow up with patients during clinical sessions. Whether this is a financially viable service delivery is commented on in the discussion.

Attendance patterns

As only the 15 participants consented for clinical information to be used in the study, attendance patterns of all patients referred cannot be described beyond accepting or declining, or being unable to attend the first invitation to a session. See Figure 1 for a consort diagram for attendance and participant selection process.

Figure 1. Attendance and participant selection

Participants' attendance.

For the 15 participants interviewed, the duration of therapy ranged between one and nine sessions (median: 2 sessions) with one participant receiving nine sessions spanning periods of inpatient and outpatient contact over four months (length: 117 days). Though this participant received considerably more therapy sessions than the rest of the participants, they were included in analysis due to the standalone nature of MOL sessions. See introduction section for elaboration on this concept. See Figure 2 for pattern of attendance for study participants.

Week																																							
Part	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	Total
1			DEC		DEC				x	x	DIS																													2
2		x	x	x	DIS																																			3
3					x	DIS																																		1
4									x	x	DIS																													2
5									x	x	DIS																													2
6									x	x	DIS																													2
7																	x	DIS																						1
8																				x	DIS	x	x	x	x	UN	x				x	UN	x					x		9
9																												X	DIS											1
10																															x				x	DEC			DIS	2
11																																		x		x		DIS		2
12																																x	DIS							1
13																																		DEC	x			x		2
14																																				UN	x	UN		1
15																																							x	1

Key	
Both therapists	(blue)
Therapist 1	(orange)
Therapist 2	(yellow)
Therapist unavailable	(purple)
Therapist 2 training	(green)
Client attended	x
Client unavailable	UN
Client declined	DEC
Discharged	DIS

Figure 2. Attendance patterns of participants

Nine participants attended a second session, seven participants were discharged following their first appointment. All participants who did not have onward referrals to psychology services were offered appointments following discharge. One participant attended therapy sessions following discharge whilst waiting for an assessment with another service. All others (5) were either unwilling or unable to return to the hospital. Participant 10 declined to attend further sessions though it was easily accessible to her as she was still on the ward, possibly indicating that the therapy approach was not acceptable to her. The impact of the therapy sessions in this case, possibly adverse, is explored below.

Feasibility of adhering to MOL

Feasibility of implementing the approach was assessed by using the MOL Session Evaluation Forms – Self (Mansell, Carey & Tai, 2013 – see Appendix D). Table 4 details mean scores of therapists' self-rating.

Analysis of ratings across dimensions

Ratings indicate that therapists self-rated as being able to learn, use and adhere to an MOL approach in an acute setting.

A repeated measures ANOVA found a significant difference in ratings across dimensions for therapist 1 ($F (7, 40) = 6.9$, $p < 0.001$), and therapist 2 ($F (7, 12) = 8.3$, $p < 0.001$). Post hoc tests using the Bonferri correction revealed that there were significant differences between ratings on dimension 3 and dimensions 1-7 ($p<0.05$), and significant differences between dimension 8 and dimensions 1, 2 and 5 ($p<0.05$). There were no other significant differences between dimensions.

Table 4

Therapist Self-Ratings

Item	Dimension	T1 Mean (range)	T2 Mean (range)
1	Content generated by client	8.4 (6-10)	8.0 (7-10)
2	Questioned rather than advised	8.6 (5-10)	7.7 (5-10)
3	Asked about disruptions	7.2 (3-10)	5.0 (1-8)
4	Detailed questions	8.1 (5-10)	7.0 (5-10)
5	Questioned not assumed	8.4 (6-10)	8.6 (6-10)
6	Immediate experience focus	8.6 (5-10)	6.8 (3-9)
7	Followed not led	8 (4-10)	8 (6-10)
8	Sustained focus	7.3 (4-10)	7.3 (5-10)

Note. T1 = therapist 1; T2 = therapist 2

Analysis indicates that it was more difficult for therapists to adhere to dimensions relating to asking about disruptions and sustaining a focus within the session. This is reflective of discussions in supervision and comments written on self-rating forms which referred to challenges arising in trying to adhere to certain aspects of the model when working with acutely unwell patients. T2 used a period of practice (weeks 12-16) to become familiarised with the approach. She rated herself on average lower than T1 on items relating to: asking about disruptions, questioning rather than advising, asking detailed questions, and focusing on the immediate experience of the patient. Both therapists were able to deliver MOL to the standard the research and researcher supervisor considered acceptable adherence for the purpose of this research (average rating of 5 or above).

Acceptability of the approach

Thirteen out of 14 participants spoke favourably about their experience of the therapy session(s). Ten participants said they would like to attend another session and nine said they would recommend the therapy to others indicating that the therapy was acceptable to them. As is reflected in the quotes above, two participants (P2 and P10) did not like the experience and P10 declined to attend a further session offered to her, despite saying in her interview she would like to attend another. In their interviews, both spoke about the uncomfortable questioning style, indicating that it was something specific to the approach which was unacceptable to them. However, both of these participants said at the time of interview that they would attend another session if they were offered. This could indicate that the approach did not have lasting damaging effects, such as increased distress, or could simply be an example of social desirability.

P7 was referred to another service, and so as per the implementation protocol, was not offered a session following discharge. Though this was something she described as positive, at the time of the interview, she said that had she not improved so much in mental state, she would have felt as though, *"okay, his or her job has been done, that's it, ticked off"*.

Participant experience

Participant experience was addressed using a thematic analysis of interviews, and by using attendance patterns as complimentary data related to acceptability and adverse consequences.

Thematic analysis

Analysis of the 15 interview transcripts generated seven distinct themes grouped into three domains (see Table 5). These domains describe participants' experience of being in the NHS, participants having spent meaningful time with the therapist, and what participants gained from the session. Each domain will be introduced before the theme is summarised with illustrative quotes. Participants are denoted by numbers e.g. participant 1 is denoted as P1, participant 2 as P2 etc.

During analysis, it transpired that one interview (interview 11) did not endorse any subthemes of the 21 identified. The participant had difficulty understanding the interviewer's questions despite additional attempts to clarify what was being asked. Consequently, he was excluded from analysis for failing to meaningfully engage with the interview process due to poor English language skills.

From this point, presentation of themes will be of the 14 remaining participants. Table 6 illustrates the frequency of endorsement by participants. See Appendix L for a table detailing subthemes and endorsement by participants. Appendix J shows an example of extracts endorsing one subtheme.

Table 5

Domains, themes and subthemes generated

Domains and Themes		Subthemes	
1.	**BEING IN THE NHS**		
1.1	Being on the ward	1.1.1	Environment is important
		1.1.2	Privacy is important
		1.1.3	No one has time for anybody
		1.1.4	Nice to have the opportunity to talk
1.2	Being an NHS number	1.2.1	Conveyer belt care
		1.2.2	Professionals do the leading
		1.2.3	I'm not just a number
2.	**MEANINGFUL TIME SPENT**		
2.1	On the same wavelength	2.1.1	Therapist was a real person
		2.1.2	Someone was interested and listened
2.2	In-depth session	2.2.1.	Cut to the core of the problem
		2.2.2.	Lots of questions, lots came out
2.3	Being treated as a person	2.3.1	Let me do the speaking
		2.3.2	There was no intimidation
		2.3.3	My feelings are important
		2.3.4	I didn't feel judged
3. GETTING SOMETHING FROM THE SESSION			
3.1	Got something from the session	3.1.1	Having a plan
		3.1.2	Relief
		3.1.3	Reminded me who I am
3.2	New perspective	3.2.1.	Help can be good
		3.2.2	Feeling differently about myself
		3.2.3	New perspective on problems

Table 6

Prevalence of endorsement

		Participant endorsement												
	Domain and themes	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*12*	*13*	*14*	*15*
1	Being in the NHS	x	x		x	x	x	x	x	x	x	x	x	x	x
1.1	Being on the ward	x	x		x	x	x	x		x		x		x	
1.2	Being an NHS number	x	x			x		x	x	x	x	x	x	x	x
2	Meaningful time spent	x	x	x	x	x	x	x	x	x	x	x	x	x	x
2.1	On the same wavelength	x			x	x	x	x	x	x		x	x	x	x
2.2.	In-depth session	x	x	x	x	x		x	x	x	x	x	x		
2.3	Being treated as a person	x		x	x	x	x	x	x	x	x	x	x		x
3	Getting something from the session	x	x	x	x	x	x	x	x	x	x	x	x	x	x
3.1	Got something from the session	x	x	x		x		x	x	x		x			x
3.2	New perspective	x	x	x	x		x	x		x	x	x	x	x	

Presentation of themes

Domain 1: Being in the NHS.

All participants spoke about their experience of therapy in the context of their experience of being a patient in the NHS. They spoke about their experience of being in a ward environment and the importance of privacy and treatment by staff. Eleven participants spoke about an experience that resembled a feeling of being an 'NHS number'. Subthemes that were generated spoke to the routine and impersonal nature by which care in the NHS is sometimes delivered, and the power and control professionals hold over patient care.

Theme 1.1. Being on the ward

Four of the participants spoke about the environment and highlighted the importance of privacy and of being somewhere they felt comfortable. For example, two participants spoke favourably about starting their sessions in less formal settings: the ward 'breakout area' and when out on leave.

> *"It was good it was out in the open, we went for a walk, so it was good"-* *(P5).*

One participant had been moved to a quieter ward temporarily and found the quietness of the environment helped her to feel comfortable, whereas another participant did not like having their session in a meeting room, due to its close proximity to the TV room:

> *"it's not very private. It's important to get a bit of privacy"* *- (P2).*

One participant described sessions being interrupted by other patients shouting and alarms going off, while another described an abrupt ending to the session due to the ward routine. These comments indicate that conducting sessions on wards can be somewhat restrictive, whereas quieter wards or places where there is more space may be preferable.

Other participants also mentioned the importance of confidentiality. Information within NHS settings is always confidential and yet participants spoke as though having a 'confidential' space was unusual. This could indicate an atmosphere on inpatient units where privacy is perceived to be lacking.

"unless it's about suicide…knowing I was safe, it wasn't going back to anyone. So I felt okay with [one-to-one]" – (P1).

Three participants spoke about how busy wards are and staff having insufficient time to talk meaningfully to patients.

"No one has time for anybody because everyone is understaffed" – (P12).

This was in contrast to the way some participants viewed their therapy session, which was different to the regular experience of having appointments with professionals. Participants spoke about being able to talk, not feeling like they were rushed to finish and that they were listened to.

"there was no rush like "oh right you've got half an hour appointment", there was no rushing or anything like that, until we'd finished talking, and I found that helpful" – (P1).

P9 said that someone had *"bothered"* to hear her, a quote which typifies what came

through in the interviews; that people felt as though time was dedicated to them in such a way that was not their usual experience as an inpatient. Patient control over time spent talking, long or short, is an aspect of the MOL approach. It could be inferred that the experience of not feeling rushed directly related to the therapeutic approach.

Theme 1.2. Being an NHS number

A sub-theme woven throughout the data set was one of being de-humanised and of the control held by mental health professionals. Eleven participants' interviews spoke to a feeling of being an 'NHS number'.

Three participants spoke about impersonal contact as a patient in the NHS, two of whom described feeling that way after their therapy session. One participant described the questioning in appointments with professionals, including their therapy session, as "*like being on a conveyer belt*" (P2). Another said that despite having a very positive experience of the session, that afterwards they felt as though "*I was just a number…his or her job has been done, that's it, ticked off*" (P7) because there was no follow up when she was discharged.

Positively, four participants spoke about feeling treated more like a person rather a number during their therapy session. P1 said that they felt the therapist did not treat them as "*just another patient, just another number*". P12 said that after the session they felt as though "*I'm not just a number, I'm actually a person with feelings*". It is hard to say whether this was down to the MOL approach per se or the therapist's style and consideration. It does indicate that feeling like 'a number' is something inherent to inpatient, and even general NHS care.

Related to questioning, a subtheme was generated about the way general appointments are led by professionals. Two participants said that they expected there would be lots of questions.

> *"Essentially [the staff] go through their records and meet them. I feel like a hamster on a treadmill. Like here we go, you want to know everything from the beginning and then where do we go from there?" - (P12).*

Quotes from 11 participants indicated that they felt they had more control over the session in various ways. Some spoke about how helpful it was to be able to talk about what they wanted to, rather than being led by the professional.

> *"[Therapist] actually gave me authority…sometimes you don't want to go from the beginning, you want to go mid-way to what's affecting you more…I felt so comfortable starting there" – (P7).*

The same participant said that the fact she was asked by the therapist whether she wanted the door locked, if she wanted to stop or leave increased her level of comfort.

Domain 2. Meaningful time spent

The second domain generated from the data encompassed a sense that the therapy session(s) had been meaningful time spent, something all participants endorsed. Quotes from 11 participants reflected a connection with the therapist; the same number endorsed the theme that sessions were in-depth, with discussion of substantial and meaningful content. Twelve spoke about feeling as though they were treated with consideration, without intimidation or judgment and with respect of what they wanted to say and how they felt.

Theme 2.1. On the same wavelength with the therapist

Participants spoke about the importance of feeling connected and comfortable with the therapist. Some commented on the qualities of the therapist which indicated the therapist seemed "*genuine*" (P12), others spoke about the communication style between therapist and participant.

Six participants said they felt able to speak to the therapist, saying "*I could open up*" *(P5)* and that the therapist's demeanour helped them feel "*on the same level, wavelength*" *(P4)*. Participants mentioned the relaxed approach of the session, saying that the session "*was more off-the-cuff*" (P3). P13 described the therapist as "*very approachable*".

Three participants felt that the therapist was actually interested in them, and three others said they felt listened to. Participants spoke about feeling understood by the therapist, and that there was a meaningful quality to their interaction.

> "*I felt like somebody's actually listened. Did not cut me through halfway and say, 'right fine, now we have to do the next job'*" – (P7).

The MOL approach of sustaining focus on what is happening for the patient might have helped participants to feel this way. It is, however, possible quotes such as "*oh that's nice, someone wants to talk to me*" (P15), say something about interactions with NHS staff, rather than a specific aspect of the MOL approach.

Theme 2.2. In-depth session

Eleven participants spoke in terms of the session content feeling meaningful and more in-depth than previous experiences.

"We were straight to the core of the problems, no mucking about this and that… was very helpful" – (P1).

Nine participants spoke about flowing and in-depth content favourably, and that they were able to speak about "*a lot of things*" (P4). One participant disagreed however, stating that she said more than she might have done in other psychology sessions and that it "*didn't work for me*" (P10). P4 spoke about the style of the session, indicating there may have been something about the MOL approach that was different.

"[Therapist] has a good probing sense, [therapist] probes well, delves into the matter, rather than keeping it on the surface. Which is nice, I found it very helpful. Some people are very standoffish and guarded, not me. [Therapist] probed and I really enjoyed it. [Therapist] has a very malleable personality, where [they] can probe but do it in a nice way." – (P4).

Ten participants spoke about lots of questions being asked and lots of content being covered in the sessions. Three participants found the questioning style uncomfortable, although despite this, one of these thought it was helpful.

"I didn't like [therapist's] approach. [Therapist] was questioning me back and I was questioning [therapist] and [therapist] was questioning me back. And I did find that a bit uncomfortable because I did not know what to say" – (P10).

"The questions kept coming…it was like a questionnaire. I call it tick-box text book… I don't like questionnaires" – (P2).

"I was pausing and [therapist] would say 'what made you pause'…and then I'd have to give [therapist] an answer…it was uncomfortable but I think it needed to happen" - (P12).

Two participants had wondered why the therapist was asking them so many questions.

"I had questions, I asked [therapist], I felt bad mannered to ask [them] why I was having the sessions, to ask [them], "why are you questioning me like that?", it seems like a bad question to ask." – (P3).

The difference in experience could reflect personal differences in how much participants led the session and how much the participant had to be prompted to focus on topics. Alternatively, it could reflect the unusual questioning style of MOL whereby therapists ask lots of questions in order to focus on what is going through the patient's mind.

Theme 2.3. Being treated as a person

This theme encompassed subthemes relating to qualities of interactions with the therapist.

Seven participants spoke about the importance of feeling comfortable to talk and not being rushed by the therapist.

"[Therapist] was very natural. Very normal, not pushy, very natural. Let me do the speaking" - (P9).

"[the most helpful aspect of the session was] feeling free to talk about what I want" - (P8).

It is possible this experience is down to the MOL approach of letting patients lead with content but perhaps therapist qualities that helped participants to feel free to talk.

Therapists were on the wards for appointments 'as wanted', so appointments were often arranged with very short notice. There were some conflicting views about this. Participants mentioned that being informally introduced to the therapist before the session had been helpful.

"because I'd seen [therapist] around and [therapist] had introduced [therapist] to me a few times and that, so I found it easier" – (P12).

All but three participants liked the way sessions were arranged; these three participants had sessions almost immediately after being approached. One said it would be nice to know further in advance about the appointment, whereas the other two participants said that having the appointment quickly meant that they did not have time to be anxious: *"it was good because I wasn't mentally preparing myself"* (P7), but that having 15 minutes of warning or a discreet introduction before would be helpful.

Nine participants brought up the importance of being treated with respect and validation within the session(s).

"...And in a way, it's a relief to be able to confide in someone. Who's not going to laugh at me, or say I'm lying or not telling the truth...it's usually done with me" – (P9).

"[Therapist] made me feel like my thoughts and feelings are just as important as the next person's, which a lot of mental health [professionals] don't." –

(P12).

Qualities of professionalism such as being trustworthy, dependable, non-judgmental and kind were spoken about.

"It's a matter of trust and a matter of who you can and who you can't [talk to]" – (P9).

"I knew every Thursday [therapist] turned up without fail" – (P1).

"I felt I was not judged by [therapist] whereas previously I feel I have been" – (P7).

Participants spoke about these qualities as something which was sometimes lacking in previous interactions with mental health professionals, but not as different to previous therapy experiences.

Domain 3. Getting something from the session

During interviews, participants were asked questions about their overall experience of the therapy and whether they had noticed any differences to the way they thought, felt, behaved or understood their difficulties as a result of the session(s). Eight participants endorsed the theme of having gained something from the therapy whether this was in terms of a plan, feeling relieved, or a reminder of who they were. Nine participants endorsed a theme of having a new perspective following the session relating to staff, themselves and their problems.

Theme 3.1. Got something from the session

Four participants spoke in terms of having concrete plans following the session, and

that this helped them to think about the future.

> *"I feel a bit more constructive, I feel a bit more like I've got some sort of plan*
>
> *on release, on discharge" – (P5).*

A number of participants spoke about relief. One spoke about their relief that they got a chance to talk and that *"this time something's actually come out of it"* (P7) because they had an onward referral. She and five other participants expressed relief to have spoken about things on their minds and getting things "*off my chest*" (P1).

> "*I found it like, just a huge relief" – (P12).*

> *"got it out of my system, how I was actually feeling at the time" – (P14).*

Four participants spoke about feeling like they had been reminded who they were, and that the session(s) had helped them '*feel human again'* (P2).

> *"[what was helpful about the session was] reminding me of who I am,*
>
> *because I had forgotten who I am" – (P3).*

Theme 3.2. New perspective

A final theme generated from the data was one of having new or altered perspectives following the session, relating to changes in participants' attitude to help, their views about themselves, and insights into their problems.

Four participants expressed a change in their attitude towards seeking help. One person said that the session had helped to "*see the benefit now*" (P1). Another said that *"[the session] encouraged me to speak to people more and reach out"* (P4).

P7 said that the experience of therapy had changed her previously negative views

about professionals.

"It was the first time that I found [being on a ward] really beneficial... it changed my point of view about professionals" – (P7).

However, P10 said that she felt "*a bit strange about psychologists*" following her session and expressed uncertainty about whether they were helpful. She said she would have liked *"more answers"*. She concluded that though she had not had a helpful experience within the session and had "*wanted [therapist] to have an answer*", she thought that psychologists can "*help you help yourself*". The fact that P10 had spoken about how the style of questioning made her feel uncomfortable, and that she would have liked more answers indicates that there was something about the MOL approach in particular that changed her view of professionals, as she did not relate the comment to anything else.

Another shared viewpoint was participants feeling differently, mostly more positively, following their session. Five participants referenced things such as feeling more confident, strong, feeling more optimistic about the future and feeling better about themselves.

"It really did just lift my spirits" – (P12).

"I just felt better about myself" – (P14).

Five participants spoke in terms of being more aware of their problems and gaining a new perspective.

"[the session] made me see where I was hiding" – (P1).

"Sometimes you have questions yourself that you don't ask yourself. Then

someone else will ask you questions that you haven't thought of yourself –

that's what I'd say [was helpful]. Another viewpoint" – (P2).

P4 noticed that he had changed his view about himself, and now felt that:

"*it's alright to say that you have a weakness. We all have to identify that we*

have a weakness. And my weakness is asking for help. I've never done it." -

(P4).

Summary of results

The data regarding resources used and attendance patterns indicates that it was possible to implement a therapy approach flexibly when sessional therapists attended the ward one day a week. Participants were seen for varying numbers of sessions, indicating that is possible to implement MOL in the 'patient-led' manner in which it is intended, where sessions can be standalone or multiple in nature. Fifty per cent of referred patients attended at least one session which, on an inpatient ward could be considered a success. However, a quarter of referrals declined and a quarter were unable to be seen. Whilst it is possible for sessional therapists to implement the approach, low numbers of patients were seen per session, calling into question the cost-efficiency of using sessional therapists.

Thirty-four per cent of patients seen for one session were discharged before the therapist was next on the ward, and so information regarding the acceptability of the approach to them was unfortunately unavailable. Nine of 15 participants (60%) attended a second session, indicating that sessions were acceptable to a large percentage of the participants. Seven of the 15 participants were discharged following one session; five were unwilling to travel back to the ward; one returned;

one had an onward referral. The acceptability of the approach is reflected in the majority of participant interviews, but the experience was not acceptable to everyone. The main themes generated from the data reflected a sense of having spent meaningful time with the therapist and having got something from the session. This experience was often spoken in contrast with a 'usual' experience of being in the NHS, which will be reflected on further in the discussion.

Discussion

This study sought to investigate the feasibility of implementing an MOL approach in inpatient settings, and explore participants' experience of therapy sessions that used this approach, considering impact and the context in which they received therapy. This discussion will consider the evidence combining quantitative and qualitative methods of analysis.

Feasibility of implementation

Using sessional therapists to deliver MOL sessions flexibly on an acute inpatient unit one day a week is possible. There was 'buy-in' from the wards and 50 per cent of referred patients were seen for therapy during the 30 weeks that therapy was offered. The prevalence of participants who attended a second MOL session (60%) would indicate that the approach is acceptable.

In terms of the feasibility of professionals learning and adhering to the MOL model, the data indicates that as with all therapies, the longer a professional uses a trained approach, the more able they are to transfer that training to practice (Baldwin & Ford, 1988). Evaluation forms indicated more challenges in adhering to aspects of the model when having sessions with acutely unwell (i.e. psychotic) patients.

Donaghay-Spire, McGowan, Griffiths, and Barazzone (2015) noted that high service user distress levels impeded psychological input in inpatient settings, indicating that this a wider problem for other therapies, not just MOL. Despite these challenges however, it was possible in this study for therapists to talk to acutely unwell patients, indicating the suitability of a transdiagnostic approach with highly distressed individuals (Rush & Koegl, 2008).

Critique of delivery

Over a quarter of referred patients were unable to be seen by therapists for reasons varying from other appointments or family visits, to patients being asleep or on leave at the time therapists were available for sessions. These circumstances reflect the busy and often unpredictable course of inpatient stays (Clarke & Wilson, 2009). That said, this finding supports the suitability of MOL in an inpatient setting over other therapies that prescribe multiple sessions, as MOL sessions can be used 'as needed' and could fit better with the routine of the ward and the schedule of a ward psychologist. One could argue that ward psychologists using the approach could be more successful than a sessional therapist available on the ward, as the latter only offers the fixed times of the therapists' clinical sessions. Further research to investigate the feasibility of ward psychologists implementing the approach is needed in order to gauge how truly feasible and efficacious an inpatient MOL intervention is.

The unpredictability of patient turnover also created challenges in enabling patients to access therapy; patients who had attended one session were often discharged by the following week. This emphasises how ill-suited lengthy NICE treatment guidelines are to inpatient settings (Clarke & Wilson, 2009) and could

again, speak to the suitability of an MOL intervention that can be standalone in nature. However, unplanned discharges limited information about the acceptability of the approach; whether patients were satisfied with the therapy itself, the amount of therapy they received, and/or whether they would have agreed to another session had they been on the ward. Carey (2016) is a proponent of patients scheduling therapy sessions as and when they think they will benefit most, determining for themselves the level of change they require. However, where discharges are often swift, and when the usual protocol is for patients to be referred to outpatient therapy services, the aspect of patient-led access to the therapy could not be tested in the current study.

A question is raised as to whether patients who received 'standalone' sessions felt the experience of therapy helped them to achieve their desired level of change, or if they would have asked for more had it been offered in different circumstances. Whilst self-determination of patients is of great importance (Rappaport, 1984), themes within the data spoke to the power of professionals. Many people who suffer from mental health problems lack the sense of control or actual control (Rappaport, 1984) over their care and do not feel empowered to ask for what they want (Staples, 1990; WHO Regional Office for Europe, 2008). Services need to be set up in a way that offers patients the opportunities for continuity of care and empowers them to make choices about their own care (WHO Regional Office for Europe, 2010). The MOL approach goes some way in this respect, but these findings highlight some of the barriers within NHS service provision to a truly patient-centred approach. Efforts must be made to overcome these barriers by developing, delivering and evaluating thought-out service change so that interventions are meaningful and with patient well-being and choice at the centre (NHS England, 2018).

Despite the feasibility of implementation and the suitability of a 'standalone' therapy in inpatient wards, the delivery model warrants criticism. When taking into account the cost of two full days of psychological input by a trainee and qualified psychologist, an average of four patients seen over this time is small. The ward psychologist reported having a maximum of three one-to-one sessions per day, resulting in up to six one-to-one sessions over the same amount of time that sessional psychologists attended the ward. The findings demonstrate that using sessional therapists to implement therapies in inpatient settings would not be advisable when considering cost of resources.

Acceptability - participant experience of MOL

Whilst there are some challenges to a truly patient-led approach, themes generated from the data suggest that the majority of participants had a positive – and in some cases empowering – experience of the therapy. Thirteen out of fifteen participants appeared to find the approach acceptable, reflected in dominant themes of having spent meaningful time with the therapist and having gained something from the session. Of the two participants who did not like the approach, both spoke about disliking the style of questioning. One wanted to be given 'more answers' by the therapist. Positive aspects of participants' experiences were often spoken in contrast with their experience of being in the NHS, another dominant theme generated from the data.

Unfortunately, it was difficult to tell what of participants' experiences were due the MOL approach itself. With regards power and control, the quotes say something powerful about patients' perception of who has control in this inpatient setting, and perhaps the NHS as a whole. As MOL specifically aims to focus on

patient control, this aspect of having more control could be understood to be relevant to the approach itself. Another aspect that might relate specifically to the approach was the two participants' dislike of the style of questioning. MOL questioning is persistent for the purpose of focusing on a patient's current experience. It is possible participants were referring to this persistence.

It is less clear however whether other themes and subthemes generated related to the approach, the therapist, or NHS care as a whole. When participants spoke positively about not feeling rushed by the therapists, it is difficult to tell whether this was due to the unstructured nature of MOL sessions when compared to a more structured psychology session. Alternatively, participants' experience could be purely down to therapists' personal qualities. When participants spoke about trustworthiness and dependability, they spoke in comparison to previous care experiences rather than previous therapy experiences. It therefore cannot be concluded that this experience was solely due to the MOL approach, but is perhaps a reflection on their wider experiences of NHS professionals.

Two important concepts overarched all themes in the data that require highlighting: 1) being treated as a human being and 2) having a satisfactory experience of help.

Being treated as a human being

A thread woven throughout the data was one of being treated respectfully, without judgment and without intimidation. Participants highlighted the importance of feeling on the 'same wavelength' as the therapist and that they felt they could trust the person. They spoke about reconnecting with the idea that they are human beings and that they felt worthy to talk about their thoughts and feelings. Many spoke with

surprise that they had a positive experience.

Though these themes do not specifically advocate for an MOL approach over other therapies, the data suggests that overall, participants had a meaningful and 'human' experience of therapy, and that this resulted in a more positive patient experience. As MOL was not directly compared to other therapies, the findings cannot speak to whether participants had a better experience than they might have had they received a different therapy. They do however, raise serious concerns regarding patient experience within NHS care more widely. The fact that the experiences were reported as different to previous experiences in health settings is very concerning and adds to other literature indicating that 'human' relationships in NHS services feels like a rarity to service users (Small et al., 2018). Gilburt, Rose & Slade (2008) found that relationships formed the core of service user experience of psychiatric hospitalisation, yet the competing demands on staff time can lead to perceptions of ward staff as busy and uncompassionate (Bramley & Matiti, 2014; Stenhouse, 2011). More must be done to foster genuine and therapeutic relationships in NHS settings which, though recognised in the 'compassionate care' agenda (Department of Health, 2012; Francis Report, 2013), is difficult to deliver. As Small et al. (2018) state, there are still considerable challenges to delivering compassionate care at all levels of acute inpatient care. Despite this, the NHS – from front-line staff members to policy makers – should be concentrating efforts to achieve a truly compassionate way of working. Increasing investment in MOL could be a step towards more compassionate, patient-centred inpatient care.

Having a satisfactory experience of help

Having a satisfactory experience of therapy seemed to vary in what this

looked like for participants. For some people, it was about feeling listened to; for others, it was about gaining more understanding about their problems, echoing themes found by Small et al. (2018). Some participants spoke about the value of being reminded who they are; others felt that having a plan following the session helped them to think differently about the future. Participants liked having had more control within the session(s), in the context of this differing from common previous experiences with professionals. For some participants, having discussed so much content was helpful.

It is possible that specific aspects of the MOL intervention resulted in the satisfactory experience participants reported. The style of MOL questioning may have generated more patient-focused content than in previous therapy experiences, and might have contributed to the time having felt meaningfully spent. The efforts of therapists to sustain focus on 'in-the-moment' thinking for the participants might have resulted in them feeling more in control of what was spoken about, and perhaps to feel more interested in. With regards aspects such as 'gaining' a plan from the session, it could be argued that this could have been generated in a session using other therapeutic approaches, such as solution focused therapy (De Shazer et al., 1986) or motivational interviewing (Rollnick & Miller, 1995). Further, many of the themes generated spoke to generic therapeutic skills of the therapists and human connectedness between the participant and therapist, which numerous studies have found to influence outcomes and experience (Orlinsky, Rønnestad, & Willutzki, 2004). Whilst this makes it difficult to draw conclusions about what aspects of participants' experience related to MOL specifically, it demonstrates again the importance of, but also the simplicity with which, staff interactions could be altered to give patients a more satisfactory experience of treatment. NHS care lacking in this

respect could help to explain the fifty per cent of patients referred who did not accept an invitation to therapy. Though using an MOL approach when talking to patients in routine patient care would not be possible, renewing the focus on how the patient is thinking and feeling is something that can be adopted throughout all levels of care. Simply having meaningful conversations that are respectful and patient-focused could help to challenge the culture of de-humanised care that has been illustrated in this study and other research (Bramley & Matiti, 2014; Gilburt, Rose & Slade, 2008; Small et al., 2018; Stenhouse, 2011). MOL helped some participants to feel more interested in, listened to and in control, potentially over other therapeutic models. As suggested above, using it on a larger scale could help to offset some of the negative aspects of routine care that will take time to change.

Limitations

Data collection proved difficult in a number of ways. A disappointing aspect of data collection was the difficulty of getting consistent routine outcome measures. Session rating scales (SRS; Johnson, Miller & Duncan, 2002) for each participant could have complemented qualitative analysis about experience. That being said, Miller, Hubble, Chow and Seidel (2015) recommend that the scale be used to improve the therapeutic alliance between clinician and patient over sessions. As the median number of sessions attended was 1, it is possible that SRS data would have only added to information regarding the therapeutic alliance rather than collecting more specific information about the nuances of the approach.

Another aspect of data collection that could be improved upon in future research is the way in which adherence to the model was evaluated. Further research should make efforts to gain consent to use recordings of sessions so that tapes could

be co-rated by using the MOL Session Evaluation Forms – Other (Mansell, Carey & Tai, 2013). Additional to gaining a more reliable evaluation of adherence, qualitative information regarding what happened within sessions could be used to compliment the data gathered regarding participants' experiences. It may help to provide more clarity on whether clients' experience related specifically to the MOL approach over other therapeutic approaches or care experiences.

The unfruitful interview with participant eleven highlighted that the interview schedule should have been more accessible to those who use English as their second-language. The participant's level of English had seemed developed enough for two MOL sessions, but he had difficulty understanding questions in the interview and therefore was excluded from analysis on that basis. Investigations should make efforts to include people who use English as their second-language or risk limiting the generalisability of research findings.

As is previously commented on, it is difficult to tell what aspects of participants' experience related specifically to the MOL approach and which might have been their experience had the therapist used any other therapeutic model, or if participants had a positive meeting with any other professional. More detailed questioning during interviews could have garnered more information in this respect, gleaning a more detailed picture of participant experience of the approach.

Future research

A dominant theme that was generated across the data was one of participants having 'gained something' from the therapy. Though this study focused on experience rather outcomes of sessions, participants nonetheless spoke about outcomes. Further research could look more closely at outcomes of the therapy,

perhaps longitudinally. An interesting outcome to consider is whether a positive therapy or care experience impacts future engagement with psychological services.

Considering the limited evidence base behind MOL, an RCT is first required to compare MOL against other therapeutic interventions and treatment as usual to examine the efficacy of the approach. Should further research indicate the approach is efficacious, protocols for randomised controlled trials (RCTs) investigating feasibility and acceptability (Haddock et al., 2016; Jacobsen, Morris, Johns & Hodkinson; 2010) could be used to determine whether MOL suits an inpatient setting on a larger scale. In light of the findings regarding use of resources when using sessional therapists, a study using ward psychologists would be advisable in order to use the approach in a more cost-efficient way.

As discussed above, it was not possible to ascertain what aspects of the therapy were helpful or unhelpful to people with a one group post-evaluation study. Further research could address this in a number of ways. Information from participant interviews, taped session material and comments on the MOL evaluation scale by therapists could be cross-referenced. This could help to elucidate whether there were specific aspects of sessions that were particularly acceptable or unacceptable to a client, if these aspects were relevant to features of the MOL approach and whether the therapist had made comments in relation to those features.

Another possible research design could compare MOL against another therapeutic approach and against one-to-one sessions with a mental health professional in which clients lead with the content. Qualitative interviews coupled with client satisfaction measures (for example the Client Satisfaction Questionnaire-8; Attkisson, 2012) could help to glean information about whether participants'

experiences generated similar or dissimilar themes to those found and whether the type of input patients had made a difference. A design of this kind could investigate acceptability and whether MOL provides a different therapeutic experience to other therapies, informing where training resources should be directed. Consideration should be given to data collection, which this study suggests could be a challenge.

Conclusion

It was feasible for sessional therapists to implement MOL, a flexible psychotherapeutic approach, in an acute inpatient setting. However, the uptake of offered sessions by referred patients was too low for it to be financially advisable to use a sessional therapist format to implement an intervention intended to be used flexibly. The findings demonstrate that some challenges remain with regards continuity of care even in spite of the 'standalone' nature of MOL. The data indicates that therapists were able to adhere to the model when adequately trained and supervised. Data suggests that MOL was acceptable to the majority of participants; those who disliked the approach referred to the style of questioning and a desire for 'more answers'. Themes throughout participant interviews echoed other research (Small et al., 2018; Donaghay-Spire, McGowan, Griffiths & Barazzone, 2015) pertaining to the positive experience of a connected, meaningful meeting with a mental health professional, and how lacking NHS inpatient services are in delivering this on a day-to-day basis. Many participants' accounts describe a shared, worthwhile experience of therapy that was humanising and satisfactory.

Policy-makers and commissioners must allocate more resources to enable the implementation of flexible approaches such as MOL on a larger scale. Though it is difficult to conclude whether MOL was more acceptable than any other therapeutic

intervention might have been, it nonetheless resulted in a compassionate, patient-centred experience. More research investigating the efficacy of MOL is required, as is a larger scale feasibility and acceptability RCT to investigate whether MOL does give patients a different experience to other therapy or care experiences. This could inform whether resources should be directed towards the roll-out of MOL on a larger scale, or whether alternative forms of therapy and care could be equally meaningful.

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Part 3: Critical Appraisal

Introduction

This critical appraisal comprises an exploration of the main issues that preoccupied me whilst conducting this research. I will discuss how my background and assumptions influenced the research process. Firstly, I will discuss the way in which my doctoral training and therapeutic orientation influenced my ability to learn how to implement the MOL approach. Secondly, I will reflect on data collection and how my preconceptions potentially influenced the process of analysis and how I managed this. Subsequently, I will put forward ideas for research which could follow on from this study that particularly interested me.

Reflexivity in qualitative research

Qualitative research involves examining individual descriptions and interpreting meanings within these experiences (Willig, 2008). It is widely acknowledged that a researcher's own values, political views, experiences, interests, beliefs and social identities will shape the interpretation in some way (Willig, 2008). Thus, a process of personal reflexivity is required, where researchers explore the way in which their involvement in the research influences, acts upon and informs such research (Nightingale & Cromby, 1999, cited by Willig, 2008). This enables a richly contextualised account of the research findings.

I believe that the consideration of a researcher's influence upon findings generates richer analysis and allows researchers to become more receptive to novel perspectives, such that results are less restricted by prior assumptions. Through transparency with regard to my prior affiliations in Part 2, and attempts to exercise reflexivity and maintain receptivity to novel perspectives during analysis, I am hopeful that the research provides a richly contextualised account of participants'

experience of the therapeutic approach.

In what follows, I will consider how the results of my study were influenced by my background, interests and beliefs.

Background

During my undergraduate degree, I was fortunate enough to have a placement year in a medium secure forensic unit, and went on to work in a different medium secure unit as an Assistant Psychologist following graduation. I worked there for two and a half years before securing a place on the doctorate. My clinical psychologist supervisors thought in terms of systems (Bronfenbrenner, 1992) and I worked collaboratively with staff from other professions to deliver low-intensity therapeutic groups.

The therapies programme comprised of thirty low-intensity therapeutic groups a week delivered over six wards. It was efficient and successful and I believe the experience of this way of working, and my supervisors orientation influenced my more systemic view of mental health. This was solidified by witnessing the incidence of patients who revolved within the hospital and the forensic mental health system.

Almost as soon as I started working at the unit, there was a service-wide consultation introduced over the course of a year. As a result of the consultation, the therapies programme and posts across professions were cut. The consultation and cuts created a climate of frustration, despair and burn-out. There was splitting between professions, service users had less activities on the ward and there was understaffing at all levels.

I believe the experience of witnessing cuts to services and the impact on staff and

patients alike shaped a belief about the duty of psychologists and mental health professionals. At the time, I felt that we as a psychology department had not done enough to persuade senior managers and funding bodies how important psychological input and regular ward activities are to recovery. As a young professional, I was new to the realities of the NHS and experienced considerable personal stress at the prospect of losing my job. I was angry that the NHS is not adequately funded, that cuts are made with too little thought and that commissioners create what I believe is a false economy through their decisions.

The experience over the three years of the doctorate has helped to develop my understanding of the complexities of funding and its challenges. However, I still hold the belief that the duty of a psychologist, beyond our therapeutic work, is to foster collaboration rather than competition with our colleagues; use our privileged position to advocate for service users; and make efforts to actively influence commissioning and policy development. In what follows, I will discuss how my personal, professional and political views may have influenced the research process.

The research process

Implementation

It was due to my interest in therapy provision in inpatient care, rather than a particular interest in the Method of Levels approach, that I chose the project. At the beginning of the research project, I thought this would give me an advantage at the analysis stage in that I would not succumb to a biased, overly positive analysis of the project. However, it transpired that when I trained in the approach and learned more about Perceptual Control Theory (Powers, 1973), there were core aspects of the therapy and training approach that I did not personally agree with. I have come to

hold scepticism when anyone is overly wedded to one approach and aspects of the training and Carey's stance flagged some of these concerns for me. I understood the theory behind MOL but I was doubtful of the concept of having very few sessions. Carey & Mullen (2008) suggest that reorganisation can happen following one or two sessions, resulting in the client ceasing to book another. I felt that this was perhaps more likely in primary care and less suited to a complex care setting where people have longer-standing problems. I am absolutely an advocate of client-led care, and think that clients should have the last say about whether they attend sessions or not. I also think that clients lack agency to ask for sessions and my concern is that whilst it would be hopeful to think that a client who never returned had 'reorganised' their conflicts, they may have simply ceased to access help. I willingly admit that my views are most likely held because I see the value in longer-term therapy and that I believe psychologists should admit to our expertise and use it to advise on the length and direction of treatment. It was for this reason I believe that when I first implemented the intervention, I found it difficult to suspend the skills I had been developing for two years – to formulate collaboratively, to ask curious questions and make tentative suggestions in order to develop a shared understanding with clients of their presenting problems. I found the experience of concentrating solely on the content of clients' minds whilst refraining from making suggestions, giving advice or trying to create solutions collaboratively very difficult.

Despite my feelings about the approach, I wanted to contribute a worthy piece of rigorous research to the literature on MOL. I used supervision to reflect on, and to the best of my ability put aside my preconceptions and therapeutic preferences. I used the MOL self-evaluation forms (Mansell, Carey & Tai, 2013) to monitor which aspects of the approach I found more difficult and set myself targets

for improvement. A fortunate aspect of the approach is that it is very technique-driven and so despite my views, it is easy to see which techniques need more development. Though I did not come to therapeutically value the approach that much more, my competence/skills improved and I became more comfortable with delivering the therapy over time. As I undertook interviews with participants over the course of implementation, I also gained a new perspective on the approach's merits. The themes discussed in the empirical paper helped to remind me that patients were getting a worthwhile, mainly positive experience of therapy. The experience helped remind me that the purpose of therapy is not always to solve life-long problems with wide-reaching implications for their lives. Inpatient care is short-term and an approach such as MOL helped people to feel listened to and like a 'human' again.

Data collection and analysis

When it came to coding, I realised that ideally, I would have done all of the interviews and transcribed them myself. It was more difficult to become familiar with the interviews conducted by the Master's student Jordan, though it was very fortunate to have six interviews already completed. Taking a data-driven approach in a research setting was a new experience for me but, as someone who loved annotation and interpretation as English Literature student in college, it was one of the most interesting parts.

At the analysis stage I was careful to attempt to 'bracket' (Fischer, 2009) my assumptions so as not to 'see' things related to MOL in the data, and to make notes when I thought this had happened. I was taking an essentialist stance and through the noting of how certain items recurred throughout the data, tentative themes were constructed. The process of reflexivity allowed me to consider how my

background and identity shaped my interpretation of the research (Willig, 2008). Interestingly, whilst trying hard not to let my preconceptions about MOL (good and not so good) influence analysis, my experience of working in inpatient care and preconceptions about the service the NHS provides came through more strongly than MOL in the first draft of my discussion. The NHS is no doubt an important context in which the meaning derived from the research can be understood and evaluated (Elliott, Fischer & Rennie, 1999). The fact that participants received care in the NHS would have made it almost impossible to disentangle the data from this context. When implementing therapy as part of the study, I witnessed first-hand the non-therapeutic and robotic nature in which inpatient care can be implemented, building on previous experiences of forensic inpatient settings. I believe my distaste of this experience, my existing views about the impact of understaffing on compassionate and therapeutic care and my political views about government funding initially clouded my analytic observance and shaped the weight with which I gave aspects of my findings (Tufford & Newman, 2010). In writing the discussion, I gave more weight to interpreting the results in relation to the failings of the NHS.

Through the process of reflexivity, in discussions with my supervisor, and following feedback from an independent researcher, I rewrote my discussion with the MOL approach and my research question relating to their experience held more clearly in mind. This allowed for what was hopefully a more balanced interpretation of the findings, and a discussion which answered my research question in a more focused manner. Of course, as the findings were partly subjective and, although credibility checks were in place, another person might have interpreted the data in a different way.

Future research

In the empirical paper, I suggested a future feasibility and acceptability randomised controlled trial. Here I will outline another area of research that related to the project which particularly interested me.

Training and implementation the MOL approach

As has been highlighted, I found that the process of training and implementing MOL to an acceptable standard took some time. Suspending my previous and concurrent learning, and my preferences in therapeutic style required a process of reflection and determination to overcome this. In supervision, these challenges brought up interesting questions about the process of learning at different stages of a psychologists' career, and the conflicts that can occur when someone is learning a way of working that is different to their usual therapeutic orientation.

As is explained above, due to the itemisation of techniques in the MOL evaluation forms (Mansell, Carey & Tai, 2013), it was easy to see which areas needed improvement. However, I stopped using the approach when I stopped attending the ward when data collection was complete. It was therefore not possible, unless I had taken it upon myself, to investigate whether had I continued to use the approach, I would have become even more proficient. I wonder whether my personal preferences might have precluded the ability to fully immerse myself in the approach.

There are two areas for future research which I think relate to this.

The first could explore the ability of professionals at different stages of their career to learn and implement an MOL perspective. A comparison study between pre-doctoral, training and qualified psychologists could provide information on who

might be best suited to deliver this intervention. Analysis of the length of time to deliver with proficiency and ratings on MOL evaluation forms could inform who training could be delivered to in order to roll out the intervention on a larger scale.

A second area for investigation could relate to therapeutic preferences and the ability of psychologists to learn a model depending on their preferences. My supervisor uses this model almost exclusively but it would be beneficial to see whether the approach can be used by psychologists who take a more integrative approach to therapy. My experience would suggest it is, but a question arises as to whether it can authentically be used when the therapist prefers another approach. I found it difficult not to slip back into my usual style of working. Research of this kind could provide invaluable information as to whether it is feasible to teach professionals (psychologists and non-psychologists) the techniques used in the MOL approach when taking into consideration their preferences and the other ways they work. It could inform the feasibility of rolling this intervention out on a larger scale, across professions. Where inpatient stays are conducive to short-term interventions, the delivery of such an approach could be the best fit for patients. A question is whether a professional needs to be very wedded to the approach in order for it to be of most benefit to the client and most easily implemented. Were it to prove more difficult for professionals to integrate this way of working into their existing duties and therapeutic preferences, it might suggest that independent MOL 'workers' should deliver the intervention, in addition to the duties of a ward psychologist.

Conclusion

The research has important implications for the implementation of inpatient psychological input, and adds to previous suggestions that the NHS is failing to

deliver the compassionate care agenda set out by the Department of Health (2012). From a personal perspective, the process of undertaking a research project of this size evolved me as a researcher, and as a consumer of research which I think will in turn, shape the kind of clinician I am. I hope that through the process of reflexivity, I have put forward a contextualised account of participant experience which will add to the literature on inpatient therapeutic care and the implementation of the MOL approach.

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APPENDIX A: MOL explanation – Third party copywrite

Participant Information Sheet: Version 2, Date: 26/05/2017

Experiences of Psychological Support in Inpatient Settings

You are being invited to take part in a research study. This information sheet explains the purpose of the research study and what participating will involve. Please take time to read the following information and discuss it with others if you wish. If there is anything that is unclear, or if you would like more information, please ask.

What is the reason for the study and why is it important?
We would like to explore what people think about psychological therapies that are offered on inpatient wards. The information we gather may help us to find ways to make talking therapies more accessible and meaningful to individuals who are part of the ward. We hope this will give individuals more choice and variety in the services they can access.

Why have I been invited to take part?
You have been invited to participate in this study because you are or have been resident on the ward and we are inviting both people who have received psychological therapy and those that haven't.

Do I have to take part?
Participation is completely voluntary. You are free to withdraw at any point without giving a reason. Your decision will not affect your patient rights or your future care.

What will happen if I take part?
If you agree to take part, we will arrange a time to meet with you and conduct an informal interview lasting no longer than an hour. During the interview we will ask you questions about your views and experiences of receiving help while on the ward. The interview will be audio recorded; once it the recording has been typed up, the recording will be destroyed. These will be arranged at a time convenient for you. With your consent, we will audio-record the interviews so that we do not miss anything important that you tell us**. In addition, with your consent will check information recorded in your notes to see if the therapy has been helpful to you or not.**

Should you decide to participate in this study, you will be given a copy of this information sheet to keep, and you will be asked to sign a consent form to indicate that you understand the purpose of the study and agree to participate. As a thank you for your contribution to the study we are offering supermarket £10 shopping vouchers.

What will happen to the information I provide?

All interviews will be typed up and anonymised (your name or any details which could identify you will be changed or deleted). The researchers will listen to all the interviews, identify frequent themes and ideas, such as those that are talked about by more than one person. These themes will be written up into a report. If you would like a copy of the final research report you can contact the research team.

If you decide to withdraw from the study the information you have provided up to the point of withdrawal will remain in the study.

What are the risks and possible benefits of taking part?
It is possible, but unlikely, that you could find it upsetting to talk about your experience of receiving support whilst being resident on the inpatient ward. If this happens, you can ask the researcher to take a break or stop the interview at any time. You do not have to answer any questions you do not feel comfortable answering.

You may find that talking about and reflecting on your experiences is interesting and helpful. We also hope that our findings from this study will benefit other people who may wish to get psychological support whilst receiving inpatient care.

Confidentiality and anonymity
All data will be collected and stored in accordance with the Data Protection Act 1998. Audio recordings from the interviews will be stored on a password-protected computer and will be deleted once transcripts have been made. Names and other personally identifiable information will be removed from transcripts to ensure anonymity. We may include direct quotations from interviews in published reports but will not include names of participants and we will make sure that any quotations we use cannot be linked to individuals. We will store the anonymous interview transcripts in a secure location for five years after publication of the results. **If we access any information from your medical records we will remove personally identifiable information to ensure anonymity.** If you tell the researcher something that leads them to think that you or somebody else is at risk of significant harm, they may have to discuss this with somebody to ensure your safety.

What if there is a problem?
If you wish to complain, or have any concerns about any aspect of the way you have been approached or treated by members of staff you may have experienced due to your participation in the research, National Health Service or UCL complaints mechanisms are available to you. In the event you wish to complain contact the chief investigators using the details given below.

In the unlikely event that taking part in this study harms you, compensation may be available. If you suspect that the harm is the result of the Sponsor's (University College London) or the psychology service's negligence then you may be able to claim compensation. After discussing with the student researcher, please make the claim in writing to Dr Vyv Huddy who is the Chief Investigator for the research and is based at UCL. The Chief Investigator will then pass the claim to the sponsor's Insurers, via the Sponsor's office. You may have to bear the costs of the legal action initially, and you should consult a lawyer about this.

Contact for further information

If you would like further information please contact the study chief investigator Dr Vyv Huddy, Lecturer in Clinical Psychology, University College London, v.huddy@ucl.ac.uk (Tel: 020 7679 1675)
Research Department of Clinical, Educational and Health Psychology
University College London
Gower Street
London WC1E 6BT

Thank you for considering taking part

Consent form
Experiences of Psychological Support in Inpatient Settings
Version 2, 26/05/2017

I confirm that my participation in the above project has been explained to me. I have read and understood the information sheet and have had the opportunity to ask questions.

I am aware that (please initial in the boxes):

o I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily ☐

o I am free to withdraw from the project at any time and to withdraw any data that I have supplied without giving any reason. ☐

o The interview will be recorded and all data or information used for research or publication purposes will be anonymous. ☐

In addition

o I give consent for quotes from the interview I take part in to be included in reports of the research findings. ☐

o I understand that the researchers may access limited sections of my medical records. I give permission for these individuals to have access to my records. ☐

I agree to participate in the above project.

Participant's Name: ………………………………………………………..

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

Researcher's Name: …………………………………………………………..

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

If you would like any further information please contact
Dr. Claire Williams, Clinical Psychologist, Inpatient Psychology Service (North East London Foundation Trust). Claire.Williams@nelft.nhs.uk (Tel 0300 555 1200)

APPENDIX C: Ethical approval

NHS
Health Research Authority

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

Telephone: 0115 8839436

09 July 2015

Dr Vyv Huddy
University College London
1-19 Torrington Place
London
WC1E 7HB

Dear Dr Huddy

Study title:	Service User and Staff Experiences of the Provision of Psychological Support in an Inpatient Mental Health Setting
REC reference:	15/EM/0263
IRAS project ID:	171378

Thank you for your letter of 3 July 2015, responding to the Proportionate Review Sub-Committee's request for changes to the documentation for the above study.

The revised documentation has been reviewed and approved by the sub-committee.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Assistant Tad Jones, NRESCommittee.EastMidlands-Derby@nhs.net. Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

Confirmation of ethical opinion

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

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.

<u>Registration of Clinical Trials</u>

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

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 request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from NRES. Guidance on where to register is provided on the HRA website.

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).

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" above).

Approved documents

The documents reviewed and approved by the Committee are:

Document	Version	Date
Covering letter on headed paper	1	27 May 2015
Covering letter on headed paper	2	03 July 2015
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Insurance Document]	1	
Interview schedules or topic guides for participants [formal support service user]	1	

Interview schedules or topic guides for participants [Interview schedule about formal support psychological therapist]	1	29 May 2015
Interview schedules or topic guides for participants [informal support service user]	1	29 May 2015
Interview schedules or topic guides for participants [Interview schedule informal support staff member]	1	29 May 2015
IRAS Checklist XML [Checklist_03072015]		03 July 2015
Letter from sponsor [Confirmation from sponsor]	1	
Other [CV Anna Galloway]	1	01 April 2015
Other [CV for student Catherine Small]	1	02 April 2015
Participant consent form	1	01 April 2015
Participant information sheet (PIS) [Staff]	v1	01 April 2015
Participant information sheet (PIS) [Patient]	1	01 April 2015
REC Application Form [REC_Form_27052015]		27 May 2015
Referee's report or other scientific critique report	1	16 December 2014
Research protocol or project proposal	3	03 July 2015
Summary CV for Chief Investigator (CI)	1	01 April 2015
Summary CV for supervisor (student research)	1	01 April 2015

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 HRA 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 HRA website:
http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance

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/

15/EM/0263	Please quote this number on all correspondence

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

Yours sincerely

pp.

Vice-Chair
Mrs Janet Mallett

Email: NRESCommittee.EastMidlands-Derby@nhs.net

Copy to: Mr Dave Wilson

                Ms Fiona Horton, North East London Foundation Trust

APPENDIX D: Method of Levels Evaluation Form (taken from Mansell, Carey & Tai, 2013) – Third party copywrite

APPENDIX E: Outcome Rating Scale (Miller & Duncan, 2000) – Third party
copywrite

APPENDIX F: Session Rating Scale (Johnson, Miller & Duncan, 2002) – Third party copywrite

APPENDIX G: Interview schedule

Introduction
Thank you for meeting with me today. As you know, I'd like to talk with you about your experience of working with [psychologist name] as part of the research project looking at new ways of working on the unit. My aim is to better understand what it was like to meet together, what was helpful or unhelpful about it for you and whether the meetings made a difference for you. I will not ask you to speak about anything confidential that was shared in the sessions. To begin, it would be really helpful if you could tell me a bit about how you came to the unit.

Background
1.   How long have you been/were you on the unit for?
2.   Have you been to this unit before?
3.   Can you briefly describe what led to your admission?
4.   Have you ever seen a psychologist before coming to the unit?
     1.   What was your experience like?
5.   Did you have any expectations about what meeting with [psychologist name] would be like?
     1.   How did you imagine it would be like?

Description of meetings with psychologist
6.   How many times did you meet with [psychologist's name]?
7.   Have you planned to continue to see them further?
     1.   Is this what you would like to happen or not?
8.   How did things end?
     1.   How was this decided?
     2.   Did you talk about this together?

Experience of MOL sessions
9.   What has been your overall experience of working with [psychologist name]?
     1.   Was it different from what you expected or not?
     2.   Was it different from previous experiences of meeting with a psychologist? [if appropriate]
10. How did you and the psychologist use your time together?
     1.   How was this decided?
     2.   Were the meetings as you wanted them to be?
     3.   Is there anything you would have liked to be different?
11. What were the meetings like for you?
     1.   Can you give me an example of something that you felt worked really well?
     2.   Can you give me an example of something that you felt didn't work as well?
12. Who decided what you talked about?
     1.   Was this as you wanted it to be?
     2.   Can you give me an example of when this happened?
     3.   Was there anything that got in the way of doing this?
13. Did you ever have any questions about the way in which you and [psychologist's name] worked together?
     1.   Can you give me an example of when this happened?

2. How did you respond?
3. How did [psychologist's name] respond?

Impact of MOL sessions
14. In what ways were the meetings with [psychologist name] helpful or unhelpful for you?
    1. What aspects were most helpful?
    2. What aspects were most unhelpful?
    3. How important was this to you?
15. Did meeting with [psychologist's name] make a difference to you in any way?
    1. **What changes did you notice/can you give me an example?**
    2. **At what point did you notice this?**
    3. **How important was this to you?**
16. Did meeting with [psychologist's name] make any difference to the way in which you understand your difficulties?
    1. **What changes did you notice/can you give me an example?**
    2. **At what point did you notice this?**
    3. **How important was this to you?**
17. Did meeting with [psychologist's name] make a difference to the way in which you think about things?
    1. **What changes did you notice/can you give me an example?**
    2. **At what point did you notice this?**
    3. **How important was this to you?**
18. Did meeting with [psychologist's name] make a difference in how you feel about yourself?
    1. **What changes did you notice/can you give me an example?**
    2. **At what point did you notice this?**
    3. **How important was this to you?**
19. Did meeting with [psychologist's name] make a difference in how you feel about other people?
    1. **What changes did you notice/can you give me an example?**
    2. **At what point did you notice this?**
    3. **How important was this to you?**
20. Did meeting with [psychologist's name] lead you to act differently in any way?
    1. **What changes did you notice/can you give me an example?**
    2. **At what point did you notice this?**
    3. **How important was this to you?**
21. Did meeting with [psychologist's name] make any difference to the way in which you think about your future?
    1. **What changes did you notice/can you give me an example?**
    2. **At what point did you notice this?**
    3. **How important was this to you?**

Experience of booking sessions
22. What was your experience of booking meetings with [psychologist's name]
    1. Were there any aspects that were helpful/unhelpful?
    2. Can you give me an example of this?
    3. Was this what you expected?

23. How was the process explained to you?
24. Are there any ways in which booking meetings could have been better for you?
    1. What would you have liked to be different?
    2. How would this have been helpful?

Conclusion
25. Are there any ways in which your meetings could have been better for you?
    1. What would you have liked to be different?
    2. How would this have been helpful?
26. Would you recommend meeting with [psychologist's name] to other people on the unit?
    1. If you were to describe what the meetings were like to others, what would you say?

APPENDIX H: Transcription rules

Function of Transcription Coding	Example
Indicate brief response of participant during speech of researcher	{Yes}
Indicate unintelligible speech	(*unknown*)
Indicate identifiable information removed	[therapist]
Indicate interruption of interview	[interruption]
Indicate pause or hesitation	…
Indicate long pause	(*Long pause*)
Indicate action	(laughs)

Margin notes (left): client cannot / respect?

comfortable

cannot of client helpful

tickbox questioning

unfamiliar experience?

different experience / areas took time?

professional cannot

Margin notes (right): T led by client

not bombarded

no judgement

low mood

not bombarded)

no judgement)

helpful

client cannot — fast pace

time went fast?

emotional prom/feedback = felt listened to

not cut over

job = talking to client

hopeful after appointment

felt understood

P would like experience again

client had authority

talking a lot

new experience of helpfulness

previous professionals lead

Transcript:

1 [therapist] would be like 'you can stop' and I really
2 appreciated that... but I didn't want to stop. I felt so
3 comfortable because [therapist] didn't bombard me with
4 questions, [therapist] didn't judge me saying 'you've had an
5 alcohol problem, you have borderline personality disorder'.
6 [Therapist] actually just said 'what is bothering you?' and I
7 think I started from the middle of my story then I went up and
8 then I delved into the past. And I think it was me, I can't
9 remember correctly because I was quite down. It was one of
10 us said 'you haven't actually looked into your past have you?'
11 and I just felt so comfortable by not being bombarded, not
12 being judgemental...and what really helped - [therapist] asked
13 if I wanted the door locked, [therapist] asked if I wanted to
14 stop, if I wanted to leave. Sometimes you're in these meetings
15 and I have been to one and it's just nonstop. Bang bang bang.
16 Just ticking off the boxes and that's it done. But [with
17 [therapist]] I'd talk about one thing, then I'd talk about
18 another. And then I don't know where, I think it was an hour
19 that we spend together. I don't know where it went. But when
20 I went out, yeah I had a few tears. But....afterwards [therapist]
21 gave me feedback to say 'I think you're eligible for [service]
22 blah blah blah'. And whether I am or not, I felt somebody's
23 actually listened. Did not cut me through halfway and say
24 'right fine, now we have to do the next job'.
25 And after I had that appointment, I just thought 'do you know
26 what, maybe there is hope'. Because I've always... because
27 people have associated my alcohol problem, BPD very
28 differently. They've not understood the impulsiveness side of
29 me. And they've not looked at why I'm like that. And
30 [therapist] really appreciated it. I wish I could go to more
31 sessions like that to be honest.
32
33 Researcher:
34 Good I'm glad to hear it was helpful. So there was something
35 about it being non-judgmental and kind of things like having
36 you decide do you want the door locked...
37 And so how did you and [therapist] use the time together and
38 sort of decided how you used the time together?
39 Interviewee:
40 [Therapist] actually gave me authority as to how I wanted it to
41 be done. But I think in the beginning, I didn't know where I
42 was going. But I think I had verbal diarrhoea for the first ten
43 minutes. I was asking questions and answering them myself.
44 But...for once in my life I actually thought do you know what,
45 it's quite helpful'. Rather than...because normally when I've
46 spoken to professionals before they'd like 'okay, where has
47 this all started? How was your childhood? How is this?' but

1 sometimes you don't want to go from the beginning you want
2 to go mid-way to what's affecting you more. And I spoke to
3 [therapist] about a lot of personal things which I don't mind
4 mentioning right now. But I said just everything and I felt so
5 comfortable starting there and then winding myself back to
6 see if there was a problem. And….[therapist] you now, there
7 was no problem with me doing that. There was no structure
8 cause if there's structure. If I was told there was a structure in
9 the beginning, I would stress while talking to you for example,
10 I would be thinking back in my mind 'okay next thing is this
11 question, what am I going to answer?' It's just me, not
12 everybody, it's just me.
13
14 Researcher:
15 And so the experience you had with [therapist], would you say
16 it was different to what you would have expected even though
17 you say you weren't really sure what you would have
18 expected?
19 Interviewee:
20 Yeah it was actually, because I thought I'd be asked a lot of
21 questions. But somehow, actually, I just…it all naturally came
22 out. I don't know what the first question was or how we
23 started it but by the end of it, I really didn't want the time to
24 end. I know I was emotional, I had to go to sleep after because
25 I'd be crying. But I remember that…a lot came out. And I hope
26 a lot of people benefit because I know I would.
27
28 Researcher:
29 And did you ever have any questions about the way you and
30 [therapist] were working together? The fact that the session
31 was a bit different to what you might have expected?
32 Interviewee:
33 Not at all. Not at all, but I noticed it. Don't get me wrong, I did
34 notice it. Because I might have problems but I do…you know I
35 am still aware about what goes on with appointments and
36 stuff like that. But I wasn't told it was going to be different.
37 {R: So you…}
38 But I had met [therapist] on the ward before as a brief
39 introduction but not to say that I had an appointment with
40 [therapist] in a day or so.
41
42 Researcher:
43 So maybe you could tell me a bit more about what aspects
44 were most helpful or unhelpful about your session with
45 [therapist]?
46 Interviewee:

Handwritten margin notes (left):
power of professionals
Control of client
previous problem in leading?
a lot of talking?
assumptions made about people with mental health probs?
noticed difference

Handwritten margin notes (right):
don't like professionals leading?
focus on her present/her choice
felt comfortable
no problem with therapist
no structure - liked
structure stresses P out
anxiety in appointments
previous experience?
assumed (questions)
normal flow of content
didn't want it to end
emotional
lots of content
no questions
noticed the difference to other MH meetings
unexpected difference

APPENDIX J: Subtheme quote endorsement

<u>Quotes endorsing subtheme "Let me do the speaking"</u>

P1: in response to a question about who decided what they talked about…

"Oh it was me. [T]'d just ask, "how are you keeping" and then I'd just [list off] my problems, probably gave [T] a sore head!".

P6:

"Really helpful, because [the session] let me go out and express myself freely"

P7:

"[T] just told me I can talk about whatever I want".

"I felt like somebody actually listened. Did not cut me through halfway".

P8:

"It just seems to go with the flow…feeling free to talk about what I want".

P9:

"[T] just listened really. [T] asked me to speak. And listened to me warbling on (laughs)".

"I did the talking really. That I was listened to for a change. And I wasn't cut down. Or given the looks".

"[T] was very natural. Very normal, not pushy, very natural. Letting me do the talking. [T] interjected when [T] needed to but not in a pushy way, in a very natural way and let me talk again".

P12:

"I don't know because [T] didn't really do much. [T] just listened and asked questions. I can't tell you what [T] done" (with regards changes to the way she thought).

"[T] doesn't jump on you, doesn't ask you questions all the time. [T] sort of like…let's you lead and then asks you questions afterwards".

P13:

"I was just talking back. [T] made me talk (laugh)"

"I decided what I talked about. But [T] was just checking".

P15:

"[T] just sat and listened"

APPENDIX K: Trail of analysis

Step 1
- Looked at all data. Read and re-read to familiarise with the data.

Step 2
- Coded all transcripts. Queried whether interview 11 was rich enough.
- Made list of codes with corresponding page and line numbers.
- Noticed a combining of codes as I went through the transcripts so that the latter transcripts' codes doubled up with earlier ones.

Step 3
- Collated codes into subthemes across the data set.
- Generated around 50 subthemes.
- Cross-rated with an independent rater who added some codes which fitted with subthemes.

Step 4 and 5 – combined, revisiting step 3
- Collated subthemes into themes, and gave tentative names to these themes and checked whether they worked in relation to the coded extracts and entire data set.
- When it came to writing down the codes and quotes into an excel document to check if the themes and subthemes represented the data adequately, more subthemes were generated.
- Made a prevalence chart for endorsement of subthemes and themes - refined names and discarded weak themes as I noticed that some themes were not endorsed.
- Decided to discard interview 11 at this point on noticing that the person endorsed only no subthemes, and on re-reading, realised his level of English was not developed enough.
- Made tables for domains, themes and endorsement prevalence, and a more detailed table with subtheme endorsement for the appendix.

Step 5 and 6 - combined
- Started to write up the results by summarising themes and selecting extract examples.
- Made notes for the discussion at the same time as summarising these for the results section.
- During this process, I again noticed weaker themes and refined the names of subthemes to reflect the participant's voice more, following feedback from supervisor that some of the names sounded like professional terms and more 'my' voice.
- Consulted with independent researcher again to review analysis. No disagreements. Triangulated with supervisor who had some comments which were resolved. Contacted two participants for feedback. One gave her views which supported the themes generated. One could not be reached again.
- Finalised report with extracts.

APPENDIX L: Domain, theme and subtheme endorsement

		Participant endorsement												
	Domain and themes	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**12**	**13**	**14**	**15**
1	**Being in the NHS**	**x**	**x**		**x**	**x**		**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**
1.1	**Being on the ward**	**x**	**x**		**x**	**x**		**x**		**x**		**x**		**x**	
1.1.1	Environment is important		x		x	x	x							x	
1.1.2	Privacy is important	x	x							x					
1.1.3	No one has time for anybody							x	x	x		x			
1.1.4	Nice to have the opportunity to talk	x						x	x	x		x			
1.2	**Being an NHS number**	**x**	**x**			**x**		**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**
1.2.1	Conveyer belt care	x	x					x		x		x			
1.2.2	Professionals do the leading							x	x	x		x			
1.2.3	I'm not just a number	x	x			x		x	x	x	x	x	x	x	x
2	**Meaningful time spent**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**
2.1	On the same wavelength	**x**			**x**	**x**	**x**	**x**	**x**	**x**		**x**	**x**	**x**	**x**
2.1.1	Therapist was a real person	x			x	x	x	x	x	x		x	x	x	x
2.1.2	Someone was interested and listened					x	x	x		x				x	x
2.2.	**In-depth session**	**x**	**x**	**x**	**x**	**x**		**x**	**x**	**x**	**x**	**x**	**x**		
2.2.1	Cut to the core of the problem	x			x				x						
2.2.2	Lots of questions, lots came out		x	x	x	x		x	x	x	x	x	x		
2.3	**Being treated as a person**	**x**		**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**		**x**
2.3.1	Let me do the speaking	x					x	x	x	x		x	x		x
2.3.2	There was no intimidation	x		x	x	x		x		x		x	x		x
2.3.3	My feelings are important								x	x	x	x			
2.3.4	I didn't feel judged	x		x		x		x	x	x		x	x		x
3	**Getting something from the session**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**
3.1	**Got something from the session**	**x**	**x**	**x**		**x**		**x**	**x**	**x**		**x**			**x**
3.1.1	Having a plan	x				x		x	x	x					
3.1.2	Relief	x				x		x		x		x			x
3.1.3	Reminded me who I am		x	x						x					
3.2	**New perspective**	**x**	**x**	**x**	**x**		**x**	**x**		**x**	**x**	**x**	**x**	**x**	
3.2.1.	Help can be good	x			x		x				x				
3.2.2	Feeling differently about myself	x	x	x		x				x		x		x	
3.2.3	New perspective on problems	x	x		x					x		x	x		