Exploring the staff and service user perspectives on the impact of the physical and social environment on service users' engagement in therapeutic activities in an adult acute mental health inpatient unit

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ABSTRACT

Introduction

Inpatient care for people experiencing mental health crisis continues to be necessary in the United Kingdom, despite the universal availability of home treatment teams. However, these inpatient care settings have been criticised for providing limited opportunities for service users to engage in therapeutic activities. The care environment is known to impact on service users' treatment and health outcomes. While most occupational therapy theories and models attest to the importance of the environment in people's occupational performance and engagement, few reported studies have specifically focused on the mental health inpatient unit's physical and social environment.

Aim

This study aimed to explore the views of staff and service users concerning an acute inpatient unit in inner London, to identify factors that impact service users' engagement in therapeutic activities.

Methods

Participatory Action Research (PAR) was the overarching methodology used in the two Modules of this study, with multiple methods of data collection, including: quantitative questionnaires, group discussions, mapping activities and qualitative interviews.

Findings

A total of seventy-three participants, comprising both staff (n=40) and service users (n=33), completed the questionnaires. Four interviews and five PAR group

discussions were held with ten staff participants in total. Three key factors impacting service user engagement in therapeutic activities were found to be: (i) building design not fit for purpose; (ii) formal systems and policies compromising user access to spaces; (iii) profession-specific roles and responsibilities. From the findings, it was evident that the physical environment posed the greatest limitation to service user engagement in therapeutic activities and interprofessional collaborative working.

Conclusion

This study's findings add clear evidence to the understanding that the *physical* environment, in particular, but also the *social* environment within acute mental health units, requires an evidence-based approach to design, alongside robust staff and service user consultation to help facilitate service user's engagement in therapeutic activities.

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CHAPTER ONE

INTRODUCTION

In this chapter I will outline key terms and concepts used in this thesis which include the environment, environment of care, therapeutic landscape, and mental health problems. I also discuss mental healthcare, its history and the current policy context within the United Kingdom (UK). From a historical perspective I will focus on the 'periods of moral treatment era' (Peloguin,1989) and deinstitutionalisation and include relevant information from these eras to support the rationale for this PhD study. I will describe the roles of occupational therapy (OT) in an acute mental health care inpatient unit, refer to the research programme that this study is part of and then conclude by outlining the structure of the thesis.

1.1: EXPLORATION OF KEY TERMS AND CONCEPTS

The meaning of the term 'environment' is explored using broader dictionary definitions and then more specifically in terms of its conceptualisation within the profession of occupational therapy. The environment of care, commonly referred to as a hospital, is discussed with a justification of the need to set specific geographical spaces aside to offer support to those who are unwell. This is linked to the concept of the therapeutic landscape and the understanding that the environment plays a significant part in people's health and wellbeing.

1.1.1: MEANING OF THE ENVIRONMENT

According to the Oxford dictionary definition (2017), the environment is simply the surroundings or conditions in which a person, animal or plant lives or operates. Geographically, the environment represents all the settings that living organisms reside in, whether it be land, space, or water. Hamilton (2010) pointed out that the first environment that all human beings experience is the uterus which provides protection and security to the foetus, thereby highlighting that the environment is fundamental to every individual's survival. It provides the safety needs of warmth and comfort as identified in Maslow's hierarchy of needs (Martin *et al*., 2007). Other words related to the environment include habitat, territory, domain, home, abode, surrounding, context, space, and place. Although these are related concepts, attempts have been made to differentiate between them. For instance, Hasselkus argued that a place is part of a space. That space is an open geographical location, but a place is the meaning that people attach to a space. At the same time, she indicated that place is set apart from space "by the intentions and concentrated attention that it harbours" (Hasselkus, 2011, p. 42). This implies that the meaning people attach to a space is because of their own experiences and memories of geographical spaces. However, Delaisse *et al*. (2020) suggested moving beyond this dichotomous conceptualisation of space (environment) to embrace the spatial triad of conceived, perceived and lived space. This was based on the application of Lefebvre's (1991) theory about the production of space. According to this theory, space is conceived of as relational and dynamic, which includes the dimensions of geographical location, material objects and social relations.

The environment has also been categorised into the natural, the built, the social and symbolic environment (Gesler, 1992); "the particular physical, social, cultural, economic and political context" (Turpin and Iwama, 2011, p.144); and the physical, social, cultural and institutional environment (Canadian Model of Occupational Performance and Engagement (CMOP-E) (Davis, 2017). The Occupational Therapy Practice Framework (American Occupational Therapists Association (AOTA), 2014) adopts a wider perspective concerning the environment and context, which are categorised into cultural, personal, physical, social, temporal, and virtual dimensions. Apart from Gesler's (1992), these categorisations all come from occupational therapy models of practice. This highlights the relevance of the environment to the philosophy and practice of the occupational therapy profession. The models consider the environment and its relationship to a person's occupational participation and engagement. From an occupational therapy perspective, as a health profession concerned with what people do and how it contributes to their health and well-being, a transactional relationship has been established between the person, the environment and occupation (Kielhofner, 2008; Law, 2002). The interaction between the person, environment and occupation is believed to impact an individual's health and wellbeing and therefore anything that influences one of these aspects will also have an impact on the others.

The physical (natural and built), social, political, and cultural environment commonly recur in the various conceptualisations of the environment. The natural environment, as understood by Gesler (1992), constitutes everything that is in the surroundings provided by nature, including the geographical terrain, sea, animals,

mountains, and other related things. The built environment involves all the modifications that humans have made to the natural environment (American Occupational Therapists Association (AOTA), 2014). The built and natural environment together are often referred to as the physical environment (Wood *et al*., 2013b). The social environment includes the people within the environment and their relationships whereas the group's accepted set of beliefs, practices, customs, and behavioural standards constitute the cultural environment (AOTA, 2014).

There are other conceptualisations of the environment, but at this point I focus specifically on the way that the term environment is used in this thesis. The thesis is entitled, "Exploring the staff and service user perspective on the impact of the physical and social environment on service users' engagement in therapeutic activities in an adult acute mental health inpatient unit". The environment under investigation is the acute inpatient mental health unit (hereafter referred to as acute unit). This is an environment that mental health service users who are in crisis are admitted to for assessment, treatment and management, to facilitate recovery (Sims, 2014). The physical, social, and cultural environment of the acute unit is the focus of this study. Where the physical environment is conceptualised to include the building, its' design and the resources within it. The social environment that would be considered involves both the staff, the service users and relationships that exists within the acute unit (Gesler, 1992; Turpin and Iwama, 2011; AOTA, 2014; and Davis, 2017). However, the other components of an environment, such as the symbolic, virtual, temporal, institutional, economic, and political aspects, are discussed as and when relevant. More detailed

information about the acute unit is presented in Section 1.2.2. The subsequent section explores the literature on the environment within the occupational therapy profession.

1.1.2: OCCUPATIONAL PERSPECTIVE ON THE ENVIRONMENT.

Of relevance to this study is the publication by Harrison *et al.* (2016) entitled, "Defining the environment to support occupational therapy intervention in mental health practice" which aimed to define the environment based on Kielhofner's Model of Human Occupation (MOHO). They proposed that establishing an accurate definition of the environment with clinical usefulness would help to understand the impact of the environment on service users' engagement. This would also ensure that the occupational therapists' interventions address the challenges faced by service users that relate to the environment. The physical and social environment were again identified as essential to the definition. The physical environment was explained as constituting the spaces and the objects within the environment, as discussed earlier. In addition to the groups of people who come together, Harrison *et al.* (2016) introduced the concept of occupational forms as the other aspect of the social environment. Occupational forms are defined as the typical way of doing a sequence of actions. However, this opinion piece by Harrison *et al.* (2016), concluded without achieving its aim of providing a clear definition of the environment.

Rebeiro (2001) and Law and Case (2010) also discussed the general relevance of the environment in occupational therapy practices. Law and Case (2010)

presented a position statement of the AOTA on the use of the environment and context to support health and engagement in occupations. Recommendations were made using different case studies from across the life span and various areas of practise within occupational therapy. Other evidence was also drawn from the relevant United States of America (USA) legislation which included: the Rehabilitation Act of 1973, Section 504; the No Child Left Behind Act (NCLB), 2001) and the Individuals with Disabilities Education Improvement Act (IDEA, 2004).

The theme of the environment in each piece of legislation and its practical application in occupational therapy practice was put forward to support the argument about the relevance of the environment. For instance, from the Rehabilitation Act of 1973, the key construct used was that it “helps ensure students with disabilities receive the services, supports, and accommodations necessary to meet their needs” (Law and Case, 2010, p. S58). The United Kingdom has similar pieces of legislation like the Equality Act 2010, which enshrines in law the importance of providing a supportive environment for service users’ engagement. The AOTA position statement further indicated that the environment refers to the external physical and social aspects that surround service users while they engage in an occupation, and that, any interventions designed and used should focus on selecting and using an environment congruent with the service user’s needs to maximize his/her engagement. However, the position statement was wide in scope and not specific to mental health practices.

The Rebeiro (2001) study focused more specifically on mental health services and was based on a secondary analysis of data from a qualitative research study.

The study explored the importance of an affirming environment and explained how this enables participation in occupation. The original qualitative study interviewed and observed eight women with mental health problems who were discharged into the community and attended a Women's group in Northeastern Ontario, Canada (Rebeiro and Cook, 1999). The participants reported that, an environment that provides opportunity and is not prescriptive is more conducive to fostering occupational performance. In addition, such an environment provided an affirmation of the individual as a person of worth, as well as a place where he/she belonged and would be supported.

Gahnström-Strandqvist *et al.* (2003) also identified that it is important to design a supportive, tolerant, and safe therapeutic environment that gives the service users opportunity to grow. In this Sweden study, seven staff shared the narratives of their structure of occupational therapy interactions with 11 mental health service users from a psychosocial rehabilitation centre. These four papers have helped to explore how the environment is understood in the occupational therapy literature. This was relevant as occupational therapy is my professional background and therefore the stance from which I approached this study. Also, as explained in more detail in Section 1.5 of this chapter, the member of staff who extended the invitation for the study to be conducted in the acute unit was also an occupational therapist. This body of literature therefore helped to situate our worldview and conceptualisation of the environment. Bryman (2015, p. 5) pointed out that, "the training and personal values of the researcher form a component of the context of social research methods in that, they may influence the research

area". Acknowledging the aforementioned helped me to be conscious of my own biases while carrying out this research.

1.1.3: ENVIRONMENT OF CARE: THE HOSPITAL

In this thesis, the terms; environment of care and hospitals are used in the context of the current meaning of a place with resources (for example, equipment) where people who require health care services are cared for and/or supported by health professionals. The Joint Commission report (2015) identified three basic elements of the environment of care, namely, (i) the building or space, (ii) equipment used, and (iii) the people within. A categorisation of the environment linking very well to that adopted for this study is outlined on page four. The environment in which care and support are provided for those who are unwell with physical and mental health problems has evolved over the years. As early as 1972, Rivlin and Wolfe argued that a close relationship exists between the philosophy of treatment and the facility provided for use. More recently, Chrysikou (2019, p.1) alluded to this in the development of the SCP (safety and security, competence, and finally personalization and choice) model that identified "the relation between policy, care regime, and patient-focused environment". In physical healthcare settings, for instance, infection control, access to skilled staff and sophisticated equipment requires that specific places be set aside for these purposes. This is an indication that the design of most hospital buildings was influenced by their intended use.

Historically, the word ‘hospital’, had a different meaning from that which it has come to be associated with today, namely an institution providing medical and surgical treatment and nursing care for the sick or injured (Online Oxford English living dictionary, 2017). The Latin root word originally meant “reception of guest”. The Merriam-Webster online dictionary provides a definition that closely relates to this original meaning of a hospital as a charitable institution for the needy, aged, infirm, or young (Merriam-Webster online dictionary, 2020). It is argued that the differences relating to the meaning of the term ‘hospital’ make it difficult to establish its origin (Granshaw and Porter, 1989; Barry and Carruthers, 2005). In ‘*The hospital in history’*, Granshaw and Porter (1989) explained that, on a complex and broad scale, hospitals were the creation of societies and their functions have not remained constant. Hospitals have fulfilled far wider and more diverse roles than simply caring for the sick: they have provided for the poor and served as avenues for expressions of Christian charity.

In the past, hospital care was provided by monks and nuns under the influence of the church (Barry and Carruthers, 2005). As part of their duties the monks and nuns offered hospitality to passing pilgrims and travellers and helped the local sick and poor. The care provided by the monks and nuns was very disciplined and followed a strict routine, such that, between the various times set aside for prayer, those who were able to be expected to help with household chores or work in the gardens (Barry and Carruthers, 2005). Gardens were a feature of these earlier hospitals, usually enclosed by a courtyard, a key recommendation for the healing environment (Marcus and Sachs, 2013). This background information provides an insight into how the environment of care and/or hospitals

has evolved over the years and been influenced by the philosophy of care. In addition, people have engaged in different occupations following various routines to serve diverse purposes within this environment. It is necessary to provide this information as the study investigates an environment of care, the acute unit. I therefore undertook this study, focusing on the physical and social environment of the acute unit and with the assumption that the acute unit would have evolved and changed over the years that it had been in existence.

1.1.4: CONCEPT OF THE THERAPEUTIC LANDSCAPE

Another concept relevant to this thesis, that relates to hospitals in terms of meaning is the therapeutic landscape. Gesler's (1992) conceptualisation of the term has provided a basis for research that examines the relationship between the environment and health. It originally referred to religious sites that were associated with miraculous healing such as Lourdes and Bath (Gesler, 1996,1998). The therapeutic landscape is defined as: "those changing places, settings, situations, locales, and milieus that encompass both the physical, psychological and social environment associated with treatment or healing" (Williams, 1998, p. 1193). According to Cutchin (2004), a therapeutic landscape encompasses the idea of places so imbued with meaning that they have a healing effect. In contrast, Wakefield and McMullan (2004, p.299) applied the concept to healing places in decline and argued that, "it is possible for places to simultaneously hurt and heal". This conclusion was arrived at, after a secondary analysis of three data sets of (in-depth interviews) gathered from residents and city officials in the City of Hamilton, Ontario Canada. In the analysis of the data,

they realised that, although the city is regarded by outsiders as an unhealthy place due to the environmental pollution from the steel industry, the residents could still identify health affirming elements in their everyday experience of the place.

The concept of therapeutic landscape currently extends beyond places that have traditionally provided healing like those originally discussed by Gesler, to other environments like a public library (Brewster, 2014) and hospitals (Wood *et al*., 2013b). Gesler *et al*. (2004) applied the concept to hospital design which has informed the practice of evidence-based design in healthcare. Evidence-based design is, “a scientific analysis methodology that emphasises the use of data acquired in order to influence the design process in hospitals” (Alfonsi *et al.*, 2014, p. 2). It proposes that buildings purposed for use as healthcare facilities should be designed and built to meet the needs of the individuals who use them. Not only should they be structured in such a way as to meet the service users’ needs, but also the needs of the staff working there (Gesler *et al.*, 2004; Alfonsi *et al.*, 2014; Brambilla *et al.,* 2019). Ulrich *et al*. (2008) reported that factors like effective ventilation systems, nature-based distractions with appropriate access to daylight and improved ergonomic design as essential in evidence-based healthcare design.

Connellan *et al.* (2013) conducted a literature review with a specific focus on mental healthcare facility design which identified security, light, the therapeutic milieu, and a garden as key elements to be included in the design from an

evidence-based perspective. However, Curtis *et al.* (2007) suggested that it is difficult to determine precisely what form therapeutic hospital design should take, due to the changing models of care in mental health, in addition to difficulties in reaching a consensus on models of care. A model of care is defined as "an overarching design for the provision of a health care service that is shaped by a theoretical basis, evidence-based practice and defined standards" (NHS acronyms-glossary of terms online, 2020, p. 9). This study therefore aimed to explore the acute unit as a therapeutic landscape, and to ask the following questions: Is it a place of healing for people with mental health problems? Is the design of the building (physical environment) evidence-based and, as Wakefield and McMullan (2004) suggested, is it a place that can both heal and hurt service users?

1.2: Mental health problems and mental healthcare services in the United Kingdom

This section details the commonly accepted understanding of mental health problems. I predominantly use the term 'mental health problems' within this thesis, as opposed to 'mental health disorders' or 'mental illness' that are more aligned with the biomedical model. The use of the term 'mental health problem' is more in line with the social model of disability (Marks, 1997). Similar terminology is used in key documents such as the Mental Health Act of 1983. In instances where I use the term 'mental illness' or 'distress', it may be a direct quotation from a study that I have cited. I knew from the outset of this PhD study that I would be recruiting from a National Health Service (NHS) facility where staff mostly refer to the people they care for as patients. In contrast, I approached this study from the

perspective of a biopsychosocial model of care (George and Engel,1980), which posits that the causes of health problems lie beyond the simple dysfunction of a biological body part and that social and psychological factors interact to cause these problems in or for individuals.

Mental health problems have historically been conceptualised from different perspectives, including biological (Blows, 2010), psychological, social, and metaphysical (Seidmann and Di lorio, 2015). These perspectives have evolved and the World Health Organisation (WHO) has published the following definition of mental health which has been reached by common consensus: “a state of well-being in which every individual realizes his or her potential can cope with the normal stresses of life, can work productively and fruitfully, and can contribute to his and her community” (WHO, 2013, p. 38). Any deviation from this can be referred to as a mental health problem. The determinants of mental health problems are deemed to be not only an individual’s attributes but also environmental factors such as social, cultural, economic, and political dimensions (WHO, 2013; Medical Research Council, 2017).

Diagnostic manuals, like the American Psychological Diagnostic and Statistical Manual of Mental Disorders (5th edition) and the International Classification of Diseases (ICD-10) are used to categorise mental health problems. In the ICD-10, for instance, the categories include mental and behavioural disorders due to psychoactive substance use, schizophrenia, schizotypal and delusional disorders that are characterised in general by distortions of thinking, perception and affect that are inappropriate. Also included mood (affective) disorders, behavioural

syndromes, disorders of adult personality and behavioural and mental retardation (WHO, 2016). These are some of the mental health problems likely to be referred or presented to an environment of care dedicated to the care of people with mental health problems. In the United Kingdom (UK), for instance, it is estimated that, one in four people is affected by mental health problems, ranging from common to severe forms (Mind, 2017).

This study did not focus on the diagnosis given to individuals as defined in the ICD-10 or DSM-V rather, the focus was on the environment, as conceptualised earlier. The study proceeded with the assumption that, service users within the environment either have a form of diagnosis or that professionals are working towards a diagnosis, a common practice in the UK mental health care system. The people cared for within the acute unit are referred to as ‘service users’ in this thesis to follow the ethos of the research programme that this study is nested in. The Department of Health (UK) also use the same term to refer to this client group in all key documents. However, a systematic review indicated that recipients of mental health services preferred to be referred to as ‘clients’ or ‘patients’ (Dickens and Picchioni, 2012). The term ‘service user’ was also disliked more than ‘patient’ and ‘client’ according to questionnaires completed by healthcare professionals about which of the terms they prefer (Simmon *et al*., 2010). In the next section, a further look at some aspects of the history of mental healthcare in the UK helps to situate this study well within its wider context.

1.2.1: HISTORY OF MENTAL HEALTH CARE: THE MORAL TREATMENT ERA AND DEINSTITUTIONALISATION

There has been much consideration given to the best environment in which to support people with mental health problems (Gesler, 1992). In her review of the history of mental health services in England, Killaspy (2006) identified: the Monastery Priory in the City of London; the establishment of Bethlem hospitals; and the County Asylums and their closure leading to community care as the key points. Over time, both in the UK and other countries, people with mental health problems have been cared for within a specified environment (Killaspy, 2006). Parr (2008) explained that the county asylum buildings were located in rural areas away from mainstream society, which he described as an act "constituting a hugely powerful geography of differencing with a lasting implication" (Parr, 2008, p.8). Among the most significant implications of the location of the asylum's away from the mainstream society is the stigma experienced by people with mental health problems. People developed this perception that was strongly reinforced by media reports of isolated cases that, those with mental health problems are a danger to the community (McDaid, 2008). A perception that community care has since aimed to redress.

The models of care within mental healthcare have evolved from what Chrysikou (2019) described as the 'jurisdictional model', with an emphasis on safety and security (before the twentieth century), to the medical model (which the author describes as dating from the 1950s to the present day), with the introduction of antipsychotic medication. The psychosocial rehabilitation model, in which personalisation and choice for service users were also advocated, was claimed to

have existed side by side with the medical model up to the present day (Chrysikou, 2019). Each of the models described by Chrysikou was well patronised when first proposed but subsequently critiqued when shortcomings were identified. For instance, the introduction of antipsychotic medication, in addition to other factors, was largely responsible for the closure of the big institutions as there was hope that finally a cure for people with mental health problems had been found (Chrysikou, 2019; Killaspy, 2006).

Elements of the three aforementioned models of care can be found in mental health services today. For example, there is a need to balance the service users' safety on the ward with providing the opportunity for them to engage in therapeutic activities in addition to taking their prescribed medications. These elements could be identified in the acute unit where this study was set. In terms of studying the environment, there was a focus on the safety of the physical environment. In addition, as the study title indicates, there was an interest in the service users' engagement in the therapeutic activities which is also associated with the psychosocial rehabilitation model (Chrysikou, 2019). In the next section, I present some of the ideologies from the moral treatment era in the history of mental healthcare to demonstrate how and why the environment was deemed important.

1.2.1.1: MORAL TREATMENT IN MENTAL HEALTHCARE:

In the history of mental health care in the UK, the York Retreat, which opened in 1796, stands out for its model of moral management and treatment (Parr, 2008). Moral treatment is defined by Brigham (1847), cited in Peloquin (1989, p. 537) as:

> "the removal of the insane from home and former associations, with respect and kind treatment upon all circumstances, and in most cases manual labour, attendance on religious worship on Sunday, the establishment of regular habits of self-control, [and] diversion of the mind from morbid trains of thought".

This retreat in Yorkshire was managed by the Tukes, a Quaker family. It served as the blueprint for public asylums during the time when these were built, due to its success in managing the 'insane'. The moral treatment of mental health problems aimed to change the service users' personality and behaviour through placing them in the appropriate environment and ensuring that they participate in work (Jones, 1993). William Tukes advocated for an environment with the essential elements of comfort, nature, beauty and purpose with personal and social responsibility (Borthwick *et al*., 2001). They identified seven principles of the moral treatment era that are useful to revisit, two of which are;

I. the importance of useful occupation, and
II. the emphasis on the importance of the social and physical environment for the service users.

These two principles are part of the philosophy of the occupational therapy profession. The profession's roots can be traced back to the moral treatment era (O'Brien, 2017; Paterson, 2014; Schell and Gillen, 2018). In the USA, for

instance, the asylums were built to provide moral treatment based on the model of the York retreat. This later developed to include both medical and moral superintendents (Peloguin,1988). It has been argued that the demise of moral treatment in the late nineteenth century was a result of its own principles, as, "certain aspects of the practice and principles that characterised the moral treatment made its survival incompatible" with the practices at the time, especially in the public asylums that housed large numbers (Peloquin, 1989, p. 541). In America, it was "found that overcrowding, insufficient funds, a decline in public opinion, and the emergence of new treatment theories led to the shift from moral treatment to mistreatment in the asylums" (Bartlett, 2017, p. 1).

1.2.1.2: DEINSTITUTIONALISATION AND COMMUNITY CARE

The poor conditions and the human right issues that were faced by service users in the asylums drew a lot public criticism at the time, which lead to pressure on governments to take action (Sacks, 2009; Pow *et al*., 2015). 'The Water Tower Speech' by Enoch Powell,1961 in England signalled the start of a policy to close of the large asylums (Turner *et al.,* 2015). However, significant time elapsed and the closure of the first large asylum in the UK took place in 1986 (Thekingsfund.org.uk), which represented significant progress in the implementation of the deinstitutionalisation policy. Its achievements included the closure of the big asylums with most mental health service users moving into the community (Killaspy, 2006). This was strongly influenced by the Community Care Act. However, it is argued that the deinstitutionalisation policy made some mental health service users homeless, especially those in urban communities (Dear and Wolch,1987; Parr, 2008).

The debate about the real impact of deinstitutionalisation is still ongoing (Lamb and Bachrach, 2001). At the time when the asylums were closing, the original plan was for service users to be cared for in the district general hospitals (Killaspy, 2006), with an emphasis on community care for those with mental health problems. However, those who were very unwell and posed a risk to themselves and others and thus could not be cared for by services within the community began to be admitted for short stays and treatment in designated acute units (Bowers *et al*., 2005; Care Quality Commission (CQC), 2017), which is still the case, illustrating how inpatient care in the UK is now generally reserved for people who are acutely unwell.

1.2.2: THE POLICY CONTEXT OF MENTAL HEALTHCARE SERVICES IN THE UK DURING THIS STUDY

Mental health services in England are structured within the National Health Service (NHS). The NHS is a nationwide, taxpayer-funded healthcare system that provides services to people. It was established in 1948, and its vision is to help the people of this country have greater control over their health and wellbeing (NHS England website, 2020). The NHS also aims to support people to live longer, healthier lives by providing high-quality health and care services that are compassionate, inclusive and constantly improving (NHS England website, 2018). The relevant policy document issued by NHS England when this study commenced was the 'The NHS Five Year Forward View (2014)', which indicated the direction the NHS was taking from 2014 to 2019 and the possible changes needed. In the case of mental healthcare, the document acknowledged there has been an increase in mental health problems among people who use the NHS with significant impact on their ability to work.

There was a recommendation to improve mental health services. It was acknowledged that the classic divide between physical and mental health services needed to be dissolved to achieve parity of esteem between physical and mental health by 2020. This was facilitated with adequate funding and the integration of mental health crisis services was proposed and new care models that integrated General Practice (GP) and hospital services with mental health and community care services (The NHS Five Year Forward View, 2014). This policy was subsequently replaced by 'The NHS Long Term Plan' (NHS, 2019).

The NHS Long Term Plan was implemented within the policy context of a Conservative government that has been criticised for pledging the least amount of funding to the health services of any of the three main political parties (Labour, Liberal Democrat and Conservative) (The Health Foundation, 2019; The Kingsfund, 2019). For instance, whereas the Labour party promised to spend £15 billion on NHS capital investment to bring it up to international standard, the Conservative party committed to spending only £2.7 billion on six new hospital facilities. In addition of a seed funding of £100 million to develop a proposal for 34 additional hospitals (The King's Fund, 2019). Details of the organisational structure of the NHS, from the Department of Health, through to the commissioning, monitoring and regulation and training development to the primary care services are in Appendix A. Healthcare providers in England have been known as NHS Trusts (www.datadictionary.nhs.uk) since 2006. Foundation Trusts make up a large proportion of this group; they were established as independent, not for profit, public benefit corporations with accountability to their local communities rather than Central government control (Department of Health, 2005). In summary, the NHS Long-term plan aimed to establish a "new service model in which service users get more options, better support, and properly joined-up care at the right time in the optimal care setting" (p. 6). In addition, funding, staffing, and technology issues were to be addressed as a priority to optimise the effectiveness of the NHS.

1.2.3: ACUTE MENTAL HEALTHCARE SERVICES IN THE UK

Service users experiencing mental health crises (Crisp *et al*., 2016) continue to be cared for in dedicated acute inpatient wards despite the emphasis on community care within the National Health Services (NHS) and the setting up of services such as crisis resolution and home treatment (CRHT) to support them in their homes. A service user's acute episode could take the form of a sudden onset of symptoms or a gradual deterioration leading to admission (Sims, 2014). Simpson and Moriarty (2013) described the characteristics of an individual experiencing such a psychiatric emergency as one who is unable to care for themself and/or who poses a threat to the safety of others and/or themself. Most people in acute mental health crises are now treated at home by the crisis teams. Acute mental healthcare services in the UK now incorporate liaison services, crisis or home treatment teams, day hospitals, crisis houses and inpatient wards (NHS Long Term Plan, 2019). This study focuses on the inpatient services provided by acute mental healthcare services. These services remain the relevant service within the overall framework for mental healthcare in the UK and constitute the first line of admission for adult service users aged from 18 to 65 years (Sheehan *et al.,* 2013; Bowers *et al*., 2013).

The acute unit is the dedicated service to which severely unwell service users are admitted for a short period of assessment, treatment and management. Most service users are detained under the England and Wales Mental Health Act (1983) within the acute mental health unit. This Act provides information on why a service user has been detained and the rights that he/she has as a formal or informal service user. Formal service users are those detained or sectioned

under the Mental Health Act, whereas those not detained or sectioned are referred to as informal service users. The Act also includes provisions to protect service users' safety and dignity during their admission. Although this Act acknowledges that service users admitted to the acute wards may have complex and specific needs, it suggests striking a "balance of the competing priorities and interests when determining what safety measures are necessary" (Department of Health, 2015, p. 72) within the environment. This help minimises a culture of containment of the service users and ensures that staff always maintain the privacy and dignity of service users while protecting their safety. In acute mental healthcare, sometimes there is a greater emphasis on managing the service users' risks and violence using medication which may provide little opportunity for service users to engage in therapeutic activities (Gilburt *et al.,* 2008; Mullen, 2009; Bryant *et al.,* 2016; Ikiugu *et al.,* 2017). A Care Quality Commission (CQC) survey conducted in 2009 reported that 34% to 54% of service users admitted to the acute mental health wards complained that there were few activities to engage in on the wards.

1.3: Occupational therapy in acute mental healthcare services

Occupational therapy is a profession concerned with promoting service users' health and wellbeing using occupation. It is a profession based on the philosophical assumption that all individuals have an innate need and right to engage in meaningful occupations throughout their lives (College of Occupational Therapists, 2015). Previous research has explored the inherent evolutionary relationship between health and occupation and concluded that engagement in occupation is essential for human survival (Wilcock, 2006). In contributing to the

'participation agenda' of the World Health Organisation, Law (2002) advocated the need for occupational therapy researchers to examine the complex relationship between the person, the environment, and participation in occupation. This is the perspective from which I approached this PhD study: looking at the person, in this case, the service user, the environment (acute mental health inpatient unit), and their participation in therapeutic activities. This study aims to gain insight into how these factors interact and their perceived impact on the service users' health and well-being.

Occupation in the sense that it is used in occupational therapy has been defined by the American Occupational Therapy Association (2014, p. S43) as the daily life activities that people engage in which can be categorised into activities of daily living, instrumental activities of daily living, rest and sleep, education, work, play, leisure and social participation. Wilcock (2006, p. 9) expressed this concept differently, asserting that the term occupation refers to "all that people need, want or are obliged to do; what it means to them; and its ever-present potential as an agent of change". However, these conceptualisations of the term occupation have recently been criticised as too westernised and lacking cultural sensitivity (Hammel, 2015).

Occupational therapy in the United Kingdom started in mental health and occupational therapists work with individuals, groups, organisations, and communities to improve people's mental health and wellbeing (College of Occupational Therapists, 2006a). This is achieved through working in partnership

with service users, carers, and colleagues within the multidisciplinary team (MDT) to provide creative solutions to problems of daily living (College of Occupational Therapists, 2006b). The occupational therapist role in acute mental healthcare service is centred on discharge planning. It includes but is not restricted to functional assessments, home assessments, linking service users with community services, providing employment advice and supporting participation in meaningful activities on the wards (Sims, 2014; Bryant *et al.,* 2016; Lim *et al.,* 2007; RCOT, 2017). Historically, occupational therapy for service users with mental health problems has been prescribed by doctors (O'Brien, 2018). Although the profession is now autonomous and most mental health facilities use blanket referral systems, some occupational therapists have reported a perceived power imbalance within the MDT that they work in, specifically concerning decision making, with one describing the experience as "being out of the loop" (Simpson *et al*., 2005, p. 549). There is a focus in this study on the power dynamic between different MDT members. This involves the exploration of the social environment and the impact that it has on the service users' engagement in therapeutic activities.

1.4: Service users' engagement in therapeutic activities in the acute unit

A Care Quality Commission (CQC) survey in 2008 reported that more than a third of people admitted to an acute mental health inpatient unit complained that there were few activities to engage in during their stay on the unit. Antoniou (2007) cited the following excerpt, which captures a service user's experience of not having enough to do on the ward:

> "I have counted new leaves coming out on the trees outside the window, gossiped about staff, timed people in the lavatory and regard other patients' symptoms as a floor show. I have also measured the day by drugs and tea. I would play Scrabble games, knowing they would take between an hour and ninety minutes to finish... In fact, I would do anything that would make it, so I did not have to watch the minute hand of the clock crawl" (Antoniou, 2007, p. 34).

Norton (2004) suggested that, for the acute unit to function effectively, its therapeutic objectives and how they are to be achieved need to be clearly defined and articulated to everyone concerned, including the service users. In addition, the differing needs of the subgroups within the broader group of service users need to be identified and targeted with the therapeutic engagement required.

This chapter uses the terms ‘engagement’ (AOTA, 2010), ‘participation’ (Rebeiro, 2001), and ‘involvement’, interchangeably to describe service users’ activities. Therefore, I would like to clarify how they are understood and applied within the thesis. **Engagement** is used in some instances in service users being provided with the opportunity to partake in service evaluation and development. Thus, the service users are offered the chance to be heard and help make fundamental changes relating to quality improvement (Greater Manchester West Mental Health NHS service user engagement 2016 – 2019). This form of engagement actively seeks out service users’ expertise to be incorporated into their care. Historically, this source of knowledge was made limited use of, but, in recent times, more effort is being put into its generation through research and user forums (Faulkner and Thomas, 2002; Beresford, 2013).

Similarly, Newton *et al.* (2013) describe **involvement** as ensuring that mental health services, organisations and policies are shaped by the service users’ lived experience, which includes contributing to what should go into the design of the acute mental health facility, as discussed earlier. In an editorial briefing, Hickey and Chambers (2019) identified a gap in patients’ and public involvement and engagement (PPIE) in mental health services. It is worth mentioning here that the subscale of ‘involvement’ on the Ward Atmosphere Scale, one of the instruments used in this study, is defined as follows: how active and energetic service users are on the ward. Law (2002) also identified that **participation** in daily occupation is an essential part of people’s development and lived experience. Participation is defined as follows: “to take part in or become involved in an activity” (p. 641).

However, definitions of the service users' engagement in their care, whether as an inpatient or receiving treatment, vary.

Next, I discuss the meaning of service users' engagement in the acute unit from the perspective of different stakeholders. Polacek *et al.* (2015) explained that engagement from a nursing perspective refers to staff being clinically involved with a service user while the service user moves towards their treatment goals. They argued that this provides the opportunity for the nursing staff to "reach out to and connect, align, partner and collaborate in order to help" (p. 182) the service user, as professionals involved in his/her care. The phrase 'to reach out to and connect', can be understood to mean the nurse or the professional making the first attempt to form a therapeutic relationship with the service user to work together. This form of engagement is related to the nursing staff and the other team members within the acute mental health unit. Through such engagement of the staff and service users, assessments are carried out and interventions planned. Baker *et al.* (2014) qualified this as therapeutic engagement, by which they meant the quality and duration of interactions between ward staff and service users. Pereira and Woollasten's (2007) definition of therapeutic engagement also considers that it aims to empower the service users to actively participate in their care.

The quality-of-service users' involvement in an activity, and the relationship they have with the therapist, is what Creek (2010) referred to as engagement from an occupational therapy perspective. However, in the context of this study, the focus

is on service user engagement in therapeutic activities, that is, activities on the wards that form part of their treatment. These are activities that service users would like to engage in, giving them a sense of having something useful to do and preventing them from getting bored (Bryant *et al*., 2016). Service users have described their experience of occupational therapy in an acute mental health inpatient unit as providing them with an escape from a tiny sort of world, relief from illness and something to do (Bryant *et al.,* 2016), indicating that service users' engagement in the therapeutic activities offered by the occupational therapy department and other professionals had an impact on their health and wellbeing. In this study, the focus of the engagement is on the therapeutic activities that the service user engages in, in other words, those structured sessions organised by the therapy staff for the service users that involve the use of occupations. The following section explains my positionality as the researcher. It provides an overview of the people I worked with from the University, the NHS Trust, and the acute unit during this PhD study.

1.5: My positionality as the researcher in this study

I have discussed my positionality in this research from the various roles that I assumed, including an Outsider researcher, PhD student, international student, Occupational therapist and non-mental health service user. Within these roles, I worked with the various stakeholders identified in Fig. 1.1. This study was originally advertised as a PhD studentship at the University of Essex in 2016, and I was the successful applicant. The study is nested within a broader research programme that commenced in 2002 and was led by Professor Wendy Bryant (hereafter Wendy). The research programme involved service users, occupational therapists, occupational therapy students and lecturers. It aims to give "voice to direct experiences of mental health services, without campaigning for specific changes. Yet the products of the research projects are used to support service transformation" (Bryant et al., 2019 p. 1265). The impact of this study being positioned within the research programme will be discussed in other sections throughout this thesis.

I came from Ghana on study leave to start this PhD journey as a full-time student in January 2017. Although preparatory work had already been done by my then PhD supervisor -Wendy, since 2017, I became the study's principal investigator. My PhD journey started after four years working as a Clinical tutor, teaching on the newly established BSc Occupational Therapy programme at the University of Ghana. I had my Bachelor of Arts degree in Psychology from the University of Ghana in 2007 and worked as a teaching assistant in the Psychology department. In 2008, I pursued an MSc in Occupational Therapy at Brunel

University in the UK, which the University of Ghana sponsored. My relationship with Wendy dates back to when I studied for my MSc Occupational Therapy (Pre-registration) degree at Brunel University from 2008 to 2010. She supervised my MSc dissertation, which fed into one of the studies (Bryant et al., 2016) within the research programme with the Occupational Therapy department within a local NHS Trust. Post qualification, I worked as an occupational therapy technical instructor on an acute ward in a Medium Secured Forensic mental health unit. Embarking on this PhD journey was a further step in my academic career and my long interest influenced the choice of this topic in mental health and mental health services which is detailed in reflective box 1. This PhD study was designed to build on my MSc research while drawing on my experiences of working in the forensic unit.

Reflective Box 1: My interest in mental health

My decision to apply for the PhD studentship, which led to this study, resulted from my long-standing interest in mental health and mental health services. My search for more knowledge and more, importantly, to understand issues that people's mental health came from witnessing my mother's ill health, which led to her early death when I was just 10 years old. A death resulted from family members sending her to a prayer camp for treatment instead of accessing a psychiatric hospital. Although I knew she was sick and that it was a mental health problem, that was all I understood. These events had occurred in a particular context, Ghana in 1994, in which mental health services were ill developed and the cause of mental health problems to a curse from ancestors or demon possession. In the last four years of engaging in this research, reading more about mental health, the care services, being part of the PAR group meetings and listening to the experiences of mental health service users, I have broadened my understanding of mental health issues.

This PhD research study to me was to serve two purposes. First, to help progress my academic career and investigate my interest area of mental health and mental health services. The PhD journey has been an experience with both high and low points. For example, in the data collection processes, where staff shared some of the difficulties, they encountered in terms of working with service users within the acute unit in the PAR group, I felt overwhelmed, with triggered past emotions. These were managed within the PAR group by having debriefing sessions after each round of the data collection. As a group, we acknowledged the difficult conversations we have just had, which were made possible by the communicative space created by this research study. The cycles of the triggered emotions occurred at different times during the transcribing and the data analysis processes, but at this point, I had learnt to manage my emotions. Also, utilizing supervision sessions helped me explore and untangle my personal experiences and emotions relating to the research process.

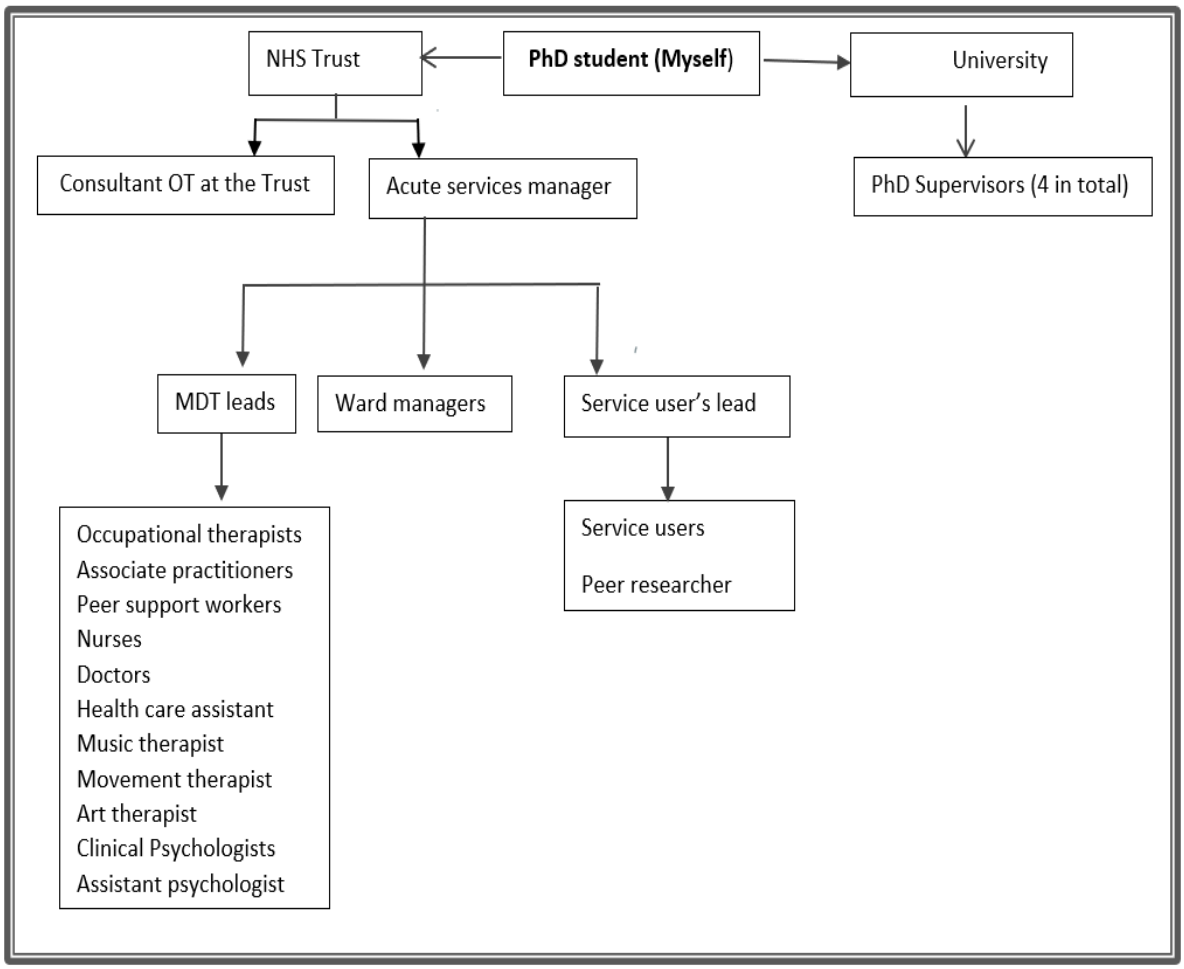
Despite the challenges encountered, my personal interest in mental health energised me to progress with this research study. Indicating that, when I am looking at a future research projects to be involved in, one of the factors I need to consider is my interest in the research area. Also, I have learned that I can explore other areas of my personal experiences for inspiration when looking at areas for further research. From engaging in this study in the UK and exploring the trend in mental healthcare in Ghana now, I have realised that there is significant progress being made in mental healthcare in Ghana currently. However, there is the need for more education, resources and the development of the mental health workforce. Within the UK, where mental health services are far more advanced, I have also learned from this study's findings that there are still areas that can be developed and improved. Indeed, I have come to love the participatory approach to conducting research and the opportunities to meaningfully involve staff and service users. Going forward, my intention is to disseminate the findings of this research to assist in improving services for mental health service users. In time, I hope to also offer support to mental health services in Ghana to ensure that the physical environment they provide for mental health service users is appropriately structured and promotes the service users' engagement in therapeutic activities. So that mental health service users do not end up in prayer camps where they are chained with no medical intervention. In addition, I plan to undertake further participatory work with people who have experienced mental health problems in other identified research areas and groups. However, I need to be mindful of my emotions, constantly reflect and utilise available supervision, as research in mental health can be emotionally demanding on me as a researcher.

According to Wendy, the occupational therapy team on the acute unit invited her to work with them to determine the most appropriate method to carry out this research, considering her expertise and the available resources. In writing about how she had used a research programme as part of participatory activism in mental healthcare, Wendy referred to this PhD research as the Oulton project, or 'project 9', which was ongoing (Bryant *et al*., 2019). The critical issue that needed to be addressed in the acute unit was the challenges within the environment in which the staff worked and the impact of the environment had on the service users' engagement in therapeutic activities. This was important to the staff, as the finding from Bryant ***et al.'s*** (2016) study was that having an occupational therapy department that was separate from the ward in an acute unit was vital for the service users.

As a PhD student from the University of Essex carrying out this research in an NHS acute unit, I saw myself as an outsider concerning the research setting. Herr and Anderson (2015) distinguished between the researcher being an insider versus the researcher being an outsider in relation to action research. They described an insider as a practitioner who carries out a study in a facility or the establishment that they already work. A researcher who is an outsider, on the other hand, is an external researcher who collaborates with an establishment they may have no prior affiliation. Wilding and Galvin (2014) identified the responsibilities of an outsider researcher, especially in the case of a PhD student, as: "coordinating research meetings, collecting and analysing data and finally reporting the findings as a thesis" (p.105). These were the exact roles that I fulfilled during this study.

The detailed processes are described in the data collection section in Chapter Three. I obtained an honorary contract post (Appendix B) with the NHS Trust to access the acute unit and some of the other NHS Trust sites, such as the venue for the Participatory Action Research (PAR) group meetings. There were limitations on my involvement as I had to strictly adhere to the role of a researcher and not an occupational therapist. Although I am a Health and Care Professions Council registered occupational therapist, I also completed all the hospital staff's mandatory training. Collaborating with insiders (in this case, the staff) was beneficial in terms of the recruitment, data collection and dissemination of the findings.

Figure 1.1: Flowchart of stakeholders involved in this study



As indicated earlier, the idea that resulted in this PhD study evolved over several years and involved different people at different stages. Figure 1.1 shows an overview of these people and my relationship with them as I proceeded on this journey. Changes in the personal circumstances of my supervisors meant that I worked with four different supervisors during this PhD study. A detailed reflection on the experiences of working with my supervisors is in Chapter Seven, reflective box 4. In addition, I also had a link person within the NHS Trust who was an occupational therapy consultant. She provided supervision and acted as the gatekeeper between the acute unit and me. Finally, the study site, the acute

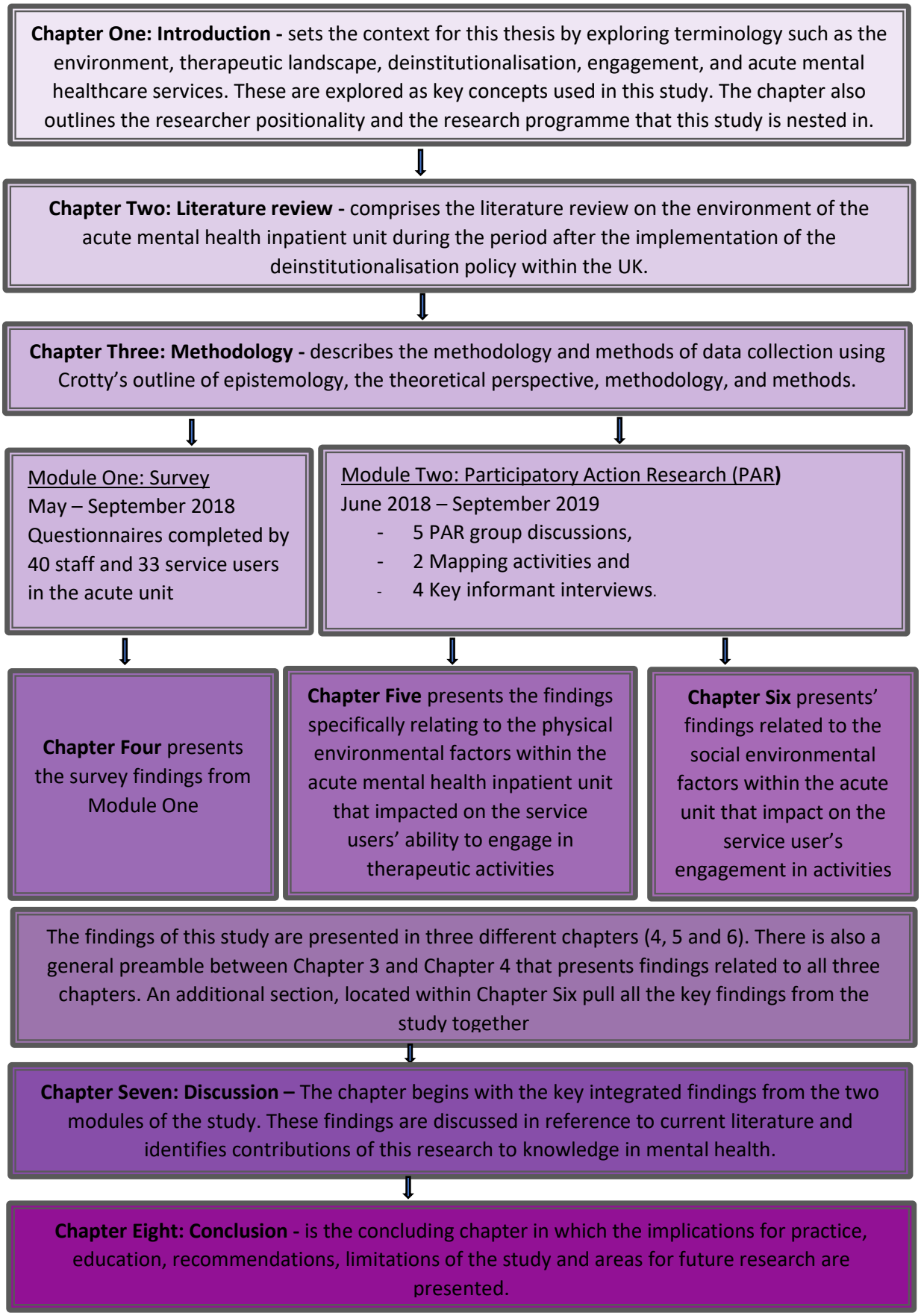
mental health unit, was headed by the service manager who helped complete most of the paperwork for the ethics approval application. During this research, from January 2017 to December 2019, I worked with three service managers of which one was an acting service manager.

In addition, the team leads of the various professions, ward managers and the service user project lead whom I contacted at various points during the recruitment, data collection and dissemination of the study findings. The final group represents the various professional groups that worked at the acute unit and the service users on admission and who completed the questionnaires. A service user was also employed as a peer researcher for this study from another NHS Trust. A detailed description of her involvement is provided in Section 3.4.3.2. for the Module One of the study and Section 3.4.4.3. for the Module Two in Chapter three of this thesis.

There are eight chapters in all in this thesis which I have provided a summary of each chapter in figure 1.2. Chapter one, two, seven and eight are summarised in single text box in figure 1.2 and cover the introduction, literature review, discussion and conclusion, respectively. Three text boxes have been used to represent chapter three, methodology, in figure 1.2. The first of the three-text box outlines the overall methodology while the other two small boxes summarise the studies' Module one and Module two. Next are the three findings chapters that I have put side by side with a summary of the aspect of the findings that each chapter covered. The decision to present the findings in the three chapters is

outlined in Section 4.0 of Chapter four. In addition, there are five reflective boxes in sections of this thesis. The overarching methodology, Participatory Action Research used for this study, which is detailed in Chapter Three section 3.3.2, involves cycles of planning, action and reflection. These reflective boxes highlight the reflection components of the PAR cycle. Including these reflections specifically helped to detail my learning as a PAR researcher. This PhD research study has been a research training experience, and therefore, it was essential to identify the challenges, successes and what I have learnt from engaging in the processes.

Figure 1.2: Schematic representation of the thesis structure



1.6: CHAPTER SUMMARY

I explained the key terms used throughout the thesis in this chapter, starting with how the environment was understood to include the physical, social, and cultural environment. It was argued that the environment impacts an individual's health and wellbeing, such that provisions have been made in legislation to ensure that supportive environment are provided for the care of people. It was made clear that the meaning given to the environment was seen through the lens of occupational therapy, the professional background from which I approached this study. The environment that I chose to explore was the acute mental health care inpatient unit linked to the studentship for this PhD. I proceeded with the assumption that the acute unit would have evolved and changed during the time that it had been in existence, as the brief history of the environment of care illustrated.

As the health and wellbeing of service users was the focus of this study, the concept of the therapeutic landscape was also explained, and the question of how it applies to the acute unit was raised. In addition, I posited that I approached this study with reference to the biopsychosocial model of care (George and Engel,1980). This perspective that emphasises that the causes of health problems go beyond the simple dysfunction of a biological body part, but instead can be found in the social and psychological factors that interact to cause these problems in individuals. This study does not focus on individuals' diagnosis, as described in the ICD-10 or DSM-V; instead, the focus is on the environment. An exploration of the relevance of the environment in the moral treatment era and

the process of deinstitutionalisation helped to situate this study well within its context. This study therefore aims to understand how the person, environment and occupation interact and to gain insight into the perceived impact on the service user's health and wellbeing. It does so by looking at the person - in this case, the service user - the environment (acute mental health unit), and their engagement in therapeutic activities. Additionally, this study focuses on the relationships between members of the MDT within the acute unit.

CHAPTER TWO

LITERATURE REVIEW

2.1: INTRODUCTION AND BACKGROUND

It was challenging to carry out a systematic review (as defined in Bryman, 2016 p. 99) of the published studies in relation to the history of acute mental healthcare services within the scope and timescale of the PhD study. Therefore, the focus of this literature review, which used a systematic approach (Aveyard, 2018) was on the literature relating to the acute mental health inpatient unit environment, during the period from 1980 to date, after deinstitutionalisation. I argued in Chapter One (Section 1.2.3) that there have been continued efforts to improve the acute mental health inpatient environment to support the care of the service users. However, an important aspect relating to the impact of the environment on service users' engagement in therapeutic activities is yet to be fully explored. Service users, staff and carers have identified the environment of the acute mental health inpatient unit as constituting an important element in service users' care (Baker *et al.*, 2014), prompting discussions about what is the most appropriate environment to support service provision.

These discussions can be traced from the era during which there was no structured care for people with mental health problems in the United Kingdom (UK), through to the building of the asylums in the 1800s and their subsequent closures in the 1960s (Killaspy, 2006; Taylor, 2011) and finally to what Parr (2008, p. 3) characterised as "neglect and marginalisation" resulting from deinstitutionalisation. For instance, the Vagrancy Act of 1714 gave authority to

local officials to take the “furiously mad to secure places” to be cared for (Philo, 2004, p. 177). Parr (2008) also described how The Poor Law Amendment Act in 1834 led to the ‘lunatic poor’ (p. 5) being separated from the ‘able poor’ within the workhouse to be offered treatment, demonstrating that, historically, both in the UK and other countries, people with mental health problems have been cared for within specified environments, depending on the model of care at the time.

Deinstitutionalisation, as explained in the previous chapter (Section 1.2.1), occurred within the context of structural changes to mental healthcare services in the UK, as in other developed countries (Hamlin and Oakes, 2008). The environment of care during this period changed significantly from the County asylums that were set in rural areas away from mainstream society to comparatively small facilities within existing district hospitals (Killaspy, 2006; Parr, 2008). This literature review focuses on studies that report on the inpatient acute mental health services environment, with the term ‘environment’ understood as including the physical, social, and cultural environment, as explained in Sections 1.1.1 to 1.1.3.

2.2: Search strategy

I completed a database search when I started the PhD in January 2017, to formulate an initial literature review and to enable me to identify knowledge gaps within this topic area. This work informed the study proposal and the ethics approval application. In 2019, I conducted a more comprehensive database and grey literature search which informed the content of this chapter. Throughout the study period, I identified relevant and newly published studies and, where relevant, included these. I searched systematically for relevant literature across six electronic databases through the University of Essex library. These databases were CINAHL complete, E-Journals, MEDLINE with Full Text, OpenDissertations, PsycARTICLES and PsycINFO. Search terms used were; “acute inpatient mental health” OR “psychiatric inpatient” OR “mental health inpatient” AND (environment OR setting OR context OR “environmental impact”). These keywords and related synonyms were carefully selected and then refined after I have looked at the key terms used in relevant studies.

The initial results of 7,063 studies were then (on 19/08/2019) limited to those published from 2005 to the current period and published in English, because there were no resources for translation. This reduced the number of studies to 3,331. The results were then further narrowed by; limiting the age of the research participants to 18 years and older, removing duplicates, only including publications from 2007 to give a time length of 10 years before the start of the PhD and to reflect current services as closely as possible. The abstracts of the remaining papers were then screened to identify those that met the inclusion criteria. The 2019 search strategy is shown in Appendix C. Only studies on adult acute mental health and those that investigated issues related to the mental

healthcare environment were included. The inclusion criteria for the studies were those that focused specifically on the acute mental health inpatient unit. Few studies that discussed the inpatient mental healthcare environments that were not acute unit were included. Studies that examined the forensic mental healthcare environment, care homes and facilities dedicated to dementia care could immediately be excluded, as they have a different philosophy of care. In addition, I drew a clear line of exclusion for studies that examined only issues relating to the mental healthcare professionals' workplace. This literature review was last updated on 16th July 2020 and thus there may be other studies, published after this date that are not included in this review.

2.3: STUDY CHARACTERISTICS

Appendix D shows a summary table of the twenty–two studies included in this literature review, containing the authors' name, publication date, keywords, study title, aims, methodology, methods of data collection, study participants, key findings, and comments on the strength and the limitations of each study that emerged after applying the critical appraisal tool consistent with the study design (Aveyard, 2018). There were seven quantitative studies, twelve qualitative studies, two discursive / literature reviews and one mixed methods study. The quantitative studies included five with a survey design (Nicholls *et al.*, 2015; Csipke *et al.,* 2014; Urbanoski *et al.*,2013; Shepley *et al.*, 2017; and Sheehan *et al.*, 2013), that were critically appraised with the McMaster quantitative critical review form (Law et at, 2019) and two interventional studies. Of these, Kemp *et al.* (2011) implemented two innovative programmes on the wards and evaluated the outcomes, whilst Wykes *et al.'s* (2018) conducted a randomised controlled trial (RCT) to elicit service users' perceptions of ward care following staff training

and support for ward-based therapeutic activities. The Critical Appraisal Skills Programme (CASP, 2019) RCT checklist was used to critically appraise the Wykes et al (2018) study instead of the generic McMaster quantitative critical appraisal tool (Law et al, 2019), to support a critique specific to that study design. Among the twelve qualitative studies, the CASP qualitative checklist was used in their critical appraisal to identify the strength and limitations of the various studies. Two of the studies used a phenomenological approach (Shattel *et al.,* 2008; Kennedy and Fortune, 2014), one used a psychoanalytic observational method (Blacker *et al*., 2018) and the Gilburt *et al.*, (2008) study used a participatory approach. The most commonly used methods of data collection were interviews. These studies were from the UK (n=12), Ireland (n=1), Australia (n=5), Canada (n=1), Sweden (n=1) and the USA (n=1). Shepley *et al*. (2017) study recruited from multiple countries including; UK, USA, Canada and Australia. Wood *et al*. (2013) and Curtis *et al*. (2013), cited in Section 2.4.2, are both based on one large study conducted in Northern England over two-year.

2.4: THEMES IDENTIFIED FROM THE LITERATURE REVIEW

I extracted six overarching themes from the twenty-two papers and discuss themes of commonality and divergence. The six main themes are (i) design features, (ii) safety and security, (iii) relocation from old to newly built or renovated facilities, (iv) engagement in therapeutic activities, (v) service users, staff and carer's satisfaction and (vi) relationships. Each theme is presented with details of the studies from which they are drawn.

2.4.1: THE DESIGN FEATURES OF THE ACUTE MENTAL HEALTH INPATIENT UNIT

Three articles (Shepley *et al.*, 2017; O'Connor *et al*., 2012; and Sheehan *et al.*, 2013) discuss mental health hospital designs, which were defined in terms of the architecture and functional design of the building, looking specifically at what should be included and which features are deemed most important. This was related to evidence-based design (Ulrich *et al*., 2008). Human geography and medical architecture are two disciplines that were identified by Gesler *et al.* (2004) and Chrysikou (2019) as important within this area. Arya (2011) highlighted the importance of mapping the processes before, rather than after, building a facility to ensure that the design has a positive impact on care. As outlined in Section 1.1.4 of this thesis**,** the principles of evidence-based design recommend that buildings intended to be used as healthcare facilities should be designed and built to meet the need of the individuals who use them. Gesler *et al*. (2004) recommended that they should meet the service users' needs in addition to the demands of the staff working in them. Ulrich *et al*. (2008) cited an effective ventilation system, nature distractions, appropriate access to daylight and good

ergonomic design as key features for any facility designed to be used for the provision of healthcare services. Shepley *et al.* (2017) and O'Connor *et al.* (2012) argued that the needs of people with mental health problems differ from those with physical health problems and hence the facility design should be tailored accordingly.

Connellan *et al*. (2013) presented a literature review of 165 articles (including conference proceedings, books, and theses with a specific focus on evidence-based mental healthcare facilities design). They identified security, light, a therapeutic milieu, and a garden as some of the thirteen key features. Staff safety, noise control, daylight and pleasant gardens and landscape were ranked by staff as very important features to be included in mental healthcare settings. In addition, indoor spaces for therapeutic activities and places for one-to-one conversation were ranked as important by Shepley *et al.* (2017). Staff satisfaction with the hospital-built environment was higher in those facilities with ensuite bedrooms and non-corridor design according to the participants in Sheehan *et al.'s* (2013) study. They also reported that the respondents viewed features that appeared to reflect modern design principles more positively. Sheehan *et al.* (2013) observed that there was a dearth of instruments that could be used to measure and describe the built environment. Hence, their study and that of Shepley *et al*. (2017) aimed to develop measures of the built environment and to help generate design guidelines. Shepley *et al*. (2017) highlighted the challenges

involved in creating an appropriate inpatient environment for mental health service users with different diagnoses.

Curtis *et al*. (2007) also emphasized the problems associated with determining an appropriate therapeutic hospital design because of the changing model of care in psychiatry and the difficulties in developing consensus models of care. It has also been identified that, although many aspects of care have changed over the preceding thirty years, the physical environment in which care is delivered appears not to have been adapted to meet this need (O'Connor *et al.*, 2012). Furthermore, O'Connor *et al.* mentioned that there is some evidence that the capital works of health services and architectural design are influenced by an economic and legal mandate which in turn affects the quality of service for service users, staff and visitors. One observable difference in the facilities used for acute mental healthcare services recently, compared to the old asylums before deinstitutionalisation, is their small sizes.

The studies (Shepley *et al.*, 2017; O'Connor *et al*., 2012; and Sheehan *et al.*, 2013) reviewed so far, reporting on the design of facilities and what needs to be included in them, are mostly from a staff perspective. Perkin (2013) made the point that, involving staff, service users and carers in the design of a mental health facility sometimes increases the cost and can be time-consuming. As a result, the majority are designed "for a client rather than with a client" (p. 380). Service users' experiences of being on admission in an acute mental health inpatient unit have been reported in the literature, as detailed in Section 2.4.2 and 2.4.3. O'Connor *et al.* (2012) suggested that service users are usually viewed as

the recipients of care rather than as active agents and called for them to be allowed to contribute to the design of mental health facilities. There is increasing mental health service user involvement in many aspects of their care, which is anticipated that more studies will be published on their views to feed these into the design of a new mental health facility. The next theme to be discussed is safety and security within the acute mental health inpatient unit.

2.4.2: SAFETY AND SECURITY WITHIN THE ACUTE MENTAL HEALTH ENVIRONMENT

A discussive paper by O'Connor *et al*. (2012) identified a few general environmental factors to be considered in diverse inpatient care settings, namely: the design of physical space, family needs, privacy, the impact of technology and service users' safety. They believed that inpatient mental health settings should be safe for both staff and service users, as well as provide a secure space. These two terms (safety and security) are mostly used interchangeably in the literature. Service users' experiences regarding safety and security in an acute unit were described positively by Nolan *et al.* (2011) and negatively by Muir-Cochrane *et al.* (2013); and Kennedy and Fortune (2014) while others have reported both negative and positive aspects, for example Jones *et al*. (2010).

In Nolan *et a*l.'*s* study (2011) of 44 service users, some described inpatient wards as places of respite. Thirty-two were satisfied with their care in terms of provision of respite, reducing fear and uncertainty, and the opportunity to have their mental health reviewed. Pelto-Piri *et al*. (2019) advocated that service users' perceived feelings of safety could be enhanced through creating reliable treatment and care

processes, a stimulating social climate within the wards and better communication between staff and service users. However, the same authors also noted that powerlessness and unpleasant encounters on these wards served to undermine feelings of safety. Jones *et al.'s* (2010) study of 60 service users found that two out of three of their respondents valued the stability and security they experienced on the wards when they were in crisis. However, they also reported sometimes feeling unsafe, bullied, and intimidated on the wards. Other safety concerns expressed included racism, theft and witnessing other service users bringing alcohol and drugs into the wards.

Muir-Cochrane *et al.* (2013) interviewed 12 service users after they were discharged from acute inpatient wards. They identified feeling unsafe as a reason for absconding, as well as the physical environment being too crowded, noisy, busy, too cold or too hot and prison-like. To them, such an environment represented a lack of freedom and a sense of unfamiliarity (Muir-Cochrane *et al*., 2013). This took into consideration that most of the service users in an acute inpatient healthcare unit are sectioned under the Mental Health Act. The only study from this review (Kennedy and Fortune, 2014) which evaluated only women's experiences reported that they found the wards to be difficult environments, where they felt unsafe. The five respondents, who were on the same, mixed-sex ward, wanted greater gender-division of the living space. This study recommended that future research could investigate the impact of the environment on service users' perceptions of safety and their ability to participate in activities while on admission.

The service users in Gilburt *et al*.'s (2008) study reported that the safety features on the inpatient unit made them feel that they were being contained on the wards with limited freedom. Similarly, participants in studies by Shattel *et al.* (2008) and Muir-Cochrane *et al.* (2013) likened it to being confined in a prison-like environment. Curtis *et al*. (2013) argued that institutional risk governance has sought to impose technical safety measures like the installation of Close Circuit Television (CCTV) to try to ensure the security of the physical environment in inpatient units. This was one of the reviewed studies that did not specifically report on the acute unit, but more generally on the mental healthcare inpatient unit. They expressed the opinion that the risks in inpatient settings seemed to be managed by the critical judgement of staff and service users, as and when the issues arose. They therefore, advocated striking a balance between technical safety (i.e. the use of security equipment) and therapy in the design of the inpatient wards.

Staff and service users have claimed that these security installations may limit the use of some spaces originally intended for therapeutic activities, according to Curtis *et al.'s* (2013) study. For instance, service users could not access the therapy kitchen on the ward to make a cup of tea as the space was deemed unsafe for use and was consequently locked. Having escort regimes to access locked doors was also identified as restricting when service users could leave the ward. Curtis *et al*. (2007) argued that these technical safety measures may have more impact and offer more opportunities when the ward is adequately staffed.

Although Chrysikou (2019) argued that it was the jurisdictional model of care that particularly emphasised safety and security, and that this seems to have been replaced by the medical and psychosocial models of care, the need to ensure service user safety within the acute unit remains paramount. In a 2017 report, the Care Quality Commission (CQC) advocated the safety of the service users, staff and all those who access the acute mental health environment (CQC, 2017, p. 51). Bowers *et al.* (2013) studied levels of conflict and containment on acute mental health wards and associated variables (Bowers *et al.,* 2013). This was in a secondary analysis of the data that was originally gathered to examine the relationship between staff factors, levels of conflict and containment among service users. Conflict was defined as any service user's action that threatens other people's safety on the ward including self-harm, physical violence, absconding, verbal aggression, and medication refusal (Bowers *et al.,* 2013), while the "methods that staff use to prevent or manage conflict events on the wards" were regarded as a means of containment and included seclusion, special observation, search procedures, de-escalation, manual restraint, time-outs and enforced medication (Bowers *et al.,* 2013, p. 423).

The data were collected via a survey from 136 acute unit wards across England between 2004 and 2005. The study found that the unique features of high conflict and high containment wards were the use of unqualified and temporary staff. Also, wards with many service users (n=23) had a low conflict rate, but a high level of containment with a worse physical environment and more breaking of rules. One such instance of rule-breaking was smoking. By contrast, wards with low levels of conflict and low containment had few service users who were

formally detained or from socially deprived communities. The paper argued that the levels of conflict and containment on the wards may be due to the philosophy of care adopted by the setting. The paper also argued that low rates of conflict and containment were the outcomes of effective hospital management to some extent, which included management inputs like good quality of care, secure staffing, and a decent physical environment.

2.4.3: SATISFACTION: FROM OLD TO A NEW FACILITY

Post-deinstitutionalisation, new purpose-built mental health facilities were constructed to support service provision for various mental health services around the world. Four studies reviewed here, from Australia (Nicholls *et al.*, 2015; Cleary *et al*., 2009), Canada (Urbanoski *et al.*, 2013) and the UK (Wood *et al.*, 2013), reported staff, service users' and carers' experiences of moving from old facilities to new ones. Participants' in each of these studies described having a better experience in the new facilities compared to the old ones. In Nicholls *et al.* (2015), for instance, staff and service users rated the new mental health facility more favourably than the old facility on three subscales of the Ward Atmosphere Scale (WAS) (order and organisation, program clarity, and involvement). Similarly, 290 service users with a diagnosis of mood and anxiety disorders perceived the atmosphere on the newly redesigned psychiatric inpatient unit as more positive, awarding higher scores for peer support, autonomy and practical skills development (Urbanoski *et al*., 2013). Although both studies used the WAS, higher scores were recorded for six different subscales with no overlap between the subscales used in the two studies.

In one of the Australian studies, both staff and service users rated their satisfaction with the new ward environment as very high, although the study involved more than just the acute mental health inpatient unit (Cleary *et al.*, 2009). This study also reported that 83% (n=48) of the service users who smoked reduced or quit smoking during their stay on the new wards as a result of the information and interventions provided, with 51% (n=63) of the staff reporting that service users handled the no-smoking rule better in the new facility. The allied health professionals, however, were least satisfied with staffing levels and teamwork compared to nurses and doctors. There was limited focus on service users' engagement in therapeutic activities although participants were asked about the quality of groups and activities provided by the occupational therapists. The old facility investigated by Cleary *et al*. (2009) was described as Australia's oldest and largest mental health hospital. By contrast, the new facility had single occupancy rooms for service users. Another positive aspect of the relocation was that the service adopted a new model of care that the new facility could support.

The old hospital environment studied by Nicholls *et al*. (2015) was described by the authors as "cramped, dark and had few usable outdoor areas" (p. 287). These restrictions dictated that little could be done to make space for therapy areas and other activities that required space. It was significant that the new purpose-built building included individual ensuite bedrooms, multiple therapeutic spaces, and family-friendly visiting spaces. The old facility examined by Urbanoski *et al.* (2013) had similar features to those in Nicholls *et al.* (2015) and Cleary *et al*. (2009) but the renovated facility boasted private ensuite rooms, with a desk and telephone, central common room, a private visitation room and

kitchen area with stove and refrigerator. These four studies suggest that the new facilities are incorporating some of the features proposed by evidence-based mental healthcare design, namely that the facility should enhance service users' privacy, safety and dignity through the provision of private bedrooms (Sheehan *et al*., 2013; and Shepley *et al*., 2017). The smoke-free grounds policy also seemed to be well implemented in the new facilities described in Cleary ***et al.'s*** (2009) study, with 83% of the service users either reducing or quitting smoking since the relocation.

Finally, Wood *et al*. (2013) reported carers' perspectives on their experiences of the old and new facilities. Carers were defined as the informal family members or friends who were involved in the service users' care. They felt that the hospital environment either facilitated or impeded their journey along the pathway of caring within the community and in the hospital. An issue of particular concern to them was that the hospital to which the service user was admitted should be close to home and on a good transport route with permeability. Carers were less keen on the locked doors used as a security measure, which they felt made the nurses seem like gatekeepers. To them, this reflected the subordinate position of carers and service users in the hospital environment. However, when they observed good relationships between staff and service users, that helped to allay some of their fears and concerns, knowing that their loved one was being well cared for. They also found the enclosed courtyard spaces in the new hospital very useful, a feature which was lacking in the old facility. In Wood ***et al.'s*** (2013) study, the idea of the acute mental health inpatient unit as a transitional space was discussed, meaning a place where the service user is temporarily supported

to be discharged into the community. However, the carers, who were accompanying the service user on this journey, sometimes seemed to be neglected.

Broader studies by Wood *et al.* (2013) and Curtis *et al.* (2013) gathered data from service users and staff, including nurses, doctors, managers, and matrons as well as family and friends. The focus of the study was on evaluating how the new inpatient psychiatric unit was impacting service users' care. Data was collected and analysed at three different time points: before the move from the old hospital, immediately after the move, and nine months after the move. As part of the project, and to enhance the rigour of the study, one of the authors had the lived experience of staying on the ward as a volunteer before the move. This helped to provide rich insights into the experience of living in the new facility. The provision of new facilities for acute mental healthcare services also correlated positively with the satisfaction of staff, service users and carers. However, the service users' engagement in therapeutic activities, by giving them something to do to make them feel less bored, was reported as being a persistent issue within the new environment.

2.4.4: SERVICE USERS' ENGAGEMENT IN THERAPEUTIC ACTIVITIES

According to the literature, this form of engagement has been widely reported as low, and service users reported being bored with not enough to do. The symbolic environment of the acute mental health inpatient unit was described as being characterised by a lack of freedom, boredom, and nothing to do (Muir-Cochrane *et al.,* 2013). This perception of the acute unit has been supported by other studies (Shattel *et al.*, 2008; Gilburt *et al.*, 2008) and major reviews of the acute

mental health environment by independent bodies like the Care Quality Commission in the UK (CQC, 2017). Birken and Bryant (2019) published a service user-led photovoice study that reported service users' experiences of the Occupational Therapy department. They expressed the view that the department was a "distinct therapeutic place where they could practice skills, try out choices and manage themselves" (p. 532), while engaging in relevant activities that go a long way towards contributing to their recovery. This study was a collaborative study between the university, staff, and the service users that used the unique method of photovoice – a qualitative method used in community-based participatory research to document reality - in an acute mental health unit.

In Ireland, the level of service users' involvement within the acute unit was studied qualitatively as part of a sequential mixed method design (Patton, 2013). The 18-nursing staff interviewed via the telephone discussed their interactions with service users to get them more involved in their treatment by offering them choices and developing trust. They acknowledged that this process occurs gradually during the service user's admission. Other factors that were identified as impacting service user engagement included the severity of service user illness (Sharp *et al.,* 2008) and staff documentation required by policy. They referred to these two factors as representing the competing demands of caring and administration.

Csipke *et al.* (2014), in contrast, argued that the severity of symptoms did not affect the frequency of service users' participation in activities in an acute mental health unit. Rather, what they found after reviewing inpatient care fifty years after the process of deinstitutionalisation, was that the reasons for low levels of engagement in activities were staff shortages, immediate crisis management and the burden of paperwork and administrative duties for staff. They also found that less time was spent by service users in engaging in all forms of activities on the acute wards studied, compared to the least active ward of the three hospitals studied fifty years ago, as reported in the William, Wing and Brown's (1971) study.

Csipke *et al.,* (2014) argued that changes in the activities that service users engage in were a key factor contributing to lower levels of engagement. It is no longer common practice for service users to be actively involved in groundskeeping which was formerly an important part of the service users' engagement in activities before deinstitutionalisation. The activities that the service users studied identified as ones that they took part in, on the acute wards, were: formal therapy (art therapy, problem-solving skills group), community/daily planning meetings and other activities like a pottery group and bingo (Csipke *et al.*, 2014). The activity that most closely resembled groundskeeping was gardening, and some service users were able to engage in this if the hospital to which they were admitted had a garden. The factors that contribute to lower levels of service user engagement in therapeutic activities are thought to be complex and do not originate from a single source, with institutional factors like the philosophy of care, staffing levels and other factors that directly relate to the service users all playing a role.

Blacker *et al.* (2017) used what they described as a novel psychoanalytic observational method to study the complex healthcare culture in the NHS, with a focus on the acute inpatient psychiatric ward. From a psychodynamic perspective, they studied the unconscious life of an acute psychiatric ward qualitatively. The study consisted of three groups of participants: the staff, service users and a supervision group on an 11-bed ward. They concluded that the picture that emerged was of a fragile ward environment in which staff appeared "fearful of engagement with patients" (p. 15). There also seemed to be a general sense of confusion regarding roles and decision-making processes as well as a sense that the nursing team felt overburdened by responsibilities. They further argued that the environment felt repressive rather than one of containment, as reported in other studies (Bowers *et al.*, 2013).

This context of fear, scrutiny and criticism may help to explain why more open and lively interaction was perceived by the nurses as risky and best avoided. These findings were generated from the discussion group that reflected on and interpreted the notes taken by the researcher during the weekly observation session. A major critique of this study was that it missed the opportunity to include ward staff in the discussion group. In addition to using clinical psychologists from outside the wards, ward staff could also have helped to interpret the observations. However, the situation in the acute mental health environment is not all bleaks. Other studies reviewed reported that, when new programmes or interventions were implemented in the acute ward environment in addition to the usual care regime, service users, staff and carers had reported being satisfied with these services.

2.4.5: SATISFACTION RELATED TO THE IMPLEMENTATION OF PROGRAMMES AND INTERVENTIONS

Although staff, service users and carers have long expressed dissatisfaction with the service provided by, and sometimes the poor environment of, the acute inpatient unit, Baker *et al.* (2014) suggested recovery-oriented organisational policies and staff training could be used to improve the situation. The cost-effective factors they suggested included good risk management, therapeutic relationships, meaningful activities, improved physical health and social inclusion of the service users. These conclusions were reached after reviewing the government policies and legislation in force then and other published research on acute mental health care in the UK. They argued that the focus should be shifted from the literature that focuses only on the shortcomings and failures to research that reports positive and innovative practice occurring within the units. One paper that has reported on exactly this kind of innovative practice is Kemp *et al.'s* (2011) study of a service improvement project.

The project studied by Kemp *et al*. (2011) aimed to turn innovation into everyday practice through the implementation of Star wards (Janner, 2007) and a Productive ward programme on nine acute mental health wards. The Star wards were intended to improve the service users' acute mental health ward experience by improving the provision of therapeutic activities and promoting engagement. Their implementation was guided by 75 practical ideas. The idea of the productive ward aimed to make ward processes safer, more efficient, and more reliable to facilitate service users' and staff's engagement to improve the quality of care (Kemp *et al.,* 2011). Service users felt that they were offered more

information when they arrived on the wards, were more involved in decisions about their treatment as well as getting occupied in useful and relevant activities. Staff contact hours with service users increased from 21% to 60%. The service users also felt more respected and satisfied with the care that they received. Overall, the project led to reductions in the length of stay and the use of agency staff. The authors concluded that such initiatives could result in nursing staff having more time to engage with service users.

As recommended by Baker *et al.* (2014), staff training was made the focus of an intervention programme by Wykes *et al.* (2018) designed to explore the experience of service users. This study, the only randomised controlled trial study reviewed, examined the impact of the training programme on service users' perceptions of the amount of care they received, especially those who were admitted involuntarily. The training offered to staff comprised social cognition and interaction training, cognitive behaviour therapy-based communication for nurses, computerised cognitive remediation therapy for the occupational therapist and medication groups. They found that there was an increase in the mean number of activities that service users engaged in post-intervention from 6.3 to 7.8, with their attendance also rising by a factor of 6.3. Uniquely to this study, involuntary service users' (those detained under the Mental Health Act), perceptions of and satisfaction with the acute ward environment improved after the staff training.

This study did not specifically focus on the environment but service users' perceptions of ward care after staff training. The service users reported positive outcomes, indicating that when additional support and training is provided to the staff, it can have a beneficial impact on the perceptions of service users, even those less likely to have wanted inpatient admission. They reported that the cost of training per staff member was calculated to be 10 to 12 pounds, which makes it a very cost-effective intervention. Other studies have reported on how innovations such as the Accreditation for Acute Inpatient Mental Health Services (AIMS) programme (Baskind *et al.*, 2010) and Protected Engagement Time (Nolan *et al.*, 2016) impacted staff, service users' and carers' perceptions. The next section involves looking at those studies of the acute mental health inpatient unit where the focus was on relationships and the impact on the service user experience within the environment.

2.4.6: SOCIAL ASPECTS OF THE ACUTE MENTAL HEALTH ENVIRONMENT.

In linking the design of the physical environment to social relationships, Curtis *et al.* (2007) identified that the spaces provided as part of the design of these inpatient facilities are organised specifically to foster social interactions among service users and to help facilitate activities on the wards. Gilburt *et al.* (2008) discussed that, when service users shared their experiences of the acute hospital, they did so largely within the context of the people that they had encountered during their admission. The relationships that the service users experienced during their admission were central to their experience. Five out of the eight themes generated from their studies related to this idea, namely

communication, coercion, safety, trust, and culture. For instance, they reported that service users' communication within the environment constituted a third of the codes they generated and comprised listening, talking, and understanding. Gilburt *et al*. (2008) discussed service users' safety in terms of relationships while Muir-Cochrane (2013) examined it in relation to design features and the risk of absconding.

With regard to staff relationships and roles, it appeared that the multidisciplinary team working in the unit had a limited understanding of each other's roles. Both Wood *et al*. (2019) and Smith and Mackenzie (2011) reported similar findings regarding different professional groups within the acute mental health unit. The latter study explored the perceptions of seven Australian nurses of the occupational therapist role within the multidisciplinary team. The nurses reported that they always had to guess how to work with the occupational therapists and that they had to use different language with them. Although they did not fully understand their roles, the occupational therapists' presence was valued, even if it was expressed using the phrase: 'anything's better than nothing' (Smith and Mackenzie, 2011, p. 251). The MDT participants interviewed in Wood *et al.'s* (2019) study also concluded that the role of the psychologists was not clearly understood although they valued and were able to describe the direct and indirect work that they did with the service users. These two studies illustrate that, among the multidisciplinary team, there may be less understanding of other professional roles, especially when it comes to staff other than the doctors and nurses. The other social aspect of the environment is the social capital that is created when staff and service users interact. Social capital is defined as: "the networks of

relationships among people who live and work in a particular society, enabling that society to function effectively" (Oxford online dictionary, 2020).

Wood *et al.* (2013), considered the relationships between service users and staff using smoking spaces in a study set in North England that evaluated the new psychiatric hospital. The study defined social capital in terms of access to resources. They found that some behaviours, and practices are used to express membership of a social group, and that being part of the group confers benefits and access to resources. While not condoning service users smoking while on admission, the study claimed that the spaces in which service users and staff smoked had social and psychological significance. They reported the finding that it generated social capital and helped build a rapport between the service users and staff who interacted in these spaces while smoking, prior to the implementation of the smoke-free grounds policy within the NHS (Wood *et al.,* 2013).

2.5: CONCLUSION

The six themes identified from reviewing the 22 studies are: design features; safety and security; relocation from old to newly built or renovated facilities; engagement in therapeutic activities; service users, staff and carers' satisfaction; and relationships between service users', staff and carers. Regarding design features, it was found that the needs of service users with mental health problems differ from those with physical health problems, and hence the facility design should incorporate some unique features relating to safety and security, light, noise control, the therapeutic milieu and a garden. However, it is difficult to determine the most appropriate therapeutic hospital design because of the changing model of care in psychiatry, and the difficulties in developing consensus models of care. The second theme, safety and security issues within acute hospitals, emerged strongly in the experiences of all the users of the environment. Whereas some service users reported feeling safe on the unit and described it as a place offering respite, others felt unsafe which, in some cases, gave them a reason to abscond from the unit.

Other safety concerns included racism, theft and witnessing other service users bringing alcohol and drugs into the wards. There was a consensus that there should be a balance between providing a secure environment and giving service users freedom. It was also felt that, although there has been a move away from the jurisdictional model of care, the safety of service users, staff, and carers within this environment is still paramount. Significantly, the acute mental health inpatient unit environment was described as a setting in which there were

insufficient activities for the service users to engage in, which remains an ongoing concern. This challenge and others faced by the acute mental health inpatient unit has been addressed in the studies reviewed by the move from older facilities to new ones, or through the implementation of innovative ideas and interventions. Within the acute unit, the social environment was regarded as very important, including relationships between service users, carers, and staff. However, understanding of other professionals' roles within the MDT was limited.

As indicated earlier in Section 2.3 on the study characteristics, various approaches and methods were used in the studies reviewed. Interviews (Pelto-Piri *et al.,* 2019; Kennedy and Fortune, 2014; Curtis *et al.,* 2013; Muir-Cochrane *et al*., 2013; Wood *et al.*, 2013; Patton, 2012; Nolan and Bradley, 2011; Jones *et al*., 2010; Gilburt *et a*l., 2008; and Shattel *et al.,* 2008) and questionnaires (Shepley *et al.*, 2017; Nicholls *et al.*, 2015; Urbanoski *et al.*, 2013; Bowers *et al.*, 2013; and Sheehan *et al.*, 2013) were the dominant forms of data collection methods. However, while these methods have their benefits, a questionnaire cannot probe or ask additional questions about the lived experience of the participants (Bryman, 2015). The studies that collected data using interviews and focus groups may compensate for some of these limitations in the findings, though. Nonetheless, we still need to acknowledge the different focuses of the studies. Gilburt *et al.'s* (2007) study stood out because it took a more participatory approach. The authors showed an awareness of the power imbalance involved in the research process, and hence made a conscious effort where possible to empower the participants. This is demonstrated by the fact that

two of the people who completed the interviews were mental health service users.

Historically, there has been a lack of involvement of mental health service users and the public more generally in research on mental health (Telford and Faulkner, 2004; Hickey and Chambers, 2019). This challenge is gradually being addressed with more service users becoming involved in research and others leading research, while the service users' involvement campaign continues to grow in strength. Meanwhile, other researchers are adopting a more collaborative approach (Bryant *et al.*, 2016; Birken and Bryant, 2019; Curtis *et al.*, 2013). Within the studies reviewed, this perspective was not dominant, which highlighted the need for a study that took a critical approach towards how the power dynamic between the researcher and service users participating in the research would be navigated.

Although staff perspectives were reported in the findings, staff participation in the research was limited. Their involvement in the studies was mostly limited to completing questionnaires (Cleary *et al*., 2009; Sheehan *et al.,* 2013) and being interviewed (Shattel *et al*., 2008; Patton, 2012). What was missing was their involvement in the design of the research or participation in action research through which they could effect change. The final gap identified was that no study has been conducted in the field of acute mental health that specifically looked at the link between the environment of the acute unit and service users' engagement in therapeutic activities. To explore these issues holistically, this study aimed to investigate both staff and service user perspectives on how they perceive the physical and social environment of the acute mental health inpatient unit to understand more about how the environment either supports or hinders

service users' engagement. This needed to be done using a research approach that was participatory and more conscious of the power dynamics operating within the research. The aims, objectives, research questions and the hypotheses that I subsequently outline were informed by the findings from this literature review, the research gap identified, and the background information presented in Chapter One.

2.6: AIM AND OBJECTIVES OF THE STUDY

The overall aim of this study is to explore staff and the service user perspectives on the impact of the physical and social environment on the service users' engagement in therapeutic activities in the adult acute mental health inpatient unit. This will be addressed via the following objectives;

- To explore the environment of the acute mental health inpatient unit from the staff and service users' perspective.
- To explore staff and service users' perspectives on how the environment of the acute unit affects mental health service users' engagement in therapeutic activities.
- To examine the potential of the acute mental health inpatient unit environment and how it could contribute to the service users' engagement in therapeutic activities.

2.7: Research questions

- What are the service users' and staff's views on the acute mental health care environment in terms of how it promotes or inhibits service user engagement in therapeutic activities?
- What are the service users' and staff's views on the relationships that exist within the acute mental health unit?
- What are the service users' and staff's views on the environment of the acute mental health care unit in terms of how it promotes recovery?
- What are the service users' and staff's views on the acute mental health care environment in terms of how it promotes privacy, safety and dignity?

2.8: Hypotheses for Module One

H_1: Service users will be less satisfied with the physical features of the acute unit environment compared with staff.

H_2: There will be a significant difference in males' and females' satisfaction with the physical features of the acute unit environment.

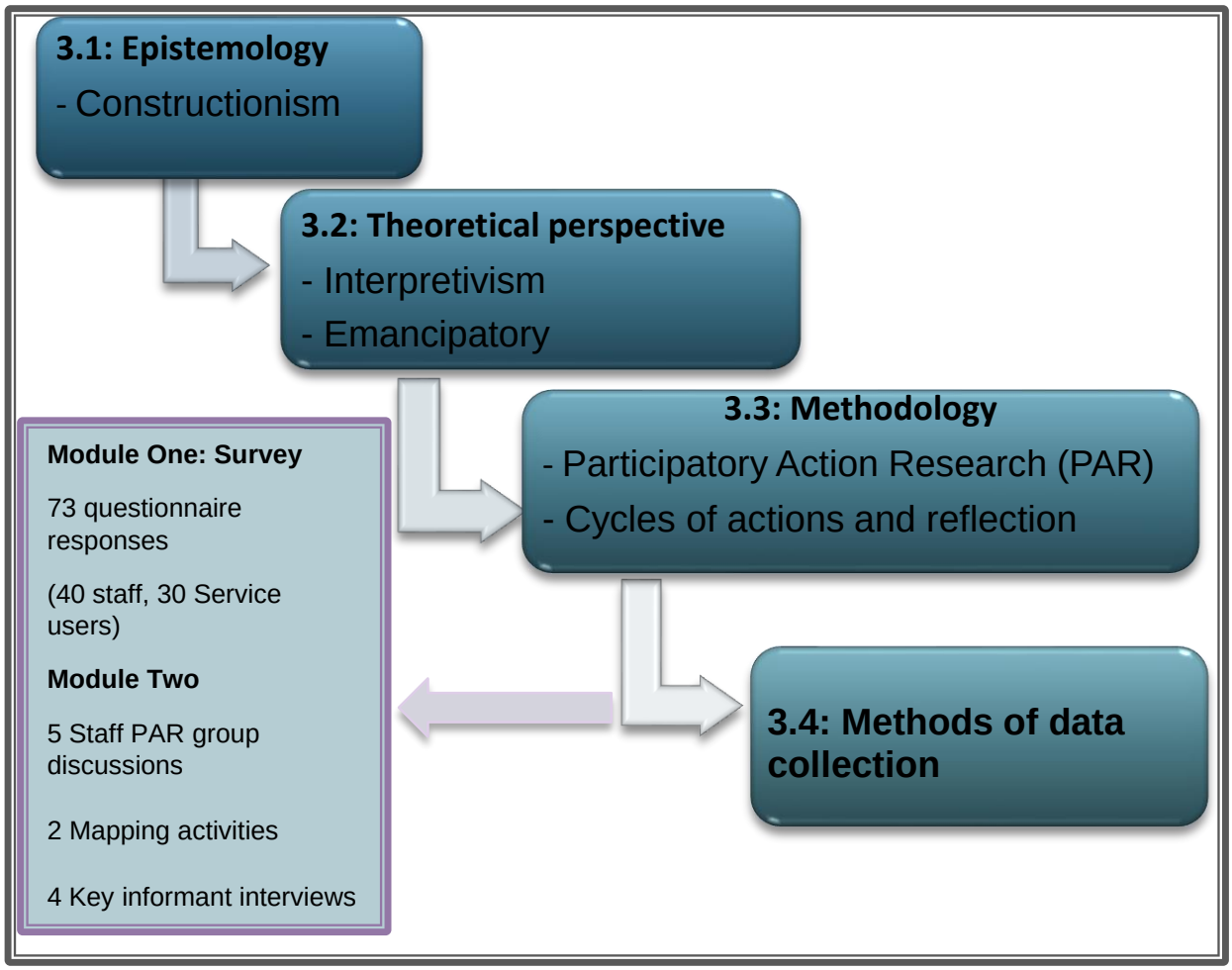
H_3: The therapy staff will be less satisfied with the physical features of the acute unit environment compared with the ward staff.

H_4: There will be significant differences in the responses of staff and service users measured on the Ward Atmosphere Scale; staff will rate the acute unit environment more favourably than service users.

CHAPTER THREE

METHODOLOGY

This chapter presents the methodology used in this study, which is structured around Crotty's classification of four levels of inter-related elements used in a research study. These are: epistemology, theoretical perspective, methodology, and methods (Crotty,1998). A similar four levels were also proposed by Reason and Bradbury (2008) for PhD students writing up the methodology section of action research to provide a structure for the theoretical perspectives and the processes involved. Figure 3.1 provides a pictorial representation of this chapter according to Crotty's 1998 four elements.



This chapter begins with an explanation of constructionism, as the epistemological stance that I adopted for this study. This is followed by definitions and explanations of interpretivism and emancipatory research perspectives, the theoretical perspectives that influenced this study. The overall methodology, participatory action research (PAR), is then explained, together with the rationale for its use and the challenges associated with it. This is followed by a description of the data collection and data analysis processes for the two modules of this study. I refer to the part of the study that collected the data using the questionnaires via a survey as Module One. The other two strands of the data collection (staff group discussions and key informant interviews) is referred to as Module Two of this study. The ethical issues identified and how they were addressed are also discussed. I conclude the chapter by explaining the limitations that relate to the methodology and methods used in this study.

3.1: Epistemology: Constructionism

Epistemology refers to what can be known, how knowledge is created and how we learn about the world we live in (Creswell, 2014). According to Crotty's four elements of research, it is described as: "the theory of knowledge embedded in the theoretical perspective" (Crotty, 1998, p. 3). Crotty argued that epistemological and ontological issues tend to emerge together and, therefore, ontology as a philosophical stance can be discussed as part of epistemology. Ontology questions reality, the real world and how reality is understood (Creswell, 2014). This study draws from constructionism as the underlying epistemology - the belief that reality is socially constructed. This is in opposition to the positivist assumption that there is a stable and existing reality that can be known through

careful scientific research (Green and Thorogood, 2014). Thus, as people engage with the world, they interpret it to make meaning and different people may construct reality differently, even in relation to the same phenomenon based on their experiences. It was therefore anticipated that, in this study, the staff and service users within the acute mental health inpatient unit would express a different reality of their experience of the environment and how they perceived it to impact on the service users' engagement.

3.2: THEORETICAL PERSPECTIVES FOR THIS STUDY

The theoretical perspective reflects the beliefs and philosophical assumptions with which the researcher approaches the research. It informs the methodology of a study and provides a context for the research process (Crotty,1998). This study was approached from the interpretivist and the emancipatory perspectives. The subsequent section provides more detail about this.

3.2.1: INTERPRETIVISM

This study is aligned with the interpretivist perspective – the idea that humans are complex, unpredictable, and reflect on their behaviours and, as a result, cannot be studied in the same way as in the natural sciences (Green and Thorogood, 2014). Three key features that distinguish the interpretivist perspective from the opposing positivist perspective have been identified by Johnson and Parry (2016):

I. human actions are meaningful, and we need to understand them;
II. we need to interpret human actions to understand them; and
III. the subjectivity of human action is appreciated and viewed as contributing to understanding.

Based on the assumption that this study included human participants with complex behaviours (Broom and Willis, 2007), a decision was made to adopt the interpretivist perspective to inform the methodology. This study therefore progressed with the assumption that it would not discover any fixed reality that existed within the acute unit, but rather the aim was to interact with the environment to construct the lived experiences within the environment,

encompassing the physical, social and cultural environment, of the staff and the service users. I sought to uncover the subjective experiences of the participants (staff and service users) within the setting. As there were different groups of people within the acute unit, they could provide a more comprehensive perspective on how they perceived the environment. The information they provided about the environment would be collected and analysed to help further our understanding of the acute unit. As is detailed later in this chapter, Module One of the study concentrated on the perspectives of the staff and the service users, while Module Two focused on the MDT staff, who shared additional information in a group discussion and key informant interviews.

The choice of an interpretivist perspective implies that an inductive research approach is used (Bryman, 2015). The qualitative research methodology is aligned with the interpretivist perspective. Bryman (2015) identified that, as a research strategy, qualitative research usually an emphasize words rather than numbers. The interpretivist perspective has been criticised for observer's bias, a lack of consensus focus and generalisability, poor replication, a lack of validity and high costs (Allsop, 2013). These shortcomings, however, have been addressed successfully in other studies (Graneheim and Lundman, 2004; Bryman, 2015). For instance, in Bryant ***et al.'s*** (2016) study, although different people were involved in it at different times, they maintained a coherent focus through the continuous involvement of the chief investigator and the service manager. In addition, drawing on the expertise of steering group members, the data analysis was peer reviewed to ensure rigour, which helped to reduce the researcher's bias. Another key feature of the interpretivist perspective is that it lends itself to research methods that generate data from the natural environment

(Allsop, 2013). The acute unit could be referred to as the natural environment of the staff and the service users who participated in this study. I had no intention of manipulating the environment, as would have occurred in a study that took a more positivist approach. The challenges to conducting this real-world research and how it impacted the methodology is discussed in the subsequent section. The qualitative methodology adopted for this study, namely participatory action research, is discussed in Section 3.3.2.

3.2.2: THE EMANCIPATORY RESEARCH PERSPECTIVE

Similarly to the interpretivist perspective, the emancipatory perspective was also proposed as an alternative to positivism (Groat and Wang, 2002). The emancipatory perspective draws from critical theory, Freirean pedagogy and feminist theory (Starkey, 2005). At the core of this perspective is the idea that knowledge generated had to be of benefit to people who are disadvantaged and marginalised. It has as its central aim to empower research participants and has particularly been used in research among disability communities to address issues of inequality (Noel, 2016). It is aligned with interpretivism in that it seeks to understand the individual but goes further in seeking to act upon the acquired knowledge to bring about change. This means that an emancipatory perspective has a political tone to it, as it is usually concerned with addressing issues of social injustice and power imbalances (Denzin *et al.*, 2008). Johnson and Parry (2016) claimed, “caring and connection are at the heart of a social justice research perspective, which aims to make the world a better place by enacting social change for marginalized and/or oppressed groups” (p.12). Key principles

used in the emancipatory perspective include openness, participation, accountability, empowerment and reciprocity (Noel, 2016).

This emancipatory perspective is similar to the occupational science ideology of occupational injustice. Occupational science is a discipline that concerns itself with the study of humans as occupational being, the relationship between occupation and health (Molineux, 2017) and addresses environmental issues that impact people's ability to engage in occupations. Mostly, occupational scientists aim to research and theorise about human occupations and its' impact on health and wellbeing. These theories and research evidence are used as part of the theoretical base for occupational therapists' practices. Within this research study, occupational injustice is a relevant issue as previous research in forensic mental health settings has linked the concept with the experience of people admitted to the inpatient units (Farnworth and Muñoz, 2009). Occupational justice is defined as "a powerful idea bridging the gap between people's wellbeing and harmful social conditions that restrict what they can do and be" (Hocking, 2017 p. 29). The commonly identified occupational injustice are; occupational alienation, occupational imbalance, occupational deprivation, occupational marginalisation and occupational apartheid (Creek, 2010). The presence of any of these factors among a person or a group of people indicates them experiencing an injustice with regard to their engagement in occupation. As such, this study explored whether any occupational injustice existed within the acute unit, and how from the emancipatory perspective, this could be addressed.

The emancipatory perspective however has been criticised because it can only be used for studies that address issues of injustice. It also advocates equal power for the researcher and the study participants. However, it is argued that, in reality, the researcher is perceived by the participants as having more power and being more privileged than them (Noel, 2016). For example, in a PhD study, only the student researcher would be awarded the degree after the dissertation is submitted, as well as developing his/her ability to apply the knowledge gained. Huisman (2008) reflected on the tension between reciprocity and positionality she encountered in her ethnographic PhD study and concluded that the PAR methodology offers a process-oriented approach that adequately promotes participation among study participants.

Ontologically, the emancipatory perspective believes in the existence of multiple realities like the interpretivist perspective. The word emancipating is defined as the release of human potential beyond the constraints of tradition, habit, coercion and self-deception (Kemmis and McTaggart, 2008). It is also informed by the central belief that knowledge should not (and is not) only be created by a knowledgeable researcher or dominant group; the people being studied also have equal capability to help generate the knowledge (Noel, 2016; Reason and Bradbury, 2008). This connects to the notion of redressing the power dynamics between the researcher and the co-researchers, which has been described as an interactive and collaborative relationship. The literature review revealed that there was a research gap in terms of service users having the opportunity to contribute to the design of mental health facilities. It was also noted that few studies involved staff as co-researchers who could identify the research needs of their

facility, become involved in the research processes and identify solutions that they could use to effect change.

This is problematic as the users of these facilities should have a say in how facilities are designed to ensure that they meet their needs. Levels of involvement by mental health service users in their care have been low in the past (Beresford, 2007) but current trends, which advocate their involvement, dictate that their voices must therefore be heard. Similarly, although clinicians work from a professional perspective to support the care of service users, they too have views on the design of the physical environment in which they work that should be considered. It is through research that makes use of methodologies like PAR that these views can be gathered. Both staff and service users can be co-researchers and work with other researchers, as in the collaborative research work carried out by Bryant *et al.* (2016), in which they involved occupational therapy staff, service users (inpatient and outpatients), and university staff and students.

These stakeholders can collaboratively work through all the stages of the research to arrive at findings that could be used to inform policy that can effect change. The emancipatory perspective adopted in this study sought to address some of these gaps in the literature. It was also important to address the issue of power dynamics between the researcher and the study participants in this study, influenced by the emancipatory perspective.

However, there were challenges to conducting the study in the true sense of the ethos of an emancipatory research study, in strictly adhering to the five principles identified by Noel (2016). Zarb (1992) suggested that emancipatory research, especially with disabled people, needs to meet the two criteria of reciprocity and empowerment. And that, whereas researchers have advanced on reciprocity, empowerment very much relies on what the people decide to do with the findings from the research. There was therefore a suggestion that "participatory" rather than "emancipatory" is the point that most researchers are at in terms of research with disabled people with further explanation that, "participatory research that involves disabled people in a meaningful way is perhaps a pre-requisite to emancipatory" research (Zarb, 1992 p.128).

Within the wider research programme that this study is nested, most of the studies had service users as participants and an example of reported benefits captured is that; "the previous research had achieved an emancipatory purpose for some service users, who took up the opportunity to get more involved in the research programme and take the findings forward" (Bryant et al., 2019 p. 1274).

In alignment with this being an emancipatory research study, the original impetus for the research study originated from a staff member from the research setting. They sought out one of my supervisors to look into the issue of the acute unit environment with them in a more systematic way, with the intention that the findings would be used to help inform change within the acute unit setting. However, as this study unfolded it went more towards staff participatory research considering the nominal involvement of the service users, which is reflected upon

as a limitation to this study in Chapter Seven. This time, in the research programme, there was more collaborating with the staff who worked in the acute unit with limited participation of the service users due to the constraint of the acute unit. In a way, this helped to factor the recommendation in Birken and Bryant (2019), one of the studies in the research programme, that there could be a study to explore "how the partnership between the occupational therapy and nursing staff impact on access to occupation" (p.541).

The service users were on short admission at the acute unit, hence limiting their participation to only the Module one of the studies. They were able to participate in the study but only within the boundaries and the impact of this on the study as discussed under the limitations of this study. Through the use of a questionnaire and the assistance of a peer researcher. After much discussion about the short timeframes that Service users were on the ward, this participation, although limited, gave voice to some important aspects of service user experience on the wards. There was therefore an evolving of the emancipatory theoretical perspective as proposed at the onset of the study to a more participatory perspective. This, demonstrates part of the "constant methodological decision" making that occur in the complexity of PAR (Herr and Anderson, 2015 p. 90).

The next section provides a discussion of the methodology that was selected based on the chosen epistemology and theoretical perspectives. This methodology was also informed by the distinct nature of the research question which asked about staff and service users' perspectives on the impact of the

physical and social environment on the service users' engagement in therapeutic activities in an acute mental health unit.

3.3: METHODOLOGY

3.3.1: ACTION RESEARCH

This study used participatory action research (PAR) methodology, which can be understood under the broad umbrella of action research. Taylor and Francis (2013) described action research as a form of qualitative critical methodology and grouped it with others such as critical ethnography, discourse analysis and feminism. It originated from the traditions of Kurt Lewin, Chris Argyris and Paulo Freire (Herr and Anderson, 2015), who were committed to creating a research methodology that could lead to social change.

Reason and Bradbury (2008) defined action research as:

> "a participating process concerned with developing practical knowing in the pursuit of worthwhile human purposes. It seeks to bring together action and reflection, theory and practice, in participation with others, in the pursuit of practical solutions to issues of pressing concern to people and more generally the flourishing of individual persons and their communities" (Reason and Bradbury, 2008, p. 4).

Action research is distinct from other forms of research in that it not only generates knowledge from research but uses the knowledge to take action. Thus, action research proceeds with the rationale of taking action either within the setting or among the group that is being studied (Herr and Anderson, 2015). Also, the research idea usually originates with the people or the community being studied, which was the case in this study: the problem which evolved into this PhD study originated from the staff at the study site. As Bryman (2015) argued, research topics in action research are sometimes motivated by a pressing social

problem that exists within a setting. The action research methodology was therefore identified as the appropriate methodology for this study and is in line with the constructionist and interpretivist theoretical perspective.

The Lewinian spiral (Kemmis and Wilkinson,1998) of cycles of actions and reflections is a key component of action research. The choice of a spiral depends on the researcher, the discipline and the subject matter being investigated. These cycles range from business-oriented versions at one end of the spectrum to the end of emancipatory practice at the other. However, they all have the essential elements of an issue or problem that needed to be identified and reflected on, a plan being put into place, followed by action to address the original issue. The outcome is then reviewed and the cycle is then potentially repeated if necessary (Wilding and Galvin, 2014; Kemmis and Wilkinson, 1998; Wimpenny, 2010). An example of the spiral is presented in Figure 3.2. Another example is the plan-act and observe-reflect cycle of participatory action research (Kemmis and Wilkinson, 1998).

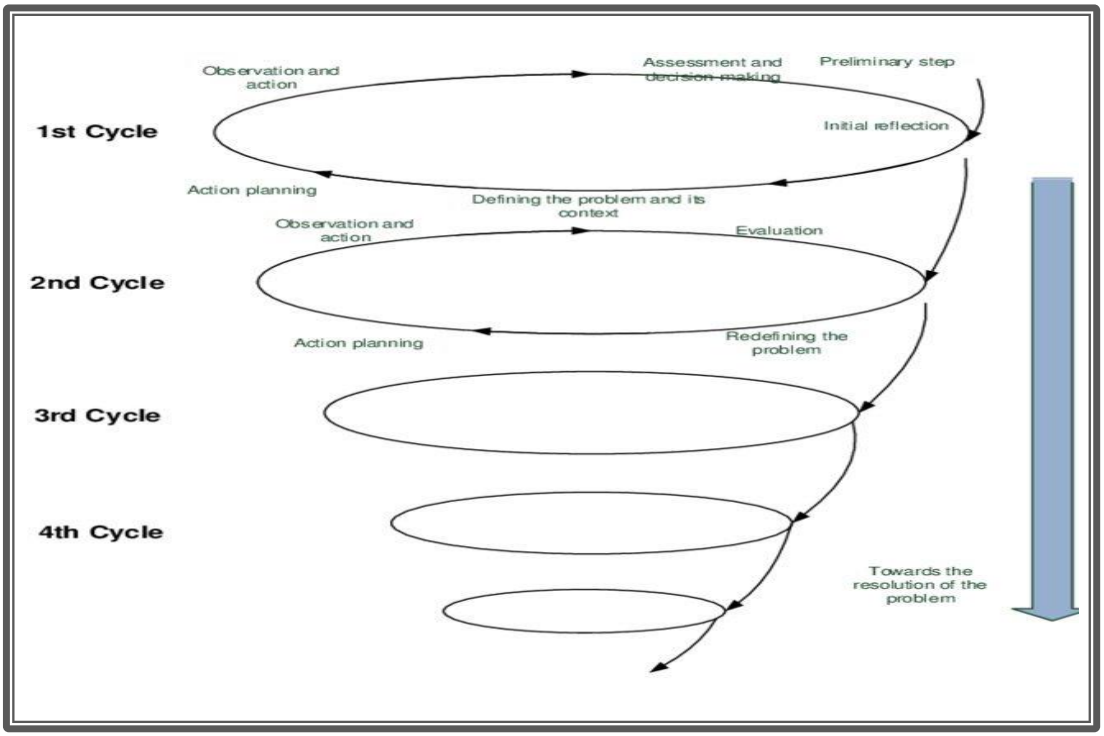


Figure 3.2: Lewinian auto-reflective spiral adapted from Santos et al. (2015).

3.3.2: PARTICIPATORY ACTION RESEARCH

PAR subscribes to all the tenets of action research. Following on from the traditions established by Kurt Lewin in the 1940s, PAR has at its core the involvement of the study participants in the whole research process. It is a research methodology used to guide community interventions, and to address issues of injustice while engaging in research that increases knowledge and informs change (Kelly, 2005). The participants in PAR are seen as co-researchers and the research is done "with" them and not "on" them (Kemmis and McTaggart, 2008; Reason and Bradbury, 2008). In this study, the relevant community was the acute mental health inpatient unit which included the staff and service users. The issue of injustice that I aimed to address was the limited engagement of service users in therapeutic activities in the acute unit. As identified in the literature review, the service users felt they were not sufficiently involved in therapeutic activities, which form an essential part of their treatment on the ward (Bryant *et al*., 2016; Hardcastle and Kennard, 2007). Engagement in occupation is fundamental to all individuals irrespective of their age, gender, or health status. Townsend and Wilcock (2004) argued that the difficulties that service users experience in accessing therapeutic activities to engage in are a social justice issue. Which is termed occupational injustice as discussed previously. Fieldhouse argued that "PAR is a suitable method for exploring people's experience of occupation (including their exclusion from it)" (Fieldhouse, 2017, p. 21).

This study, therefore, aimed that the findings could be used to improve the delivery of services within the acute unit, in line with the ethos of action research. The three changes that can be effected using PAR, identified by Maguire (1987), are: developing critical consciousness of the researcher and the participants; improving the lives of those participating in the research; and transformation of societal structures and relationships. This study, for instance, aimed to raise awareness among the multidisciplinary team working on the acute unit about the importance of the service users engaging in therapeutic activities. In PAR studies, acting and effecting change are key elements in the cycle of actions and reflection. However, what constitutes a change in PAR is not always self-evident (Herr and Anderson, 2015) and can be a slow process. It has been suggested that, at the outset of the research, the community involved in the study should be made aware that the study can end without them making any change to their situation. The community can also clearly define what constitutes change and what level of change is desired (Grant *et al.,* 2008). Implementing the findings from a PAR study to effect change is one of the challenges posed by this methodology. Others are: building relationships, acknowledging and sharing power, encouraging participation and establishing credible accounts (Grant *et al.,* 2008). The next section discusses these challenges in detail.

3.3.2.1: CHALLENGES ASSOCIATED WITH CONDUCTING PARTICIPATORY ACTION RESEARCH

To begin building relationships, researchers intending to conduct studies using PAR need to be either a member of the community or be invited by its members to be aware of their social issues. In cases where the researcher is an outsider, collaborating with the people within the community may be difficult at first. The

members of the community need to agree to be part of the study and to understand their role. However, this challenge can be overcome by the researcher communicating openly and honestly with the members of the community, learning about them and building informal relationships (Gibbon, 2002). In this study, I was an outsider from a university who collaborated with the acute mental health inpatient unit to conduct the study. A detailed description of how I established relationships with the research participants is presented in section 7.5.1. The power dynamics that exist within a PAR group can also be a barrier to conducting effective research (Herr and Anderson, 2015). In PAR, the researcher and the participants hold equal power to conduct the study, and the project is regarded as a learning opportunity for all (Grant, Nelson, and Mitchell, 2008). MacDonald (2012) outlined the types of power imbalances that may exist among the members of the research group in PAR and proposed that an egalitarian relationship should be established from the outset. In this research, the participants in the PAR group were all staff employed at different grades within the acute unit. During the workshop in PAR 1, I, shared with the participants that each of the group members was coming into the research with varied experiences and differing perspectives. The importance of maintaining a safe communicative space (Kemmis and McTaggart, 2008) at all times was emphasised during group meetings for collecting data, to ensure that no one felt intimidated or uncomfortable. However, I acknowledged the research was being conducted in fulfilment of my PhD and, in that sense, there cannot be equal power as I was the only one who would obtain a PhD at the end of the research.

Another challenge is the length of time it takes to conduct a participatory action research study. PAR usually tends to be carried out over an extended period and participants need to commit to it. Some participants, however, may struggle to commit to the study for the whole duration (Gillis and Jackson, 2002). There can be time and financial constraints, a sense of being overwhelmed or complete burn-out among the study participants, as the study progresses over a long period. In the healthcare context, getting the study participants to commit to being involved in the study for a long period can sometimes be a challenge. Ideally, service users should have been included in the PAR group but, due to the time length of the study, this idea was eventually discarded and other methods were used to collect data from the service users. This was due to the service users only being on admission for short periods of approximately 30 days, in most cases (NHS Mental Health Implementation Plan, 2019), whereas the PAR groups meetings were anticipated to last for eight months. The challenge posed by the time limit was addressed by setting out some timelines to follow. Although this may be regarded as a limitation to the study, the practicalities of this research constituting part of a PhD study had to be dealt with.

Apart from the general challenges involved in conducting a PAR study, additional difficulties have been identified when it is conducted as part of a doctoral thesis and within a healthcare setting. Gibbon (2002) identified the two obstacles to using PAR in a doctoral thesis: the scepticism surrounding the use of the method; and the institutional obstacles that need to be navigated before the study commences. These challenges were addressed via the ethics application process which is explored in detail in Section 3.6. Klocher (2012) has written about the

challenges associated with PAR PhDs from her own experience of conducting a PAR study in human geography for her PhD. She argued that the general literature on PAR PhDs, “has overstated” the extent of the tension and the challenges faced when PAR is used in PhD research (Klocher, 2012, p. 152). The paper suggested ways of navigating these challenges, such as formulating a proposal and ethics approval application before engaging with the research community, and subsequently amending it if anything changes after engaging with the participants. Klocher ends on an encouraging note, however, concluding that, “it is possible to write a thesis without a ‘neat’ ending to the PAR process” (Klocher, 2012, p. 154).

3.4: METHODS OF DATA COLLECTION AND PROCESSES.

3.4.1: OVERVIEW OF THE DATA COLLECTION

Participatory action research has no allegiance to qualitative or quantitative methods of data collection. It lends itself to different methods depending on the subject matter, and the methods that the co-researchers decide are most appropriate to investigate the agreed research question (Wilding and Galvin, 2014; Chandler and Torbert, 2003; Marti, 2016). Bryant *et al*. (2016b) have argued that PAR is not a single method, and that, “multiple methods can be used to build a detailed dataset and interpret it to elicit new knowledge and understanding of human experience” (p. 74). For instance, Matthew and Barron (2015) used a survey with questionnaires to collect data for their participatory action research on help-seeking behaviours of self-defined ritual abuse. I have as much as possible, presented a ‘tidied’, coherent version of the actual data collection processes in this section, however, the process as Herr and Anderson (2015) referred to was ‘messy’. It involved ongoing cycles of reflection and decision making, which led to changes to the original study protocol. Such changes sought to ensure that the research process remained accessible to and inclusive of both staff and service users. Indeed, I actively worked with the staff to identify the issues within the physical and the social environment that they wanted to change to promote service user engagement in therapeutic activities. Details of the processes, reflections and some decisions made are captured in the reflective boxes and also in the text boxes depicting extracts from my fieldnotes, which are included throughout this thesis.

In this study, I used questionnaires, groups discussions, mapping activities with photo-elicitation, a diary and personal log, as well as collecting other forms of

artefacts, as data collection methods (Wilding and Galvin, 2014; Kemmis and McTaggart, 2008).

These methods were used in two separate modules, forming three different strands of data collection, as depicted in Figure 3.3. This was in line with the assumptions of action research that it should involve at least two cycles of data collection (Kemmis and Wilkinson, 1998). The two modules were chosen to make good use of the available time and to ensure adequate involvement of all prospective participants in the study. Module One of the data collection took the form of a survey in which questionnaires were completed by all staff and service users with the capacity to consent. This method was deemed relevant as it allowed a relatively large group of peoples' views to be gathered during a short time (Tacchi *et al*., 2008). For instance, the service users' stays at the acute unit were usually short and they could be discharged at any time. It was therefore not possible to include them in Module Two as it would have required them to commit to the study for eight months. The survey was initially used to gather the participants' perceptions of the atmosphere on the acute ward and their level of satisfaction with the physical features of the hospital environment. In Module One, the purpose of the survey was to help fulfil the aim of exploring service users' and staff's views on the environment of the acute unit. To effectively do this, the hypotheses outlined in Chapter 2 Section 2.8 were stated and the rationale for including these hypotheses is outlined in Section 3.4.3.5 of this Chapter under the data analysis.

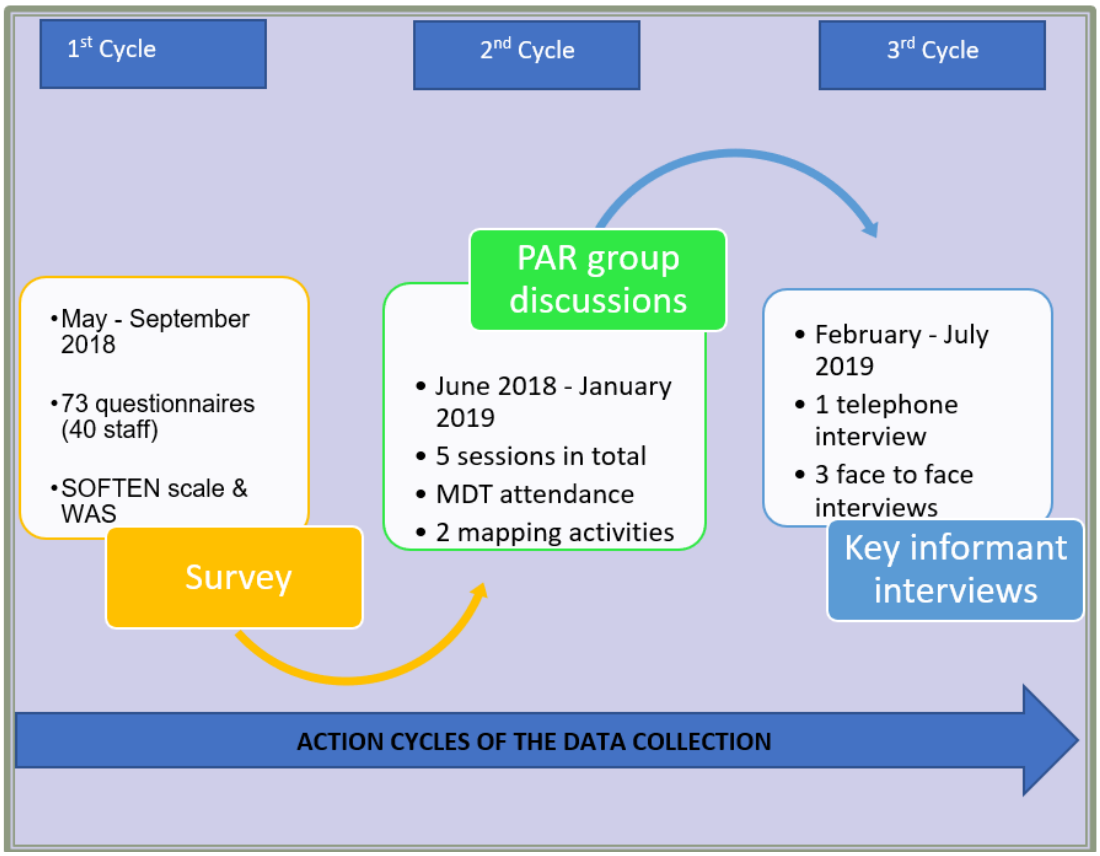


Figure 3.3: Summary of action cycles of the data collection

Module Two used group discussions, mapping activities and key informant interviews to engage participants in the cycle of reflections and action. Informal conversations with staff and the initial data from the staff questionnaires indicated that I could recruit staff who would commit to the study for about eight months, as most staff had worked there for more than a year. However, getting junior doctors to be involved in Module Two presented a challenge as they only worked at the acute unit on a six-month rotation. The gathering of different forms of data was designed to elicit multiple perspectives from the participants (Creswell and Plano Clark, 2018, p. 42). In this respect, the study collected mixed-method data comprising figures, words, and images. Marti (2016) referred to instances where qualitative methods are used in action research as the “type I sequential

integration QUAN-PART: from measure to participation" (Marti, 2016, p. 173). The explanatory sequential design of mixed-method research (Creswell and Plano Clark, 2018) was used to structure the sequence of the data collection. This is captured in Figure 3.4. How these methods were used and in which module is discussed in Sections 3.4.3 for Module One and Section 3.4.4 for Module Two.

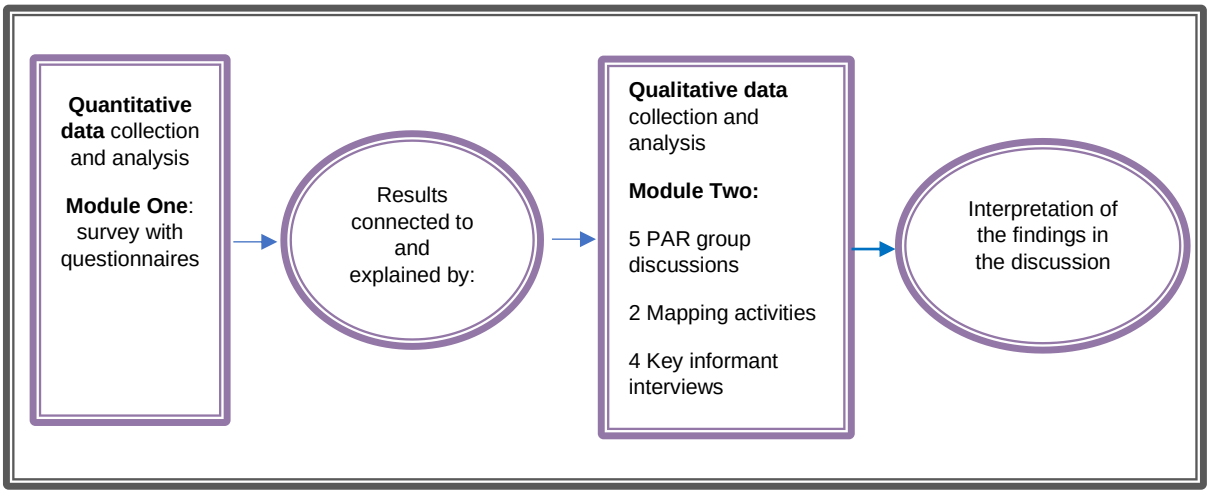


Figure 3.4: Explanatory sequential design of the methods of data collection.

3.4.2: STUDY SITE

The study site for this research was determined by foundational work and relationships between one of my supervisors and the occupational therapy staff within a mental health unit in central London. The occupational therapy staff working there at the time identified an area for further investigation, and my supervisor worked with them to determine the most appropriate method by which to do this, taking into account her expertise and the resources available. The acute unit was opened in 1986 as a psychiatric unit but had originally been built in 1884 as a hospital for colon and rectal diseases (National Archive, 2018). At the time when the research was conducted, the acute unit was part of a large NHS

mental healthcare organisation: a foundation Trust, as explained in Section 1.2.2 of Chapter One. Acute wards within NHS England provide 24-hour care and access to adults of working age suffering from mental health problems which cannot be managed outside of a hospital environment by the range of other community mental health services available (CQC, 2017), as detailed in Section 1.2.3.

The acute unit contained three mixed-gender wards and 55 beds, ranging from 18 to 20 on each ward. The wards were on separate floors, and the building had six levels in total, including a basement, and was situated between other buildings and a park at the rear. The main entrance had two locked doors that opened onto the main reception area on the ground floor. The internal layout of each ward had long corridors with rooms on each side serving as offices, bedrooms, utility rooms and activity/group rooms. Being in inner London meant that the unit had very good access to public transport (buses, trains, and Tube) and was close to local shops. The building had an enclosed rooftop garden on the sixth floor. Admissions to the unit were sanctioned or ‘gate kept’ by the local community home treatment team (also known as the crisis team), who provided acute care in the community as an alternative to hospital treatment (CQC, 2017). A multidisciplinary team of approximately 60 staff provided clinical care within the unit, supported by a team of administrative and ancillary staff.

3.4.3: MODULE ONE: SURVEY USING THE QUESTIONNAIRES

3.4.3.1: Recruitment strategies.

Within the survey component, Module one of the study, I engaged in the first complete cycle of the action research spiral as in figure 3.2. To commence recruitment, I presented the proposed study at staff meetings held at the unit. I also met with service user groups to talk about the study. These presentations were mostly informal, and I explained the study aims, who could participate, what participation involved and any potential risks and benefits. Some of these meetings were attended before putting together the study proposal and others took place during the data collection period. Table 3.1 provides a summary of the meeting that I attended at the acute unit to present the study and to recruit staff to participate in the study.

Table 3.1: Meetings attended to present the study and for recruitment

Date/ time	Meeting type	Professionals present	Outcome
Prior to data collection			
19/05/2017 10:30	Ward managers' meeting	Ward managers, matron, and OT consultant within Trust	Created awareness of proposed study
18/07/17 13:00	Therapy team meeting	Occupational therapists, Clinical psychologists, Peer support workers, Associate practitioners.	Created awareness of the proposed study. Asked for ideas that may be important to include in the study
18/07/17 13:40	Ward A handover	Doctor, nurses, and Health Care Assistants (HCA)	Created awareness of proposed study
18/07/17 15:30	One-to-one	Service manager	Gathered useful information to inform study sample size
04/08/2017 13:00	One-to-one	Service user advisory lead	Shared details of the proposed study, enquired about trust policy on service user involvement
15/12/2017	Service user forum	7 service users & 2 clinical staff	Got feedback on materials to be used for the SU data collection
During data collection			
11/05/18 @13:30	Ward B handover	Doctors, nurses, HCAs	Talked about the study and gave out questionnaires. Invited staff to participate in PAR group meetings. Recruitment
17/05/18 @11:40	Team meeting	Art psychotherapists… music therapist, movement therapist	Gave out questionnaires and recruited for PAR group
22/05/2018 @ 13:00	Therapy team meeting	Occupational therapists, assistant psychologists, peer support workers, associate practitioners	Gave out questionnaires and recruited for PAR group

3.4.3.2: SERVICE USER PARTICIPANTS AND RECRUITMENT

Inclusion criteria: Service users who had been on any of the three wards for a minimum period of seven days were eligible to be included in the study. I considered including those who had been discharged from the wards but decided against this due to the challenges with recruitment and the length of time from discharge which could potentially cause recall bias. Recall bias is defined as instances where study participants can provide erroneous responses when they have to rely on their ability to recall past events (Althubaiti, 2016). The minimum period of seven days was agreed upon within the supervision team as an acceptable amount of time within which a service user could become familiar with the ward processes and may have established relationships with others in the environment. The seven days stay inclusion criteria is commensurate with similar studies conducted in acute mental health units by Csipke *et al.* (2013) and Wykes *et al.* (2018), although Sweeney *et al.* (2014), used a minimum fourteen-day period for which service users should have been on the wards in a study that involved both crisis houses and acute inpatient units.

Preliminary information gathered from the study site indicated that, on average, 30 service users who had been admitted for seven days or more were discharged each month. Thus, the turnover of potential participants for the 55 beds on the three wards was approximately 30 service users per month.

The final inclusion criteria for the service users were:

- Those with the capacity to consent
- Service users who had been admitted for at least seven days

- Service users with the ability to read or understand the English language when explained to them.

During the data collection period, from May to September 2018, the peer researcher, with support from the hospital staff, pragmatically recruited 33 service users from across the three wards to complete the questionnaires. This indicated a response rate of 27.5% of the prospective service users who could have been recruited for the study. The 27.5% figure appears relatively low but, realistically, that was the maximum number of service users that the study could recruit due to financial constraints.

Bryman (2015) reported that the average response rate for a survey is 55.6%; however, some measures can be used to boost these numbers although it would involve additional costs. This study had a limited budget of £1,000, within which to pay participants for their time, and it was estimated that this would support the recruitment of 25 participants, considering reimbursement of £10 for participants, and £20 for the peer researcher who assisted with the data collection. The difference in the payment was to cover the travel costs of the peer researcher. Therefore, for each service user's questionnaire completed, there was a cost of £30: £20 for the peer researcher and £10 for the service user.

The recruitment of the service users to complete the questionnaires was done collaboratively by the peer researcher, the occupational therapy team lead and the ward staff. My role as the researcher involved recruiting the peer researcher and introducing her to the OT team lead who acted as the gatekeepers. Details of

the recruitment process for the peer researcher are provided in Section 3.4.4.2. I gave the paperwork and resources for the service user data collection to the peer researcher and the gatekeeper. The resources included all the questionnaires, participant information sheets (PIS), consent forms and the money to reimburse the service users. The ward staff first assessed those service users with the capacity to give consent and who met the inclusion criteria.

The service user was then given the PIS (Appendix G) or it was explained to him/her in the first instance by ward staff. The service user then completed the tear-off slip at the bottom of the PIS, with their name and contact details. An example of a tear-off slip is provided in Appendix M. He/she was then contacted by the OT team lead or an appropriate person on the ward that she delegated the task to on days she was not available, and the peer researcher, to arrange a meeting to complete the questionnaire. The peer researcher then went to the ward to complete the questionnaire with the service user at the agreed time on her own. On days when the peer researcher arrived at the acute unit and there were no names of service users who were willing to be contacted, she and the OT team lead went to the ward and liaised with ward staff to find out if there were any service users they could invite to participate in the study and recruited via that channel. Finally, the largest number of participants recruited in a day was on the occasion when the peer researcher attended a ward community meeting and presented the study to the service users.

Consent for the service users' participation was obtained when they completed and signed the tear-off slip of the PIS. The Mental Capacity Act (2005) assumes a person has capacity unless it is established that they lack it, for example if they struggle to understand and retain relevant information to decide. The service users on the acute unit may be deemed as not having capacity to make decisions about their care, because they were sectioned under the Mental Health Act 1998, but they could be deemed to have the capacity to decide to participate in a research study after information had been given to them in ways that they could understand. This approach to the recruitment of the service users embedded the participatory nature of the study. The ward staff helped to assess service users with the ability to give consent to participate in the study, ensuring that we recruited those who met the inclusion criteria.

However, it could be argued that the ward staff could have been biased in their selection of those service users they contacted to participate in the study. The other methods of approaching the service users, such as the presentation at the community meeting, helped to ensure that as many service users as possible got to know about the study and expressed their interest if they wanted to participate. The use of the peer researcher in completing the questionnaires with the service users also ensured that the service users felt comfortable doing so, and that the relationship was not like that between a member of staff and a service user. Finally, the use of the peer researcher minimised any conflict of interest that could have occurred if I had supported the service users to complete the questionnaires.

3.4.3.3: STAFF PARTICIPANTS AND RECRUITMENT

Inclusion criteria: All staff involved in delivering clinical care in the unit were eligible to participate in the study. The total numbers of clinical staff were obtained from the then service manager, in July 2017, which totalled approximately 60. This study focused on clinical staff as opposed to all other staff within the building, some of whom were not directly involved in the service users' care. A total of 45 staff, 12 from each of the three wards (12 X 3=36) and nine (9) from the therapies department, were proposed to complete the survey. I ensured that the staff recruited were representative of the staff population in terms of profession, age, gender, and ethnicity. Within the four months - the same as for the service users - 40 staff (including 7 students) were recruited to complete the questionnaires. This indicated a response rate of 55% for the clinical staff based on the 2017 total staff figure of 60. This is very close to the 55.6 % average respondent threshold suggested by Bryman (2015), although not as high as the 72% response rate obtained by Sweeney *et al*. (2014) that was originally aimed for in the study protocol. It should be noted, however, that during the data collection period, some staff left the unit and new staff were also recruited. The staff in this study were grouped into ward staff and therapy staff. The ward staff included the doctors, nurses, and health care assistants, while the therapy staff included the therapy team members who worked in the basement of the hospital. They comprised occupational therapists, art psychotherapists, psychologists, fitness instructors, associate practitioners, and peer support workers.

The staff questionnaires (Appendix E) were given to staff with the participant information sheets (PIS) (Appendix H) after I had presented the study to them at various meetings. At other times, I went to the wards specifically to recruit for the

study. Extra copies of the questionnaires were left on the wards at the nursing stations for those staff who were not present when I visited the wards. However, no recruitment occurred via this channel. The main challenge I encountered was getting staff to return the completed questionnaire after taking it away to complete. In addition, there were days that I was on the acute unit but had to suspend data collection after assessing the ward atmosphere. Fieldnote 1 (Fieldnote dairy, p 41.18/05/2018) is an example. The questionnaire took 15 minutes on average for staff to complete. Up to 12 questionnaires needed to be given out a second time to staff before they were completed because they could not find the first copy. It was assumed that staff had consented to participate in the study once they had completed and returned the questionnaire. The subsequent sections focus on the measures used to collect the data in Module One.

Thoughts on today's data collection

As at 13:37 today, a Friday 18/05/2018 that I have been at the hospital for three days, Wednesday – Friday, I have received five completed questionnaires and most of them are from the therapy staff. On the wards, as mentioned previously, it has been a very hectic week. Alarms has been going on constantly across all three wards.

I feel that I need to give ward staff space to attend more to service users instead of talking to them about my research. I have also been told on two instances by staff that I should come back later as it is not a good timing. I have heard that two staff, one ward manager and HCA has been attacked only this week so I feel it is a very difficult week. I chanced upon another researcher involved in the ENRICH project who had three people down to complete interviews with today but all of them were not possible. One of the service user was Away Without Leave (AWOL). I have been thinking in the midst of such period, what can be said in terms of my study? Are therapeutic activities relevant in such time?

Just across from the corridor, I can hear music, some nice tunes from musical instrument. Not sure what is it, but the clear evidence is that music sessions are going on. Not sure whether they are inpatient or service users from the community as the psychotherapy team also attend to service users from the community.

From the occupational therapy team, there was poor attendance at the Recovery college this morning. Only two service users attended, instead of the usual five or more. I have decided to cancel the Monday visit, just to give a day gap and continue to Tuesday.

… and finally, at 3:16pm, when I was getting ready to leave, the alarm went on in the third ward. So today, between 9:45 and 3:30 that I was here, the alarm has gone off for all the three wards. Is a Friday, what a day for the staff on the wards, I guessed!!

(FIELDNOTE 1, P41. 18/05/2018)

3.4.3.4: MEASURES

A significant challenge of using quantitative methods of data collection in action research is ensuring epistemological and ontological compatibility (Marti, 2016). In relation to the questionnaires, I used measures that were developed from a positivist perspective, although I previously indicated that this study was based on the interpretivist perspective. The positivist perspective has been critiqued on the grounds that the measures used in quantitative research are artificial and can only measure phenomena approximately rather than accurately (Allsop, 2013). For example, in the case of surveys, they may only be able to measure people's responses at a single time point, and do not consider the human capacity to change and self-reflect. However, Marti (2016) emphasised the benefits of using

these quantitative measures in action research, in that they help us to measure the phenomena that we intend to study, prior to the participatory part which helps us to understand the participants' perspective. He suggested that the focus should instead be on how the use of these measures incorporates knowledge, power and social practice, which are essential characteristics of action research.

I had to make many decisions concerning the choice of the questionnaire; whether to use existing questionnaires or to develop new ones, test for validity and reliability before using for the data collection. The latter was less appealing as that was beyond the scope of this research study. However, getting the appropriate instrument to adapt also came with some challenges. The existing questionnaires that could be selected from at the time included: Design in Mind (Csipke et al., 2016), Therapeutic Engagement Questionnaire (TEQ) (Chambers et al., 2016), Service User views on inpatient care (VOICE) (Evans et al., 2012) and View of the therapeutic environment (VOTE) (Laker et al, 2012). These were UK specific measures that could have been adopted for use. However, I identified limitations and found they were not appropriate for this research study. For example; TEQ had a clear focus on measuring the service user therapeutic engagement and not specifically on the perception of the ward environment or the ward atmosphere, which was the focus of this study. The Design in Mind Questionnaire (Csipke et al., 2016) which measures the service user's perception of the design could have been used but it focused only on the design of the physical environment of the ward, with no scope to caption information on other features of the physical environment like access to the garden. Considering all these, together with using an appropriate tool in the context of this study aims,

two existing questionnaires that had been validated (Ward Atmosphere Scale and Service users' experience of activities on the wards) were adapted for use. In addition, one short scale (the SOFTEN) was developed based on the conceptual framework from the literature review (Ng, 2006).

The staff version of the final questionnaire contained four sections, while the service user version contained five sections, which are detailed below:

a) demographic information about participants:
    - staff (gender, age, grade, profession, ward/unit and number of months worked at the unit)
    - service users (gender, ward, detention under Mental Health Act and length of stay)
b) The shortened Ward Atmosphere Scale (WAS)(Real Form) in the Manual on WAS (1974).
c) SOFTEN scale: a scale developed specifically for this study on satisfaction with the physical features of the acute unit
d) two open-ended questions
e) service users' experience of activities on the wards

The WAS (Real Form-brief version) is a standardised tool with 40 items that measure perceptions of the ward environment in relation to ten areas (subscales), namely: involvement, support, spontaneity, autonomy, practical orientation, personal problem orientation, anger and aggression, order and organisation, program clarity, and staff control. I modified some words on the WAS so that they could be understood within the UK context as the questionnaire is originally from the USA. These minor modifications involved changing 'program' to 'ward', 'patients' to 'service users' and 'nurses or doctors' to 'staff'. I

contemplated contacting the authors regarding the modifications but decided against that, as the three modifications were minor that would not have an impact on the scores of the subscales and the validity or reliability of the questionnaire. Although, I decided in 2017 to adapt the WAS in this study as it was the widely validated questionnaire at that time, a more recent systematic review on “scales for assessing the therapeutic milieu” in psychiatric inpatient unit has confirmed this assertion (Banks and Priebe, 2020) with a call that, given the changes in inpatient care, a shorter scale needs to be developed.

Each item was answered by responses indicating ‘true’ or ‘false’. The measure had no overall total score but each of the ten subscales had a total score that ranged from 0 to 4. Descriptions of the subscales are provided in Table 3.2. and the detailed questions on the scale are shown in Section C of both the staff and service users’ questionnaires (Appendix E and Appendix F).

Table 3.2: Ward Atmosphere Subscales with descriptions

WAS (Subscales)	Descriptions
Involvement	How active and energetic service users are on the ward
Support	How much service users help and support each other and how supportive the staff are towards the service users
Spontaneity	How much the ward encourages the open expression of feelings by service users and staff
Autonomy	How self-sufficient and independent service users are in making their own decisions.
Practical orientation	The extent to which service users learn practical skills and are prepared for discharge from the wards.
Personal problem orientation	The extent to which service users seek to understand their feelings and personal problems.
Anger and aggression	The extent to which service users argue with others and staff, become openly angry and display other aggressive behaviour.
Order and organisation	How important order and organisation are on the ward.
Program clarity	The extent to which service users know what to expect in their day to day routine and the explicitness of the ward rules and procedures
Staff control	The extent to which the staff use measures to keep service users under necessary control.

SOFTEN Scale: I developed a 16-item measure of satisfaction with the physical design of the ward in collaboration with my supervisors. The measure is based on the conceptual framework developed after the review of three studies described in Chapter 2 (O'Connor *et al*., 2012; Sheehan *et al.*, 2013; Shepley *et al.*, 2017), which explored features included in the design of mental healthcare facilities. The common physical features that were suggested to be considered for a facility to be used for a mental health facility by the studies were included in the measure (Shepley et al, 2017). We considered using factor analysis of the items in the SOFTEN questionnaire could have been a formal approach to factor analyse (Al-Abbadey, 2020) the items on the SOFTEN to indicate to what degree they related

to each other as a whole, or in sub-groups, and to exclude those that were less related. Given the resources in terms of time and funding for this study, we were unable to recruit an adequate number of participants, which would have allowed factor analysis to be completed. Fabrigar et al. (1999) suggest there should be 10 participants per item on the questionnaire. Going by this, an appropriate number to effectively test this measure would have been 160, far less than our aim of 100 participants at the start. We, therefore, need to exercise some caution in interpreting the findings from the questionnaire and encourage validation of its items in future larger-scale research. Al-Abbadey (2020), in a reflection that shared the lessons learnt in the processes engaged in, to factor analyse a questionnaire on the *Impact of Female Chronic Pelvic Pain Questionnaire* (IF-CPPQ) indicated that, three different studies were conducted and the questionnaire design and validation was the main focus of the PhD. Hence, a limitation to this research that should be taken into consideration in interpreting the findings from this stream of data collection. In developing the scale, however, the supervisory team and I paid particular attention to the choice of words and avoided often encountered errors in questionnaire design such as the use of double-barrelled questions, ambiguous wording, leading questions and social desirability questions (Duesbery and Twyman, 2020). This ensure that these errors were minimised or avoided. I also had the opportunity to get feedback on the scale from a service users research forum on 21.11.2017. This feedback included highlighting sections of the draft version of the questionnaire that the members of the forum felt were unclear or could be easily misunderstood. I took this feedback into account and modified the questionnaire accordingly to

incorporate their suggestions for clearer language and signposting between questions.

Further reviews of the draft version of SOFTEN was carried out by other PhD students enrolled in the Research Module I undertook during my PhD fellowship. Two suggestions, in particular, were incorporated into the final versions. These were firstly to arrange the 16 items in alphabetical order thereby addressing the issue of ordering effect (Duesbery and Twyman, 2020 and Ng, 2006) and secondly to add a section for 'other' to enable participants to add additional features they would like to be considered. The test for internal consistency for the SOFTEN is discussed subsequently under the data analysis section. The name, SOFTEN, is an acronym generated from https://acronymify.com/ using the phrase: SatisfactiOn with the physical FeaTures of the ENvironment. Each item was rated on a five-point Likert scale from 1 to 5, where 1 was low satisfaction and 5 was high.

In addition, I included 2 closed and 2 open-ended questions:

- Do you think the environment has any effect on what service users do on the ward? YES/NO.
- If yes, can you say in what way?
- Do you think the environment could be improved? YES/NO.
- If yes, can you say how?

Service users' experience of activities on the wards: This measure was adopted from an earlier study by Nolan *et al.* (2011), funded by the National Institute for Health Research (NIHR), (a preliminary comparison of acute mental

health inpatient wards which use patient protected time, with other wards delivering standard care alone (Reference PB-PG-0808-17014)). This measure was added to the service user questionnaire after the amendment to the initial ethics approval. The measure records the activities that participants had engaged in over the preceding seven days, the frequency with which they had engaged in the activities, and the value they placed on those activities. They were scored on a five-point (1-5) Likert scale where 1 is low and 5 is high.

3.4.3.5: DATA ANALYSIS

The questionnaire data were analysed using the software IBM SPSS Statistics 24.0, licensed to the University of Essex.

Data preparation: it was observed during the data collection that some participants (staff and service users) struggled to choose either a true or a false response for some items on the WAS. Some of them wrote “sometimes” as their response in a few instances, others circled both answers and others left some items blank. In such instances, no mark was awarded and the item was scored as zero. Service users particularly struggled to answer item 22, which asked about the follow-up after they were discharged. Where one or two of the items that made up a sub-score were missing, the mean for the remainder of the items was substituted. Two out of the four art psychotherapists who completed the questionnaires left the section on the WAS blank, stating … “as I am not nurse staff, I could not answer some of the T/F questions on this form”, indicating that they worked primarily in the basement and not on the ward.

Although no hypothesis was stated in the study proposal, after obtaining the descriptive findings, it was deemed necessary to test statistically whether the numerical differences observed in the responses of staff and service users, ward and therapy staff, and participants of different genders were significant. Hence, a post-hoc inferential statistical analysis of the data was carried out which is reported in Sections 4.2.2, 4.3.2 and 4.3.3 of Chapter Four. Post-hoc analysis is usually referred to as 'after the fact' (Curran-Everett and Milgrom, 2013). It has both positive and negative features, and Srinivas *et al.* (2015) argued that, when properly used, a post-hoc analysis could lead to new clinically valuable insights. Poor use, on the other hand, could lead to an association or a causal effect between variables being confirmed that may not be correct. It should therefore be used and interpreted cautiously, and this was taken into consideration when the findings were discussed.

Analysis of the survey data: The plan was to conduct frequency analysis of the demographic information about gender, ward, age, length of stay and months worked at the hospital. The validity and reliability of the SOFTEN scale were measured using tests for internal consistency. Cronbach's alpha values of 0.70 and 0.90 were interpreted as good indicators of reliability (Kline, 2000). To proceed with the inferential statistics test of the hypotheses, the normality of the satisfaction with physical features scale was checked. A Shapiro-Wilk's test ($p>.05$) and the histogram (Appendix K) showed that the total scores of the SOFTEN scale were approximately normally distributed for both staff and service users, with a skewness value of 0.13 (SE = .37) and a kurtosis value of -0.21(SE= 0.73) for staff. Service users scores had a skewness value of - 0.88

(SE = .41) and a kurtosis value of 1.16 (SE .81) (Doane and Seward, 2011). Examples of the SPSS output are provided in Appendix L. Charts were generated in Microsoft Excel using the mean scores of the participants in instances where the data needed to be presented graphically. Analysis of the responses to the two open-ended questions was conducted using the thematic analysis framework developed by Braun and Clarke (2006).

3.4.4: MODULE TWO: PARTICIPATORY ACTION RESEARCH (PAR)

3.4.4.1: PAR PARTICIPANTS' GROUP

I proposed to recruit a total of between six and ten staff working at the acute unit to constitute the PAR group. The maximum number of ten was chosen as it was thought that this would be a manageable size (Green, 2007), and so that it could include at least one professional from the identified staff groups presented in Figure 1.1, as well as to be able to meet the cost of the staff involvement.

The inclusion criteria were as follows:

- clinical staff, registered or non-registered, including doctors, mental health nurses, occupational therapists, psychologists, associate practitioners, art therapists, peer support workers, healthcare assistants and support workers;
- have active responsibility for delivering care and treatment to service users at the acute unit;
- either facilitate, support, or provide therapeutic activities and group sessions to service users; and
- have worked at the acute unit for a minimum of three months. This was to ensure that only staff who had experience working at the acute unit and understood how the setting operated were recruited.

The exclusion criteria for the PAR group were as follows:

- Non-clinical staff, e.g., administrative staff
- Temporary agency or bank staff (due to transitory nature)
- Trainees – including nurses, doctors, occupational therapists, psychologists

- Social workers and pharmacists as they were not directly involved in activities for service users' engagement at the acute unit
- Service users

3.4.4.2: RECRUITMENT OF PAR GROUP PARTICIPANTS AND INFORMED CONSENT

Module two of the study completed additional two cycles of the action research spiral as in figure 3.2 and figure 3.3. The PAR group discussions were the second cycle while the key informant interviews were the third cycle. Staff interested in participating in the PAR group discussions were encouraged to contact me directly on the ward, by telephone or by email after the presentation about the study at meetings, outlined in Table 3.2. I encouraged them to make contact within two weeks of the presentation to express their interest in participating. Purposive sampling techniques were used to select the members of the PAR group, taking into consideration their profession, grade, gender, age and ethnicity, to obtain a representative sample of the staff (Wilding and Galvin, 2014). Purposive sampling is a non-probability sampling strategy that aims to recruit study participants who can logically be assumed to be representative of the study population (Boswell and Cannon, 2014). However, there was no recruitment of medical doctors and clinical psychologists (none being in post at the time of recruitment), to attend the PAR group meetings. The professionals recruited were occupational therapists, a music therapist, fitness instructor, nurses, and health care assistants.

In the study protocol, I indicated that the selection of staff with similar characteristics would be made by drawing names from a hat so that the process was transparent and fair. However, there was an instance where two staff from the same profession and the same ward volunteered to participate in the PAR group meeting. This was resolved pragmatically by looking at the list at it currently stood; this revealed that there were no male participants, so I spoke to both staff members and the female member of staff agreed that the male member of staff should join the group to help ensure a gender balance. At the time, I thought that was the best decision but, with hindsight, given that the male member of staff subsequently dropped out, I should have recruited both.

A maximum of four hours and a minimum of two and half hours was the time length proposed for staff to be present at each of the PAR group meetings. Staff were asked to attend all the PAR group meetings in their own time, either on one of their days off the ward or as annual leave. They were reimbursed £50 per session for their transport costs and time, which was increased to £100 after an amendment to the ethics approval of the study protocol. This decision was arrived at because requesting staff be released from clinical duties was deemed not feasible, without considerable recompense to themselves or the employing organisation. There was also a major challenge in recruiting the nurses and doctors which led to an amendment being made to the study protocol for ethics approval to increase the amount of reimbursement they received for participating in the study. However, the eight months duration that staff needed to commit to, attending the PAR meetings, was the main challenge to recruitment. Also, the initial amount of £50 agreed by the ethics committee to reimburse staff who attended was deemed very low. This contrasted with the £80 that the study team

had originally proposed. Further details about these financial issues are discussed in the section on ethics and funding later in this chapter. The amendment to the ethics approval which allowed staff to be recompensed £100 to participate in the study in their own time helped to recruit two nurses for the fourth and fifth meetings of the PAR group. Staff participants signed the consent form (Appendix P), after having read the participant information sheet (Appendix I) and having had the opportunity to raise any concerns with me. Details of the final PAR group participants and which session they attended are shown in Table 5.3.

3.4.4.3: PEER RESEARCHER AS CO-FACILITATOR FOR PAR GROUP MEETINGS.

In this study, a peer researcher who was a mental health service user was recruited as a co-facilitator for the PAR group with the rationale of including a service user's perspective in the discussions. She is the same person who completed all the data collection with the service users in Module One of the study. In Figure 1.1, she is the peer researcher (co-facilitator) and was present at all the PAR group meetings. An attempt was made to recruit the service user/peer researcher from the local service user forum within the NHS Trust, but this was unsuccessful due to the person initially recruited relapsing and requiring hospital admission. Appendix R shows the information circulated to aid with the recruitment of the peer researcher. The possibility of recruiting via other service user organisations such as the McPin Foundation (http://mcpin.org) and Experts by Experience (www.expertsbyexperience.worldpress.com) was investigated, but the charges for doing so were prohibitive. Recruitment eventually took place

through word of mouth in the form of a recommendation from one of my supervisors of a peer researcher she had worked with on a previous research study. Her role included helping me set up the venue for the meetings, taking notes during the group discussions, asking questions, and making contributions from a service user perspective during the group meetings. An anonymised example of her notes is shown in Appendix S.

I worked with this peer researcher from May 2018 to September 2019. Her professional background was being a qualified teacher with seven years' experience as a peer researcher. She had been involved in 17 completed studies as a service user researcher as of May 2018 when she was recruited for this study. The support extended to her included obtaining an honorary contract with the NHS Trust before her commencement of the data collection. As part of this, she completed the NHS Trust mandatory training that staff working with service users are required to take. She also received support and supervision from the OT consultant within the trust who was involved in this study and had access to one of my academic supervisors for additional support. At the acute unit, especially during the time that she completed the data collection with the service users, she worked directly with the OT team lead on each visit. On my part, I had regular meetings and phone conversations with her for feedback, to answer queries and provide support during the data collection period for Module One. It was in one of such supervision meeting that I picked up that I should add to the service user questionnaire an additional section to capture their engagement in activities. In Module two data collection, I regularly had a debriefing section after each of the PAR group meetings and there were also emails conversations in between the meetings. On reflection, these support processes could have been

more formalised, structured and named as the formal supervisions offered to the service users peer researcher.

3.4.4.4: DATA COLLECTION: PARTICIPATORY ACTION RESEARCH GROUP DISCUSSIONS

I worked collaboratively with the PAR group of staff and the peer researcher co-facilitator to collect the data. In all, five PAR group meetings were held, as shown in the table of attendance, Table 5.1 in Section 5.0 in Chapter Five. A group discussion approach was adopted, so that the PAR group meetings were run like focus groups. A focus group is a form of qualitative data collection where several people are brought together to discuss topics in a focused way (Green, 2007). It is a form of an interview but, in this case, with a group of people at the same time. The focus group has the advantage of addressing the traditional imbalances between researcher and research participants, as participants have some control over the research agenda. It also helps to include broader views about issues from different perspectives (Green, 2007; Berg, 2007). However, the use of focus groups in research has been criticised because participants may tend to intellectualise responses, make up answers when unsure about what to say and in some cases for allowing dominant individuals to take over the discussions (Krueger and Casey, 2014). There could also be issues of power imbalances and disclosure if the focus group contains people with a line management relationship. In this study, the focus group was used to enhance the collaborative nature of the research, as advocated in participatory action research. When using focus groups, Berg (2007) suggested it is advisable to have both a facilitator and an assistant or a co-facilitator. The co-facilitator can help to take field notes about the group dynamics and be responsible for taking notes as well as managing the

recording equipment. As indicated earlier in Section 3.4.4.3, the peer researcher was also the co-facilitator in all five PAR group meetings.

Data collection processes: I held five PAR group meetings with the staff over the eight months, once every two months except for the first and second meetings, which were five weeks apart. The preparatory activities for the first session, which were the same as for the other four sessions, included:

- Ordering lunch which was paid for from the study funding.
- Getting all the paperwork and the materials that would be needed ready for me to take to the research site from the University. A box was kept at the Occupational Therapy department at the acute unit containing a supply of tea, coffee and snacks that were used during the session.

The first meeting, held on 8th June 2018, was an orientation meeting for the PAR group, to discuss the aims and objectives of the research and what was expected of them as participants. In attendance were two occupational therapists, a Fitness Instructor, two health care assistants, and a music psychotherapist, as indicated in Table 5.1. The workshop on participatory action research was held to help them become familiar with the methodology so that they could participate in the study effectively. This session was co-facilitated by one of my supervisors, who has considerable experience in conducting participatory action research, and myself. The six participants were given a certificate of attendance (see Appendix T) which they would then be able to use as evidence of their Continuous Professional Development (CPD). The participants signed the attendance sheet, consent form and completed a form with their bank details to facilitate payment

for their participation through the University. The session was also used as a trial run for the data collection. It was held in the room that would be used for the subsequent data collection sessions. The room layout was as shown in Figure 3.5. This room was booked in advance for all the meetings through the receptionist at the venue. The recording equipment was also tested to check its effectiveness. Towards the end of the session, after the research question had been introduced, the staff began sharing useful information that was recorded and used as part of the data, with their consent. Quotes from this PAR group meeting are referred to as 'PAR 1', indicating participatory action research group meeting 1. The dates for the subsequent meetings were agreed upon with the participants. For the sake of consistency, the group agreed to meet on the second Friday of each month in which a meeting was to be held.

Figure 3.5: the layout of the PAR group meeting room

The second PAR group meeting was held on 13th July 2018 and was attended by the four-therapy staff in addition to the peer researcher and me. The male HCA could not get time off work and the female HCA reported sick. However, she sent an email containing some information about the acute unit environment based on her reflections on the discussion in the previous meeting. This information was included in the data analysis with her consent. That was the last time I heard from her as she did not return to practice. The group discussion for the day was focused on looking at the research question, as stated in the study protocol used for the ethics application, to explore the participants' views. The discussion guide for the session was as follows:

- exploring key terms in the research question such as 'environment', 'engagement', and 'therapeutic activities'
- how do service users engage in therapeutic activities at the acute unit?
- exploring the barriers and facilitators to service users' engagement in therapeutic activities in the unit
- discussion about whether to change the research question, as stated in the proposal, or to keep it the same
- identify key issues relating to the acute unit environment that the participant would like to focus on for the research.

The participants appeared enthusiastic about sharing their experiences of working in the environment, although some of the discussions became very emotional. The research question was written on a large flipchart sheet, and participants wrote some of their views on sticky notes and affixed these to the flipchart. An example is shown in Figure 3.6 below.

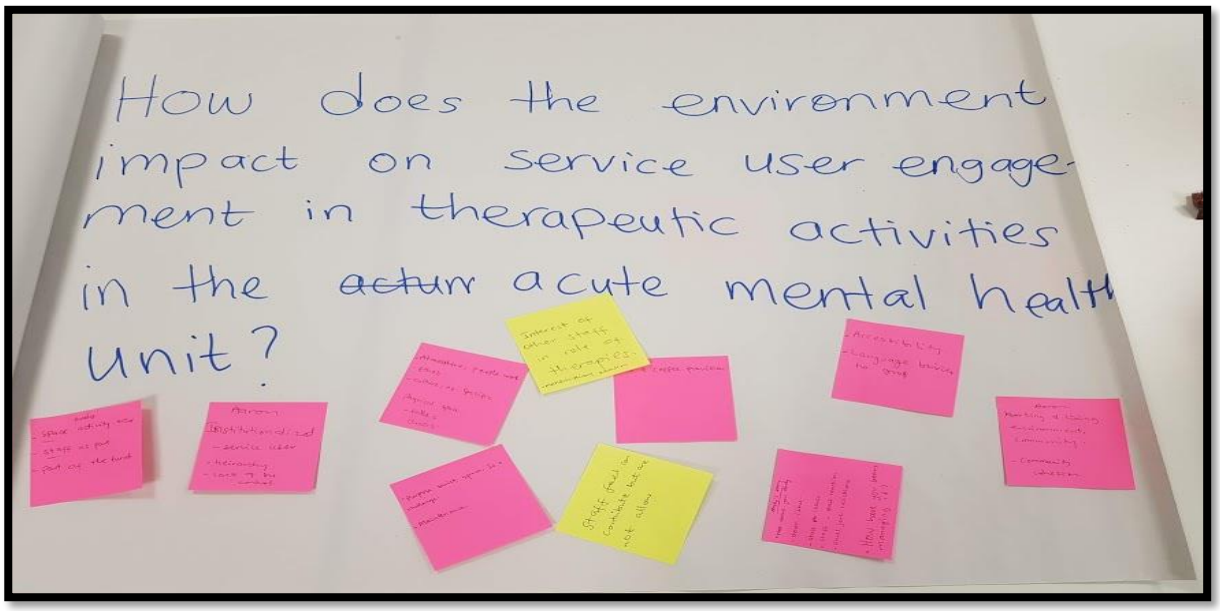


Figure 3.6: research question on the flipchart sheet with participants' summarised views on sticky notes.

All the discussions were audio-recorded and the recordings were transcribed verbatim for the analysis. The sticky notes were also collected as part of the data for analysis. The session ended with the participants agreeing on what they needed to do for the next session. They agreed to take pictures of the acute unit environment that they could use to facilitate the discussions in our next session. The session started at 9:50 am, ended at 1:00 pm and one of the participants had to leave before the session ended. I learnt that the participants had not been paid by the University for their attendance at the first session which I agreed to investigate. Details of the financial challenges I encountered are provided in Sections 3.7 in this Chapter

The third PAR group meeting was held a week earlier than the original date which was agreed by the participants on 7th September 2018. Before this session, I tried to recruit nurses and doctors to join the PAR group, by going to the acute unit to talk to people individually, at ward handover meetings and by sending emails to the head of the doctors but was unsuccessful. The four participants who had attended the previous meeting dropped to three: the two occupational therapists and the music psychotherapist. I was aware from the email conversation that the attendance was going to be low so I was very uncertain about how the session would go. In participatory action research, it is not unusual for participants' interest to dwindle as the study progresses, as Wilding and Galvin (2014) pointed out. In addition, I experienced a challenge common to researching with healthcare staff, especially in terms of recruiting doctors (Parkinson *et al.,* 2015). To ensure the session ran smoothly on the day, I planned a mapping activity in addition to the group discussion and went along with the materials that would be needed. These included a piece of cloth, markers, pencils, assorted coloured pens, glues and various arts and craft resources. The outline for the day was as follows:

1. Participants share individual experiences of what they have reflected on, acted on or changed in their practice since the last meeting that they feel was influenced by their involvement in the research. An individual approach was taken as staff informed me beforehand that they would arrive at different times due to various commitments. I took turns with the peer researcher for this activity. The prompt questions we used were:

I. Share with us anything you have been reflecting on regarding the research and your practice since the last meeting.

II. Think about a time or an incident in your practice when you experienced the impact of the environment on your work.

2. The next activity involved the staff discussing what they would like the ideal environment in the unit to be. They discussed this after each of them had diagrammed their views as shown in Figure 3.7. The question asked was:

- What is the ideal adult acute mental health inpatient unit for me, focusing on the physical and social environment and therapeutic activities?

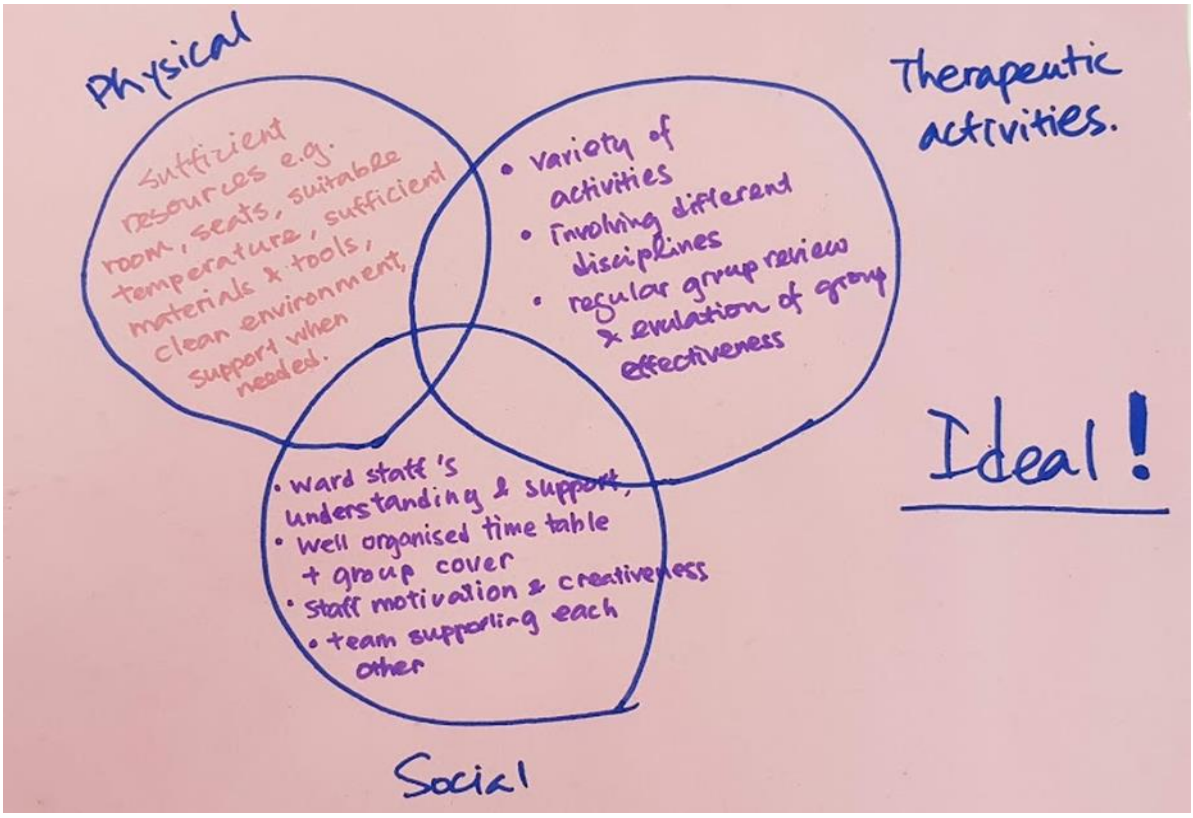


Figure 3.7: a member of staff's ideal ward environment

Staff discussions about what they would include in their ideal environment were recorded and used as part of the data in addition to the diagrams.

3. After this activity, the initial findings from the survey were discussed with the staff to help explore some of the emerging themes and findings. The final activity for the day was the mapping activity.

4. **Mapping activity - mapping the basement:** the staff agreed that they would map the basement as it was the space within the environment that the three staff present usually worked in. They were introduced to mapping in the workshop as a method of data collection, so they were already familiar with it. The idea was to visually represent the basement to show how the space was used and factors that inhibit or facilitate the service users' engagement in therapeutic activities within the basement. The drawing was led by the music instructor with contributions from the two occupational therapists. I went to the session that day with printed pictures of the hospital environment that the staff had emailed to me earlier. These were cut out and affixed to the piece of cloth in addition to the other art and craft resources. The choice of resources was purely pragmatic. I got basic items from the craft shop but decided to use a piece of cloth instead of a sheet of paper because it was more durable. Other items like pebbles, pieces of rotten wood, and toothpicks were randomly taken along to represent items found within the environment. After the mapping activity, the staff talked me through the image, which was audio-recorded and transcribed for analysis.

By PAR 4, held on 9th November 2018, I had gone back to the NHS research ethics committee to request an amendment to the study protocol to increase the amount of money paid to staff for attending the PAR session to £100. I also applied to hold key informant interviews with staff whose views were not captured in the PAR group. This was possible due to the flexibility of the participatory action research methodology (Herr and Anderson, 2015). It, therefore, led to another cycle of data collection, and the key informant interviews are discussed further in this section. I learnt that one reason why it proved so difficult to recruit nursing staff and doctors was that the £50 reimbursement for attending the PAR group session was far less than what they could earn from doing a bank shift, especially in the case of the nurses and the HCAs. The interim service manager provided a letter in support of this amendment to the study protocol to reimburse staff £100 for attending a session.

This resulted in the recruitment of the first staff nurse for PAR 4.

- The focus of the data collection then shifted to the ward environment as the last two sessions had involved a lot of discussion about the basement.
- Most of the discussions were led by the staff nurse with contributions from the therapy staff as they also work on the wards. The research question was explored from the nursing team perspective.

The session started at 9:30 am and ended at 1:00 pm, with five staff attending, in addition to the peer researcher and myself.

The final group meeting (PAR 5) for data collection was held on 11th January 2019 and it focused on the PAR group analysis of the data. There were two nurses in attendance who decided to complete a mapping activity to map one of the wards in the same way as had been done for the basement. This was led by the two nurses with the support of the two occupational therapists and the music psychotherapist. As this decision was only taken by the group on the day of the data collection, there were no pictures of the ward that could be used in the mapping activities. They decided to make do with the art and craft resources instead. The final product of the second mapping activity is shown in Figure 5.4 in Chapter 5. I took notes as the participants made decisions and engaged with the activity. The discussion at the end was audio recorded.

The final activity was the group analysis of the data. As already explained, my role within the PAR group as a PhD student and facilitator meant that it was my responsibility to begin the data analysis process. This included transcribing all the data, and coding and generating themes with supporting quotes. A summary table was emailed to the participants before the session on 7th January 2019 so that staff could prepare for the session. The summary table was also displayed on the flipchart on the day of the meeting as shown in Figure 3.5. We went through it as a group and the staff made some changes to the themes but mostly agreed with how I had presented the information which they felt was a representative summary of what had been discussed in the PAR meetings. This is shown in Appendix U.

Key informant interviews: The challenges posed by recruitment led to the key informant interview strand of the data collection. The target group were members of the MDT whose views were not captured in the PAR group meetings. In addition, there were some emerging themes, such as smoking and its impact, that required key staff to be contacted to explore them further.

In all, four interviews were conducted with the following staff members; the length of time they lasted for is also given:

- a ward manager (35 minutes);
- the occupational therapy team lead (45 minutes);
- a consultant (doctor) (12 minutes); and
- the deputy smoking cessation leads in the NHS Trust via telephone (10 minutes).

The interview guide used is shown in Appendix V. The three face-to-face interviews were audio-recorded and transcribed verbatim for analysis. The audio-recordings of the PAR group meetings and the interviews were uploaded to my university one-drive at the acute unit after each session and later downloaded to my university office computer which is password protected. They were then deleted from the recording device to ensure the data was well protected. The data corpus (Braun and Clarke, 2006) for Module Two of the study, therefore, included the audio-recordings of the five PAR group meetings, images of the mapping activities, sticky notes containing information about staff views and pieces of papers that staff used in activities. The other data comprised the four key informant interviews, my fieldnotes and pieces of evidence such as timetables and images of the unit shared by the participants. My reflections on

the challenges on the recruitment of the diverse staff mix from the MDT to the PAR groups is captured in reflective box two. In Chapter seven, under the limitations of the studies, reflective box 5 share more light on the impact of the nominal involvement of service users in this research study.

Reflective Box 2: Ensuring a diverse mix of the Multidisciplinary Team (MDT)

There were many challenges encountered when recruiting the doctors and nurses to participate in the PAR groups in the Module two of the study to help get the diverse mix of the MDT. The two Health Care Assistant (HCA) from the ward did not attend the PAR 2 meeting and I had not recruited any doctor, neither has the two nurses who had verbally agreed to attend the sessions shown up to the two prior meetings. This was discussed in supervision; spoke to a ward manager and the interim service manager and reviewed the literature on data collection in Participatory Action Research to explore why I was struggling to recruit and to solicit for ideas. The consensus from the investigation was that I include key informant interviews as some staff could only attend a short, one-off section that an interview format was more suitable compared to the commitment required by the PAR groups.

It was essential that the different groups of staff within the MDT perspectives and experiences on the environment are gathered and failure to do this would mean that the study lacked it democratic validity (Herr and Anderson, 2015), a quality criteria in an action research. I was worried whether the aims of the research study to explore the views and perspectives from the MDT that worked in the acute unit would be achieved. I thought about possible reasons why the therapy staff were engaging in the research and if this had to do with the study originating from their team. It was crucial at that point that I come up with a plan to recruit the nurses and the doctors to the study as the data collection was coming to an end. I had only two planned PAR session remaining and most of the data were from the therapy staff perspectives. At PAR 3, when the mapping activity was completed, the participants agreed to only mapped the basement as there was no ward staff present.

This experience with the recruitment of staff to the PAR group meeting helped me to fully appreciate that, in a research study, things may not go as planned and that as a researcher timelines for research study needs to be agreed with room for some flexibilities when there are uncertainties, or as in this case challenges to recruitment. The ability to include the key informant interview, halfway in the data collection with the amendment to the study protocol helped justify why PAR was the best methodology for this research study. Its' flexibility that the method of data collection can be modify as you go through the cycles of plan-reflect-act helped to find a new way (key informant interviews) to include the other members of the MDT who could not attend the PAR group meetings.

Going forward as an early academic researcher likely to use participatory action research again, I am more aware of the challenges that can be encountered with recruitment. Especially, participants who may not have that sense of belonging, where it comes to a research study. Although, exploring the acute unit environment from staff and service users from my perspective was to have been a shared issues for all the staff, I realised that the therapy team felt more committed and participated in the study. In future, I have learnt to commit more time to explore whether prospective participant feel part of the proposed research study, especially if the plan is to use a participatory research approach that would require them to be part of the research study. If not, then the study design needs to be such that, only those who are likely to commit and participate are included to help minimize such challenges of recruitment and the retention of study participants. Finally, I have learnt that, building good relationship with prospective participants is likely to facilitate recruitment to a study as the two nurses and the doctor I finally recruited to the study, did so out of goodwill.

3.4.4.5: DATA ANALYSIS

The qualitative data were analysed using the six stages of thematic analysis developed by Braun and Clarke (2006) shown in Table 3.3 and supplemented by ideas from Bazeley (2009) and Fereday and Muir-Cochrane (2006). Thematic analysis was chosen due to its flexibility for use with complex data. It is also in line with the constructionist viewpoint adopted for this study which posits that reality, meaning, and experience are the effect of a "range of discourse operating within society" (Braun and Clarke, 2006, p. 81). I started the analysis by transcribing each PAR group discussion immediately after the meeting.

Table 3.3: phases of thematic analysis

Phase		Description of the process
1.	Familiarising yourself with your data:	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2.	Generating initial codes:	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3.	Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme.
4.	Reviewing themes:	Checking if the themes work with the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.
5.	Defining and naming themes:	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6.	Producing the report:	The final opportunity for analysis. Selection of vivid, compelling extract examples, the final analysis of selected extracts, relating of the analysis to the research question and literature, producing a scholarly report of the analysis.

Adopted from: Braun and Clarke (2006)

For PAR 1, only the section in which participants discussed the research question was transcribed as the initial part of the audio-recording related to the training session. I fully transcribed PAR 2 to PAR 5 and the three key informant interviews. The transcribing was initially done using NVivo software but this was later discarded due to the challenges that I encountered as a result of being unfamiliar with it. I, therefore, used a Microsoft media player and a Word document to complete the transcribing. In all, there were 157 Word document pages of transcribed data for the PAR group meetings and 28 pages for the key informant interviews. Each data set was prepared by attributing line and page numbers and was typed in Arial font size 11 with 1.5 line spacing.

I started the line-by-line coding (Charmaz, 2014) with the two data sets, PAR 1 and PAR 2 audio-recordings. The analysis was manually completed in the Word document using various colour codes and notes made in a codebook. The codebook was a small book in which I kept all my notes regarding the decisions, actions, and changes that I made in the analysis process. The meanings of the colours used were also written in this book. I have included an extract from the codebook in Appendix W. I then progressed the analysis of the PAR 1 and PAR 2 data to the third stage of searching for themes (Braun and Clarke, 2006). This involved gathering all the data relevant to each potential theme, which was done by grouping similar codes and names together as a theme. These themes were reviewed to ensure supporting quotes were congruent with the meaning ascribed to them. The themes generated in the analysis were used to guide the analysis of the PAR 3, 4 and 5 data, and hence the method used was theme led analysis (Fereday and Muir-Cochrane, 2006).

The data were further analysed after the theme led the analysis to identify additional themes that had not already been identified. Patterns identified within the themes were mapped during the review of the themes to further reduce the number of themes and to decide on the main themes and sub-themes. The data presented for the group analysis in PAR 5 was generated after the analysis of PAR 1, 2, 3 and 4 and included the themes and related quotes. The findings were written up using the “describe - compare - relate” approach discussed by Bazeley (2009, p. 10). A similar thematic analysis process was used for the analysis of the three key informant interviews to generate the themes. A systematic search across all the data gathered was undertaken to find repeated patterns and meaning. In a recursive process, I continued the analysis until the main themes and sub-themes had been identified inductively from the data. These were presented as the study findings. The findings from the PAR group discussions and the key informant interviews are written up together in Chapters Five and Six. Appendix AN is a snapshot of the data analysis.

3.5: QUALITY CRITERIA OF THIS STUDY

Choosing a quality criterion to apply to an action research study like this one is very challenging as there is an ongoing dialogue between key authors about which criteria are most appropriate (Herr and Anderson, 2015; McNiff *et al*., 2003). On the one hand it is argued that the approaches used by the quantitative positivist paradigm may not be applicable. However, those currently used in general qualitative research like credibility, transferability, dependability, and confirmability (Bryman, 2015) seemed inadequate due to the focus on action research. Consequently, different action researchers have come up with different criteria that are still being tested. In this study, I used Herr and Anderson's five "tentative" validity criteria for defining rigour in action research which are the following: process, democratic, catalytic, outcome and dialogic validity (Herr and Anderson, 2015 p. 67). This may not be the 'gold standard' but was found to be a useful indication of the current thinking in the ongoing dialogue within the literature, particularly because I collected both quantitative and qualitative data. The subsequent section discusses how these quality criteria apply to this study.

I begin by describing the process validity, which is described as the extent to which the research problems were framed and solved in a manner that permits ongoing learning. In this study, there was a clear focus on the issue being investigated, that is, the acute unit environment and how it impacts service users' engagement in therapeutic activities. The design of the data collection, using the various methods described previously - the questionnaires, group discussions, key informant interviews and the mapping activities - led to a robust process that

ensured adequate data were gathered and analysed to identify actions that could be taken to address the problems. Triangulation was achieved through the use of these methods, detailed in the introduction of the discussion chapter. According to Herr and Anderson (2015), process validity can be linked to the criteria of credibility (multiple accounts) and dependability (audit trail) to ensure quality in qualitative research (Bryman, 2015). The study protocol (Appendix X) used for the ethics application outlined the study processes in detail. The research was carried out following the processes outlined and any changes were agreed upon and recorded via an amendment to the ethical approval, demonstrating that the study process was very transparent. Taking into consideration all the challenges involved in conducting participatory action research.

The next criteria, democratic validity, which means the extent to which the study is done in collaboration with all parties concerned, was achieved to a large extent. This study included all relevant stakeholders and in instances where recruitment proved challenging, the maximum effort was put into recruiting participants, for instance, in the case of recruiting the doctor for the key informant interview, which was done after the deadline set for recruitment had passed. I returned to the acute unit for three more days until I contacted the prospective participant and arranged an appointment for the interview. Working collaboratively with some groups of participants in this study was relatively simple, whereas maximum effort was needed to involve others. At the outset, the therapy team embraced the study and were very proactive about engaging in the process. The service users' nominal involvement, which is a limitation in this study is expanded on in Section 7.7 of this thesis. However, the process validity was limited in terms of PAR group

participants involvement in the data analysis detailed in the limitations in chapter seven.

Catalytic and outcome validity, and how they were achieved in this study, are discussed together. There was catalytic validity in this study in instances where staff in the PAR group described their engagement in the research as a real opportunity within the NHS to talk about their practice and how to make changes. Post data collection, a PAR participant mentioned that her decision to resign from her post at the acute unit and take up a new post was influenced by her involvement in this study, which was not an expected outcome though. There was a positive re-orientation by another participant who shared she was ready to set up a new therapeutic activity group in the acute unit which was inspired by her involvement in this study. This study is not an example of a study that was aborted at the point of diagnosing the problem (Herr and Anderson, 2015) but continued to a conclusion utilizing three different strands of data collection. There has been good dissemination of the findings both within the host organisation and externally at seminars and conferences (details in Appendix Y). With work undertaken with the stakeholders who could use the information to make changes within the acute unit. The initial findings from this study emerged at a time when the unit was going through an improvement programme. There was an opportunity to present the findings at the NHS Trust board meeting at the organisation's headquarters. However, as an outsider researcher, I was limited by the fact that I could only depend on the participants and stakeholders to take the actions recommended, as this was beyond my remit.

Finally, the dialogic validity, as explained by Herr and Anderson (2015), which means the extent to which the study was peer-reviewed before publication, was low in this study up to the point when the thesis was written up. The main reviews of the write up were those by my supervisors to give feedback. In addition, I had a critical discussion with a friend who had some experience of working within the acute unit, about some of the initial findings to check if she had alternative explanations for the research data. Considering all these five validity criteria, this study can be justified to be a piece of action research. In addition, it satisfies most of the criteria set out by Kemmis and Wilkinson (1998) in terms of what constitutes participatory action research, as discussed in Section 3.3.2.

In light of the quantitative data gathered for Module one of the study, which aligns mostly to the positivist perspective, I share how researchers bias and a possible conflict of interest were dealt with in this study. Conflict of interest was minimised through the use of a service user peer researcher for the survey data collection with the service users. Stepping away for the peer researcher, with shared experience with the service user, to support the service users with the completion of the questionnaire, was an expression of sharing power with the co-researcher. Details of her involvement are discussed in Section 3.4.4.3 of this chapter. The recruitment of the service users to complete the questionnaire were all supported by the staff at the acute unit and approved by the NHS Research Ethics Committee. As much as this approach reduced researcher bias, there was a possibility of the ward staff selectively approaching only some service users. This was addressed by the peer researcher attending ward community meetings,

extending an open invitation to all the service users and ensuring those who finally participated in the study met the inclusion criteria.

Reflexivity, an essential component in the qualitative study used to ensure rigour and reduce the researcher's own bias was well utilised throughout the research process. Especially within the PAR data collection and the data analysis. As an outsider researcher, with limited experience working in the acute unit, I first reflected on the themes I had presented from the analysis and checked with the PAR group members such that they agree and that it was a true reflection of the findings. In addition, there were questioning and feedback from the supervisory team that helped in constantly reflecting on the findings.

3.6: Ethics process and reflections

This study obtained ethical clearance from the Camden and Islington NHS Research Ethics Committee (REC) (reference: 18/LO/0331 – Appendix AI and AJ) and the University of Essex (Reference: 17036 – Appendix AK). I engaged with both processes separately. The University's approval was dependent on the NHS REC's approval. The NHS REC process involved the completion of an application using the Integrated Research Application System (IRAS), the platform for all applications to the NHS REC. I worked collaboratively with the University Research and Enterprise Office (REO) on the application to the NHS REC. The University sponsored this study and issued the sponsorship letter (Appendix Z) and the indemnity letter (Appendix AA and Appendix AB) in support of the application to the NHS REC. This ethics application was necessary as the study was undertaken at an NHS site and involved mental health service users who are deemed a vulnerable group. Going through the ethics approval application process provided an opportunity for the study to be independently reviewed. The NHS REC is a committee usually consisting of 15 members, of whom one-third are lay persons, who review research proposals and give their opinion about whether a study is ethical (Health Research Authority, 2020). The main challenge that I encountered during the ethics application process was in regarding the payment to be made to staff participants for attending the PAR group meetings. This is largely related to the understanding of the pragmatic nature of the action research methodology in higher education (Herr and Anderson, 2015). Further details are available in the funding section: 3.7 with a reflective account of the process in the box below.

Reflective Box 3: Challenges with the ethics processes

To gain ethics approval for this project, I required three approvals: from the NHS Ethics committee, the Health Research Authority and from the University of Essex (UoE) before the data collection started in May 2018. This process to obtain the ethics approval was one of the most challenging moments in conducting this research study. It took approximately one year to complete this process from developing the study protocols, liaising with the UoE Research Enterprise Office (REO), to the making the application to the NHS Research Ethics Committee (REC) for the final approval.

The process required hard work and constantly engaging with different individuals, organisations and tested my ability to clearly articulate the rationale for decisions I had made as to why I had designed the study in the way proposed. The research process stalled when the UoE REC would not consent to the reimburse of £80 to staff per each attendance of the PAR meeting. The main arguments for this were that this amount would potentially 'coerce' staff to participate in the study instead of the voluntary participation. I had realised that staff needed to be adequately recompensed for the time that they were devoting to participate. In the end, the UoE REO did not approve the amount so I took my chances with the NHS REC for the actual ethics approval process. They approved an amount of £50 per attendance and following a poor recruitment to these groups, this fee was amended to £100 with agreement by the NHS REC. I felt frustrated with the ethics application processes as it halted the progress of the study and questioned if I could complete the study on time.

I learnt a great deal in terms of the ethics application process, the need to persevere and to stand for that which you can adequately justify as the best decision, especially when conducting qualitative research that would involve the participation of both staff and service users. From this experience, I now feel more confident and prepared for future ethics applications that I would engage in. I had to rely, worked with and learn from my supervisors. Now, I can lead and also support others through this processes, especially the NHS Ethics application processes using the Integrated Research application System. This new knowledge will help me to continue to carryout research within the NHS and also support future students as I can confidently navigate the ethics application processes. I have started to put this into practice by sharing knowledge with a PhD colleague who was using the new UoE ethics application platform similar to the NHS IRAS. I have also learnt to identify the ethical issues that are the priority of the ethics committee and to address these when putting a study protocol together. For example, how the identified risks would be managed or minimised to promote the safety of study participants.

The participants for both modules were provided with participant information sheets (Appendix G, H, I and J) and asked to sign a consent form (Appendix N, O, P and Q) to participate in the study (Bryman, 2015). In addition, a conscious effort was made to use a fair selection criterion as explained in the description of how the PAR group members were recruited in Section 3.4.4.2. To ensure a favourable risk-benefit ratio for the participants, an amendment was made to the ethics approval to increase the payment to £100 (National Institute of Health, 2018). In addition, all the questionnaire responses, PAR group discussions and key informant interviews were treated confidentially and adequately protected, as previously discussed concerning the data collection process. Detailed information about the data management can be found in the various PIS shown in Appendix G, H, I and J. Provisions for managing any risk relating to the participants' involvement are also included in the PIS and the study protocol shown in Appendix X. The final ethical issue, that was considered was not including service users in the PAR group discussions which were mostly informed by the pragmatic decision based on the service user's relatively short length of stay at the acute unit as discussed in Section 3.4.1. of this chapter.

3.7: FUNDING

The NHS Trust acute services allocated £6,000 to support the proposed research that later became part of this PhD study. The money was transferred to the supervisor's research account at the University and allocated a cost code. It was initially proposed that the money would be used to provide cover for staff who attended the PAR group using temporary staff, but this was no longer feasible at the time of the actual study with hospitals cutting down on agency staff to minimise incidents on the ward. The decision was therefore made that staff would need to attend the sessions in their own time and be reimbursed £80 per session. This presented a challenge because the University REO thought the amount was too high and could have the effect of coercing staff into attending the PAR group. This sentiment was shared by the NHS REC and the amount was reduced to £50 per session attendance. However, this hampered the recruitment of nurses and doctors to join the PAR group. An amendment was requested from the ethics committee and the amount was increased to £100. The reimbursement of study participants with money and other tokens is not a new practice and is commonly done in studies like that by Bryant *et al.* (2016). However, the ethical issues around this and the impact of the payment on participants and the study's integrity needs to be carefully considered (Ripley, 2006).

The issue in question was whether the payment was commensurate with the demand on the staff's time in sharing their expertise for the research. This concern was raised by the University of Essex Research Enterprise Office (REO) which delayed their issuing of the three key letters to support the application to

the NHS ethics committee. The other stream of funding for this study was £1,000 from the Elizabeth Casson Trust fund (https://elizabethcasson.org.uk/) which was used for service users' involvement and was also secured by the supervisor who initiated this study. Two-thirds of the funding was used to reimburse the peer researcher for her involvement in the data collection with the service users in Module One of the study. The remainder was used to reimburse the 33 service users who completed the questionnaires with £10 each. This money was transferred from the supervisor's occupational therapy budget at the research site where it was disbursed. Appendix AC. shows the template of the sign-in sheet for the service users who received the money.

3.9: SUMMARY OF THE METHODOLOGY

In this chapter I have outlined the methodology and methods of data collection employed in this study. The study adopted a constructionist paradigm with which to investigate existence reality, in this case what the participants perceived as impacting on service users' engagement in therapeutic activities at the acute unit. The study operated according to the belief that reality is socially constructed as opposed to the positivist assumption that there is a stable and existing reality that can be known through careful scientific research (Green and Thorogood, 2014). Based on the assumption that this study involved human participants with complex behaviours (Broom and Willis, 2007), a decision was made to adopt the interpretivist perspective to inform this research. In addition, the research questions and the aims of the research suggested that the emancipatory perspective would be beneficial as it would help ensure that the knowledge generated would be of benefit to the service users.

As discussed previously, the research methodology used was action research, and specifically participatory action research. Action research proceeds with the rationale of taking action either within the setting or among the group that is being studied (Herr and Anderson, 2015). It is a research methodology used to guide community interventions, and to address issues of injustice while engaging in research that increases knowledge and informs change (Kelly, 2005). The PAR participants are seen as co-researchers and the research is done "with" them and not "on" them (Kemmis and McTaggart, 2008; Reason and Bradbury, 2008).

Bryant *et al*. (2016b) argued that PAR is not a single method, and that "multiple methods can be used to build a detailed dataset and interpreted to elicit new knowledge and understanding of human experience" (p. 74). For these reasons, I collected both quantitative and qualitative data in different cycles to complete the spirals that are an essential component of action research. This chapter also discussed the two modules of data collection separately by explaining the processes of recruitment and data collection, the types of data collected and how they were analysed, using SPSS for Module One and thematic analysis for Module Two data. Below is a summary table of the activities and the data gathered for the five PAR sessions.

Table 3.4: Summary table of PAR group activities and data generated

Date / PAR		**Activities and key data sources**	**Type of data**
1	8.06.19	- workshop on participatory action research - initial paperwork completion and signing of consent forms - Group discussion about the research question	- audio recordings - fieldnote entry in a research diary
2	13.07.19	- email from an HCA (female) identifying issues within the environment - flipchart with the research question and participants' responses on sticky notes - group discussions	- Word document - images - audio recordings - fieldnotes
3	07.09.19	- participants' reflections, one-to-one facilitator - group activity on the ideal environment - discussions of initial findings from the survey data - Basement mapping activity	- audio recordings - images of the activities - audio recordings -fieldnotes - images of the final product
4	9.11.19	- Further group discussions of issues relating to the environment (Mostly nurse-led discussions)	- audio recordings - fieldnotes
5	11.06.20	- PAR group analysis of the data - mapping activity (2) of the ward environment	- audio recordings - images of changes staff made to chosen themes - images of the final product

Finally, this chapter has included a discussion of issues relating to the methodology and methods, such as funding, ethical issues, and quality criteria. This chapter has adequately captured the majority of the actions that I engaged in to collect the data, which were then analysed to generate the findings. Appendix AD is the complete timeline for the data collection for both Modules of this study. The next chapter, chapter four presents the findings from the survey. I have an

introduction section in the chapter that outlines the rationale of why I decided to have three different finding chapters for this study.

CHAPTER FOUR

SURVEY RESULTS FOR MODULE ONE

4.0: INTRODUCTION

As explained in the section on the structure of this thesis in Chapter One (Section 1.6), this section is an introduction to the three findings chapters. It provides some justification for why there are three findings' chapters. Participatory action research is known to provide complex and messy data (Herr and Anderson, 2015) that the researcher then needs to make sense of and, as a PhD student, to write up as a thesis. Structuring the study in terms of two modules of data collection at different time points made it logical to have two corresponding findings chapters. However, the themes from the PAR group discussions and the key informant interviews were such that they also lent themselves to being presented in two separate chapters.

- Chapter Four presents the survey findings including the responses from the staff and service users' questionnaires in Module One.
- Chapter Five is dedicated to the findings relating to the building and the physical environment of the acute unit and how it impacted the service users' ability to engage in therapeutic activities. Images from the two mapping activities are also used to illustrate the findings.
- The final findings chapter, Chapter Six, presents the themes relating to the social environment, the conflicts, and co-operation between the people within the environment and how they impacted the service users' ability to engage in therapeutic activities.

This chapter presents findings from Module One of this study, which comprised a survey design using questionnaires. The survey explored staff and service users' views on the physical environment of the acute mental health inpatient unit and of their perceptions of the ward atmosphere of the three wards within the acute unit. I present the survey participants' characteristics using tables, followed by information about their satisfaction with the physical features of the acute unit environment and then their perceptions of the ward atmosphere. Both descriptive data and inferential test results are presented. In addition, graphs provide a visual depiction of comparisons between the groups' responses. Finally, the responses to the open-ended questions are presented as themes with supporting quotes.

4.1: PARTICIPANTS' CHARACTERISTICS

A total of 73 participants, of whom 40 (54.79%) were staff and 33 (45.21%) were service users, completed the questionnaires. Most participants were male (43 = 58.90%) and they were evenly distributed across the three host wards and the therapy department. The fact that male respondents were in the majority does not indicate there were more males than females on the wards, as this data was not gathered, and nor is it an indication that more men were involved in research in the acute mental health unit. It could simply reflect the fact that more men than women chose to complete the survey. The three wards on the acute unit are referred to as Wards A, B and C in this chapter. Ward B had the highest number of participants (29 = 39%) out of the total number of staff and service users who completed the questionnaires. Table 4.1 presents detailed information about the participants from the wards and therapy departments.

Table 4.1: number of participants from the wards and therapy department

Groups		**Wards or Unit**				**Total**
		Ward A	Ward B	Ward C	Therapy D.	
Staff	Males	7	7	-	4	**18**
	Females	6	5	2	9	**22**
	Total	13	12	2	13	**40**
Service users	Males	4	11	10	-	**25**
	Females	1	6	1	-	**8**
	Total	5	17	11	-	**33**

The next table presents the participants' characteristics with the means (M) and standard deviations (SD). The table includes a range of characteristics, some of which do not apply to certain participants, and hence no values are allocated. These sections are marked as (-).

Table 4.2: Characteristics of staff and service users

Items	**Staff n= 40**		**Service user n=33**	
Age	n (30)		n (31)	
	M=37.25	SD =13.11	M=42.32	SD=13.28
Months worked at the Hospital (adjusted to exclude less than one month) (months)	n (27)		-	-
	M = 60.19	SD = 50.39	-	-
	Min = 9	*Max* = 200	-	-
Length of stay on the ward (in days)	-	-	n (32)	
	-	-	M = 55.19	SD = 85.1
	-	-	*Min* = 7	*Max* = 392
Length of stay in days (adjusted to exclude three outliers)	-	-	n (29)	
			M= 30	SD= 22.01
Detention under Mental Health Act	-	-	n (31)	
	-	-	*Yes* (73%) =24	*No* (21%) = 7

The majority of the service users reported being detained under either Section 2 or 3 of the Mental Health Act 1983, as indicated in the Care Quality Commission (2018) report, in which an increase in the number of service users detained under the Mental Health Act in England was recorded. The adjusted mean length of stay of 30 days is approximately the same threshold as the national average of

32 days (NHS Mental Health Implementation Plan, 2019), although the service users who completed the questionnaires were still on admission when they did so.

Table 4.3: Staff profession

Total staff employed at the hospital as of March 2018 before data collection		**Participants**	**Percentage of employees**
Art Psychotherapists	6	4	67
Associate practitioners	3	3	100
Doctors	-	2	-
Nurses	41	12	29
Occupational Therapists	4	4	100
Peer Support Workers	2	1	50
Clinical Psychologist	1	1	100
Support workers/ HCA	31	4	13
Medical student	n/a	3	n/a
Nursing student	n/a	2	n/a
Occupational therapy student	n/a	1	n/a
Other (Therapy staff 1)	1	1	100
Not indicated	-	2	-
Total		40	

The staff who participated were employed in different grades, including students. The exact number of doctors employed at the hospital was unavailable as there was no opportunity to meet the medical team lead. Details of this difficulty are reported in Section 3.4.4.4 of this thesis. Most of the art psychotherapists worked part-time, which added up to an equivalent of 2.5 full-time staff, with two trainees. NHS staffing levels in core acute mental healthcare services are such that the number of nursing staff exceeds that of allied health professionals and doctors. However, a greater proportion of allied health staff than nursing staff responded to the questionnaires in this research, although, I made a conscious effort to recruit from the multidisciplinary team. A reflection on the challenges encountered in recruiting diverse staff mix is in reflective box 2 on page 129 in Chapter three of this thesis.

4.2: SATISFACTION WITH PHYSICAL FEATURES OF THE ACUTE UNIT ENVIRONMENT

4.2.1: RESPONSES FROM STAFF AND SERVICE USERS

The participants' responses to Section B of the questionnaires (the SOFTEN scale) for both staff and service users are presented below in Table 4.4. The mean (M) and standard deviation (SD) of each feature of the physical environment are presented separately for staff and service users. This section of the questionnaire was completed by all 73 participants with no missing values on the five-point Likert scale, which ranged from extremely dissatisfied (1) to extremely satisfied (5).

Table 4.4: satisfaction with physical features of the acute unit environment.

Physical features of the hospital	**Staff (n=40)**		**Service user (n=33)**	
	Score (1-5)			
	M	SD	M	SD
Access to daylight	3.05	1.10	3.45	1.25
Access to garden	2.21	1.22	2.19	1.25
Aesthetic and comfort	2.95	1.02	3.24	1.17
Colour of environment	3.03	0.89	3.45	1.03
Damage resistant furniture	3.49	0.94	3.50	1.08
Flooring of environment	3.65	0.70	3.82	1.04
Location of nursing station	3.51	0.91	3.27	1.18
Level of noise	2.69	1.10	2.33	0.96
Mixed sex accommodation	2.95	0.90	3.72	0.92
Order and organisation	2.72	1.02	3.22	1.01
Outdoor facilities	2.26	1.04	2.84	1.46
Room privacy	3.03	1.07	3.12	1.27
Seating mix	3.23	0.86	3.64	0.93
Security	3.05	1.18	3.30	1.31
Views from bedroom	3.34	0.88	3.58	1.15
Ward layout and design	3.03	1.10	3.52	1.09

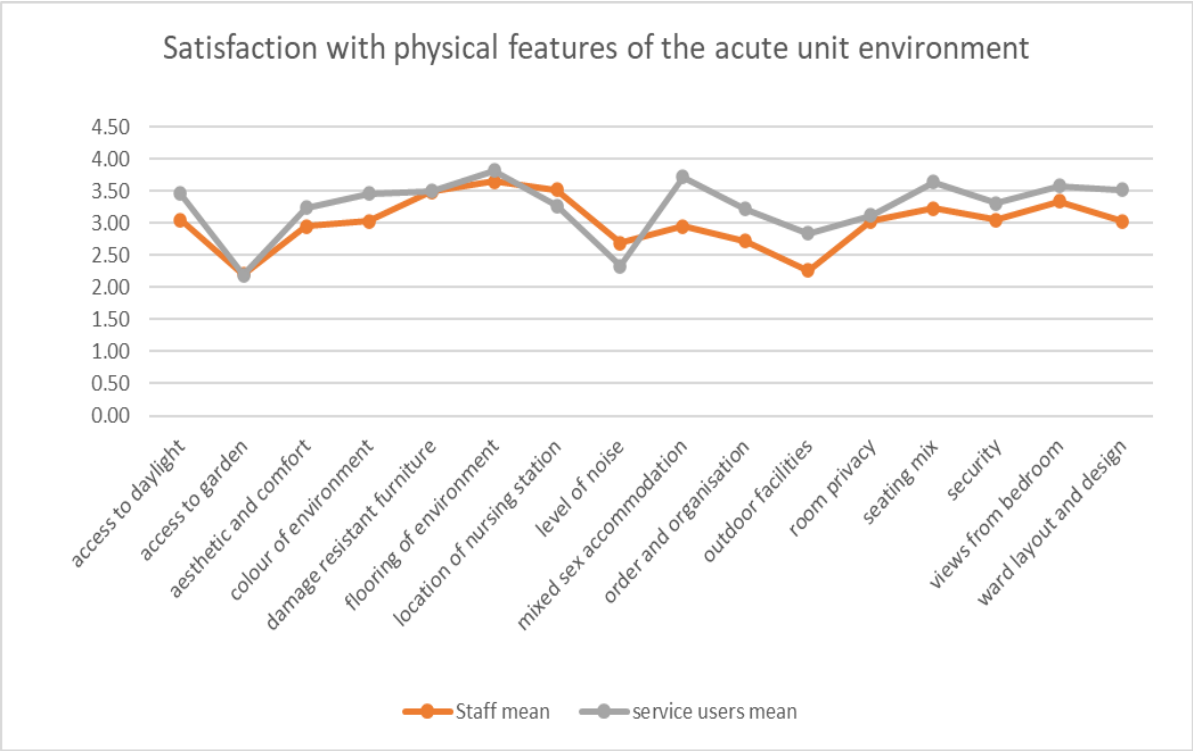


Figure 4.1: Participants' perceptions of the physical features of the environment

Staff and service users' scores were similar for the top three physical features they were dissatisfied with, although in a different order. The therapy staff, who worked in the basement, were extremely dissatisfied (12 out of 13 respondents) with the level of access to daylight. The service users were generally satisfied with mixed sex-accommodation, but these findings may not be as representative as the majority of the service user respondents were male. Overall, it can be seen from Figure 4.1 that service users had slightly higher means scores for most of the items compared with the staff's mean scores. The standard deviations for all the features were low (between 0.7 and 1.32) indicating that the data points tend to be closer to their means. The statistical significance of the differences in the means is presented below.

4.2.2: HYPOTHESES TESTING OF SATISFACTION WITH PHYSICAL FEATURES OF THE ACUTE UNIT

To gain an overview of the responses to the survey questions about the participant's satisfaction with the physical features of the acute unit, the scores were aggregated by the study team to determine overall scores. A decision was made to interpret overall scores of 55 and above as being satisfied with the physical features of the environment. This decision was arrived at after the following had been taken into consideration:

- If someone scored 3 (neutral) throughout the 16 items on the questionnaire (Appendix E and F) the overall score would be 48.
- A score of 4, indicating satisfaction, throughout the 16 items would yield an overall score of 64.
- Allowing for some flexibility, 55 was settled on as a good gauge of overall satisfaction.

From Table 4.5, it can be seen that the total mean score (M= 49.82, SD = 10.46) for all the participants is less than 55, which implied that the participants in this study were dissatisfied with the physical features of the acute unit environment. I conducted a 'between groups' comparison of satisfaction with the physical environment, measured by the total score for the 16-items using the independent sample t-test. Homogeneity of variance was assumed after a Levenè F test, $F(71) = 0.289$, p=0.593 (See Appendix L for SPSS output). Hence, parametric tests were used to test for any significant differences in the level of satisfaction between the groups. The results for hypotheses 1 to 3 are presented in Table 4.5.

Table 4.5: independent sample t-test results

	Groups	N	M	SD	*t*	df	*p*-value	(r)
Total score for Satisfaction with physical features of the hospital environment.	**H_1: Service users will be less satisfied with the physical features of the acute unit environment compared with staff.**							
	Staff	40	48.18	10.25	-1.494	71	0.140	0.03
	Service users	33	51.82	10.51				
	Total	73	49.82	10.46	-	-	-	
	H_2: There will be significant differences between men and women's satisfaction with physical features of the acute unit environment							
	Men	43	52.21	9.31	2.412	71	**0.018****	0.08
	Women	30	46.40	11.20				
	H_3: The therapy staff will be less satisfied with the physical features of the acute unit environment compared with the ward staff							
	Ward staff	23	50.91	8.80	2.043	38	**.048****	.10
	Therapy staff	17	44.47	11.16				

N = number of participants, M = Mean, SD = Standard deviation, t = t-test result, p = level of statistical significance at 95% confidence interval, r = eta squared value
**** = significant at p<0.05**.

From Table 4.5, it can be seen that the independent sample *t* test was not statistically significant for staff (M = 48.18, SD = 10.25) and service users (M = 51.82, SD = 10.51), t (71) = -1.494, $p > 0.05$ (two tailed).

- Thus, the hypothesis, H_1 was rejected and the null hypothesis retained, that no significant differences existed between the means of staff and

service users in terms of their satisfaction with physical features of the acute unit environment.

For hypothesis H_2, the test results displayed in Table 4.5 confirmed a significant difference in mean scores for Males (M =52.21, SD =9.31) and Females (M = 46.40, SD =11.20; t (71) = 2.412, $p < 0.05$ (two-tailed).

- This means the males had statistically significant higher levels of satisfaction with physical features of the acute unit compared with female participants.

The magnitude of the differences in the means (mean difference = 5.81, 95% CI: 1.00 to 10.61) was very moderate (eta squared = 0.08). Hypothesis 3, H_3 was also confirmed. Statistically significant differences were found in the means scores for ward staff (M = 50.91, SD =8.80) and therapy staff (M = 44.47, SD = 11.16; t (38) = 2.043, p = 0.048, two-tailed) in terms of satisfaction with physical features of the acute unit.

- Thus, the ward staff had higher levels of satisfaction with the physical features of the hospital compared with the therapy staff.

An analysis of the variance was also used to test the statistically significant difference between the responses across the three wards and the therapy department.

Table 4.6: satisfaction with physical features of the acute unit across the three wards and therapy department.

Wards/Units	**N**	**M**	**SD**
Ward A	18	51.56	8.10
Ward B	29	51.24	10.49
Ward C	13	50.69	11.91
Therapy Department	13	43.38	10.45

Analysis of Variance (ANOVA)

	Sum of squares	***df***	**Mean squares**	**F**	**Sig.**
Between groups	661.08	3	220.36	2.108	0.107
Within groups	7211.60	69	104.52	-	-
Total	7872.69	72	-	-	-

The F test revealed that there was no statistically significant difference between the three wards and the therapy department F (3,69) = 2.108, p >0.05 in terms of the level of satisfaction with the physical features of the acute unit. These findings are discussed in Chapter Seven as part of the integrated findings from this study, taking into consideration the limitations of the tool (SOFTEN) as outlined on page 107 in Chapter Three.

4.3: Perceptions of the ward atmosphere.

4.3.1: STAFF AND SERVICE USERS' PERCEPTIONS OF THE WARD ATMOSPHERE.

This section reports findings from Section C of the questionnaires to which 70 participants responded: staff (n=37) and service users (n=33). Three of the staff participants left this section blank, for reasons explained in Section 3.4.3.5 in relation to the analysis of the data preparation for Module One. Most of the service users did not complete item 22, which asked them about follow-up care, and formed part of the support subscale. The means and standard deviations of the responses for the ten subscales of the Ward Atmosphere Scale are presented in Table 4.7 and the mean figures were used to plot the line graph in Figure 4.2.

Table 4.7: staff and service users' perceptions of the ward atmosphere

Perceptions of ward atmosphere (WAS)	**Staff (n=38) Score (0-4)**		**Service users (n=33) Score (0-4)**	
	M	**SD**	**M**	**SD**
Involvement	2.89	1.24	2.52	1.15
Support	2.49	1.24	1.92	1.38
Spontaneity	2.54	1.22	1.61	1.09
Autonomy	2.19	1.29	2.24	1.06
Practical orientation	2.73	1.17	1.73	1.04
Personal problem orientation	2.05	1.29	1.88	1.19
Anger and aggression	2.68	1.05	2.67	1.11
Order and organisation	2.49	1.24	2.42	1.37
Program clarity	3.05	1.15	2.30	1.21
Staff control	1.41	1.26	2.21	1.05

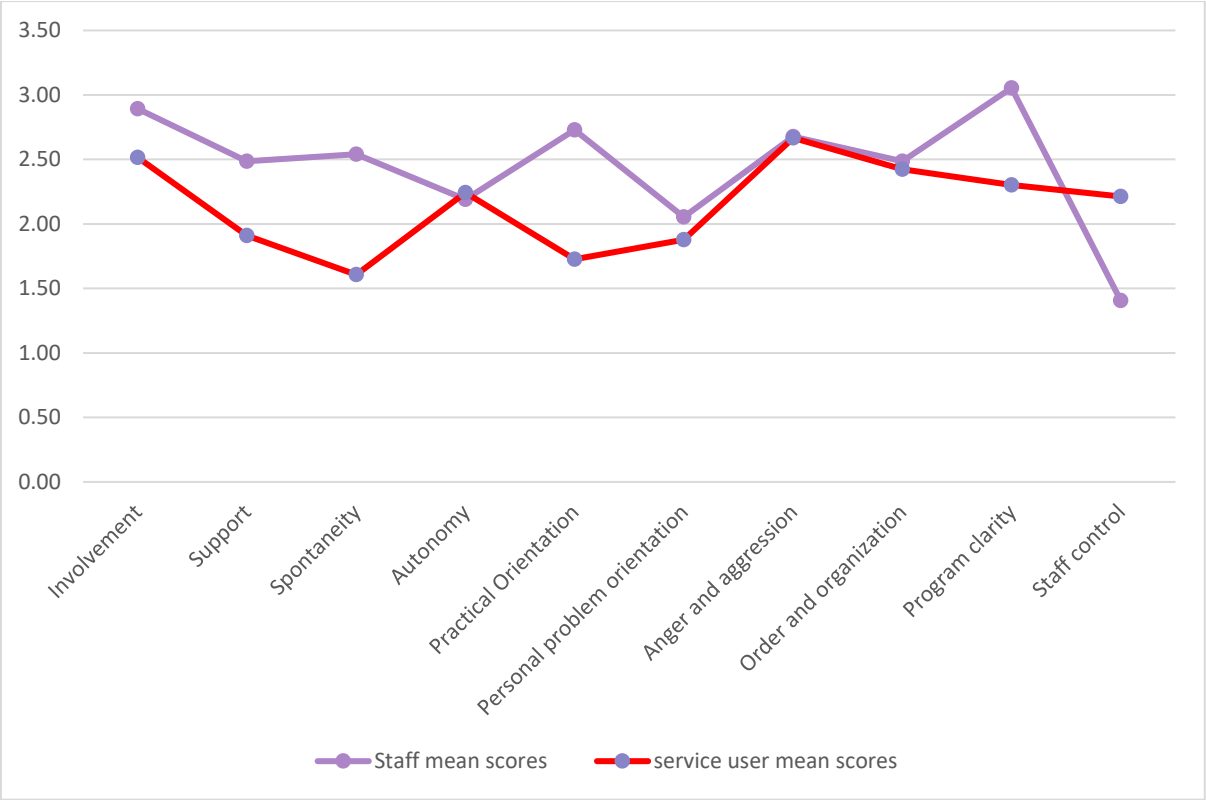


Fig 4.2: staff and service user perceptions of the ward atmosphere

Staff had higher mean scores than service users on most of the subscales except for staff control. Both groups agreed that there was a high level of service user involvement on the wards. However, they also perceived high levels of anger and aggression on the wards. Differences in staff and service users' perceptions were most noticeable in relation to support, spontaneity, practical orientation, and program clarity. These differences were tested for statistical significance using a Mann Whitney *U* test as shown below in Table 4.8 for hypothesis 4.

4.3.2: HYPOTHESIS TESTING OF STAFF AND SERVICE USERS' PERCEPTIONS OF THE WARD ATMOSPHERE

H_4: There will be significant differences in the responses of staff and service users on the ward atmosphere scale with staff rating the acute unit environment more favourably than service users.

Table 4.8: Median scores and Mann Whitney U test for staff and service users on perceptions of ward atmosphere

Ward Atmosphere Scale subscales	**Staff (n=37)**	**Service user (n=33)**	***U***	***Z***	**Sig.**
	Median	**Median**			
Involvement	3	3	482.00	-1.571	0.116
Support	3	2	458.50	-1.831	0.067
Spontaneity	3	2	360.00	-3.026	0.002**
Autonomy	2	2	592.50	-0.219	0.826
Practical Orientation	3	2	308.00	-3.666	0.000**
Personal problem orientn.	2	2	571.50	-0.471	0.637
Anger and aggression	3	3	606.00	-0.055	0.956
Order and organization	3	3	607.00	-0.043	0.966
Program clarity	4	2	398.00	-2.611	0.009**
Staff control	1	2	403.50	-2.519	0.012**

**** significant at $p < 0.05$ (two tailed)**

I completed a test of normality on the Ward Atmosphere Scale subscales (Manual on WAS, 1974) using the Shapiro Wilk test, skewness and kurtosis for the staff and service users' data. It was shown that the data were not normally distributed for staff and service users. The scores for the Ward Atmosphere Scale

were assumed to be measured on an interval scale, and therefore a Mann-Whitney U test, a form of non-parametric test, was conducted to test hypothesis 4. The test revealed a significant difference in the perceptions of ward atmosphere between the staff and service users on the subscales for:

- Spontaneity (U=360, p=0.002),
- Practical orientation (U=308, p=0.000),
- Program clarity (U=398, p=0.009) and
- Staff control (U=403.5, p=0.012).

Staff perceptions of spontaneity, practical orientation and program clarity were higher than those of service users. This indicates that the staff perceived that the service users spontaneously participated in their care and activities on the wards, received interventions directed toward their practical needs and adequately understood the ward programmes and routine. However, the service users did not share this view. Similarly, the service users perceived that the staff were very controlling on the wards, but the staff themselves thought otherwise. This result was expected as indicated in hypothesis 4, that the staff would rate the acute unit environment more favourably than the service users.

4.3.3: WARD AND THERAPY STAFF'S PERCEPTIONS OF THE WARD ATMOSPHERE

The differences between the ward and therapy staff's perceptions of the ward atmosphere were also compared and are presented in Figure 4.3.

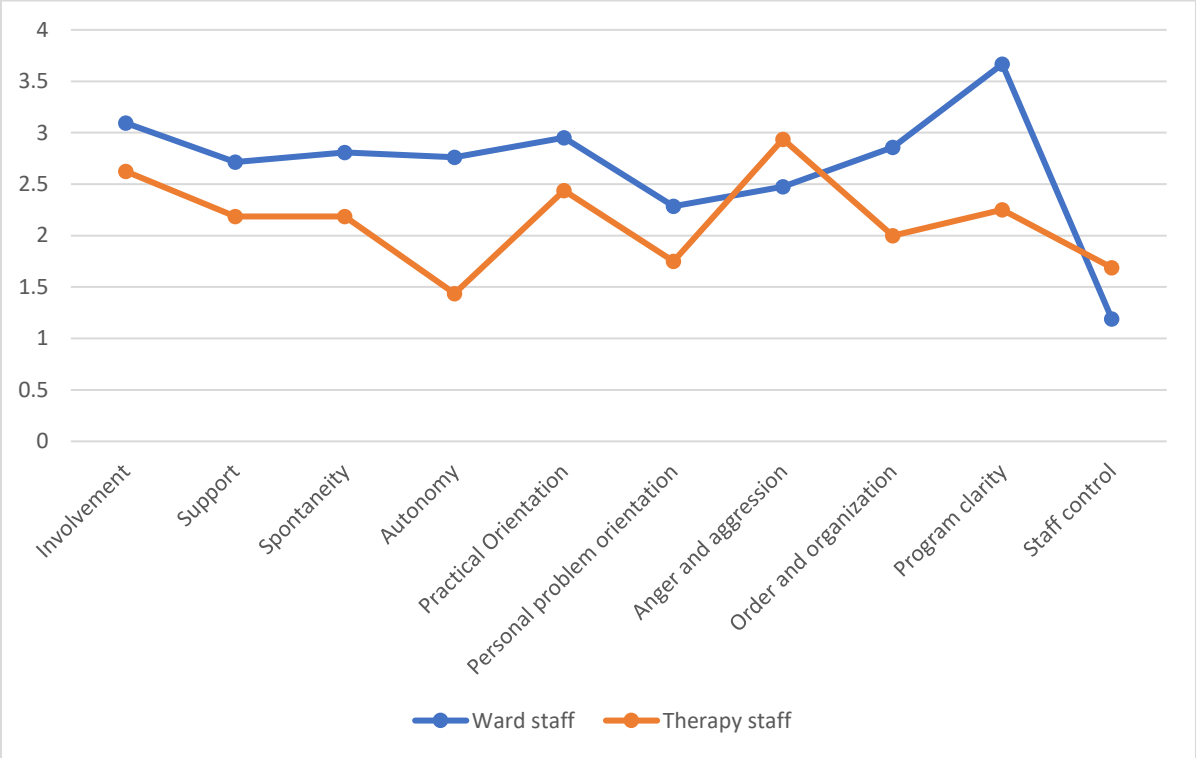


Fig 4.3: ward and therapy staff perception of the ward atmosphere

It can be observed from the graph that the ward staff had slightly higher mean scores for most of the subscales compared to the mean scores for the therapy staff. The data for the ward and therapy staff were found to be not normally distributed, hence a Mann Whitney U test was used to test for statistically significant differences between the two groups' perceptions of the ward atmosphere.

Table 4.9: Median scores and Mann Whitney U test for ward and therapy staff on perceptions of ward atmosphere.

Ward Atmosphere Scale subscales	**Ward staff (n=21)**	**Therapy staff (n=16)**	***U***	***Z***	**Sig.**
	Median	**Median**			
Involvement	3	3	133.00	-1.129	0.259
Support	3	2.5	130.50	-1.191	0.233
Spontaneity	3	2	121.50	-1.471	0.141
Autonomy	3	1	69.00	-3.123	0.002**
Practical Orientation	3	3	132.50	-1.143	0.253
Personal problem orientn.	2	2	130.00	-1.196	0.232
Anger and aggression	3	3	115.00	-1.709	0.087
Order and organization	3	2	102.50	-2.081	0.037**
Program clarity	4	2	55.50	-3.740	0.000**
Staff control	1	1.5	131.50	-1.172	0.241

**** significant at *p* < 0.05 (two tailed)**

The test revealed that there were statistically significant differences in the perceptions of the ward and therapy staff for the following:

- autonomy (U=69, p= 0.002),
- order and organisation (U=102.50, p= 0.037) and
- program clarity (U=55.50, p= 0.000).

This finding indicates that the ward staff rated the ward atmosphere more favourably than the therapy staff ratings. These findings should be interpreted with caution as there was a difference in the number of staff who responded in

each of the two groups: there were 21 ward staff and 13 therapy staff, as indicated in Table 4.1. However, this shows a further negative view expressed by the therapy staff regarding their perceptions of the ward, the first being their dissatisfaction with access to daylight on the SOFTEN scale. These differences between the three host wards in terms of their engagement with the study prompted me to check if there were also differences in their perceptions of the ward atmosphere. To investigate this, the mean scores from the subscales were compared, as shown in Figure 4.3.4.

4.3.4: THE THREE HOST WARDS PERCEPTION OF THE WARD ATMOSPHERE

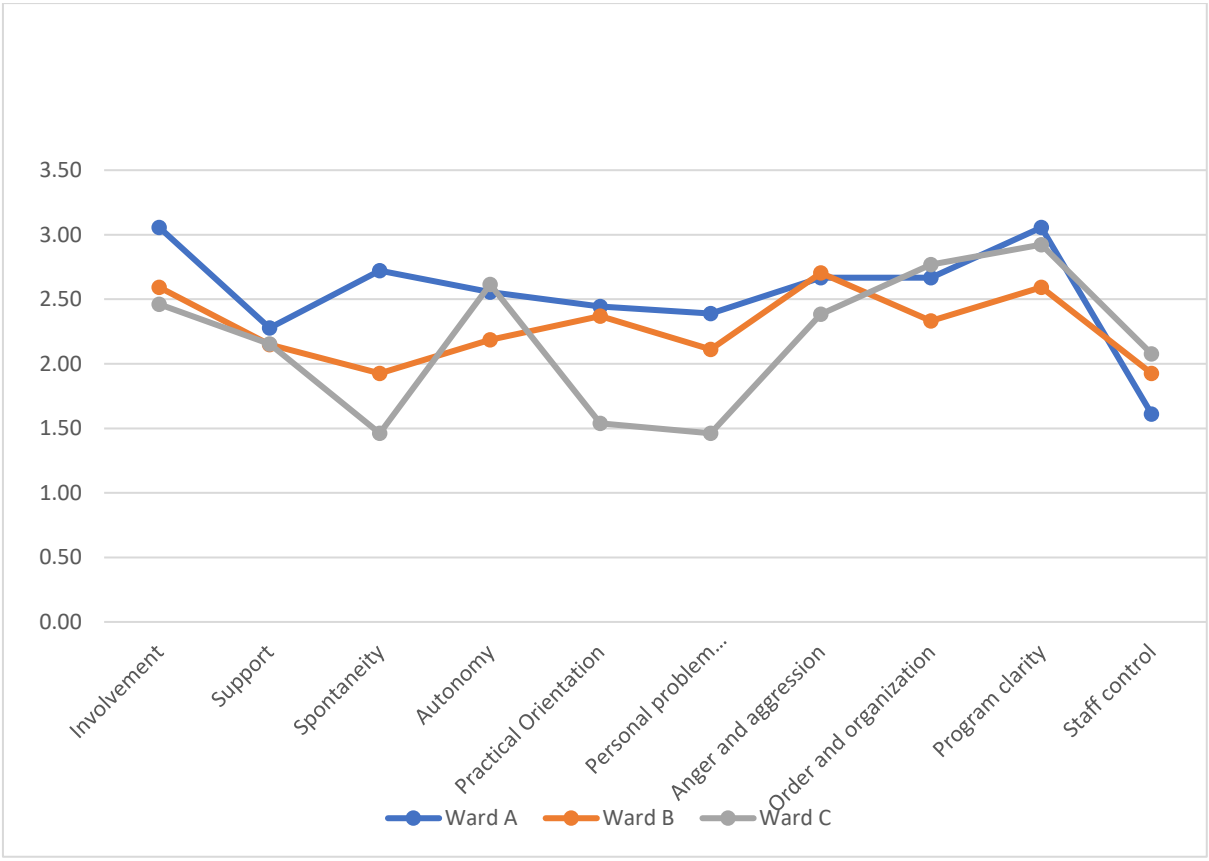


Figure 4.4: Respondents from the three-wards' perceptions of the ward atmosphere

The mean scores were broadly similar, with nearly unanimous agreement on the support subscale. This could be due to the staff feeling confident in the support they offered to the service users on the ward or were providing socially desirable responses (Bryman, 2015) to the questionnaires. However, the scores for ward C were consistently low (M= 1.5) for spontaneity, practical orientation, and personal problem orientation. This is an interesting finding as Ward C had the lowest response to the questionnaire with just 13 participants, as shown in Table 4.1. Although the relationship between the ward's level of engagement in the research and the staff's perceptions of the ward atmosphere was not formally investigated in this study, this could be an area for further development in another study.

4.4: SERVICE USERS' EXPERIENCES OF ACTIVITIES ON THE WARD

This section presents the service users' responses to questions about their experiences of activities on the wards. These questions were part of the service users' questionnaires and they were added after the initial data collection had commenced, as explained in Section 3.4.3.4 of Chapter Three. Hence, only 13 service users responded. The rationale was to gather information about the service users' experience of the activities that they engaged in on the wards. The responses are presented in Table 4.10 below. Most of the respondents knew that the selected activities occurred on the wards, as indicated by the 'Yes' responses. From the Table, it can be seen that the hospital allowing family and friends to visit the wards was "valued quite a lot" by the service users. However, five of the service users thought that there was "no or little value" in having occupational therapists on the wards. This may have had an impact on the service users engaging in therapeutic activities in the acute unit.

Table 4.10: Service users' responses regarding knowledge of activities on the wards and how highly they value them.

Activities that occurred on the wards				**Number of respondents and how they Valued the activities**		
		Yes n (%)	**No n (%)**	**No or little**	**Moderate**	**Quite a lot**
A	There is/are occupational therapy staff allocated to this ward	10 (77)	3 (23)	5	3	3
B	Staff meet mainly with their allocated service user for one to one time	6 (46)	7 (54)	4	1	2
C	Staff meet with any service user for one to one time	9 (69)	4 (31)	3	3	3
D	Organised groups are run *(please note which)*	12 (92)	1 (8)	2	4	5
E	Games and activities are organised *(please note which)*	8 (62)	5 (38)	2	1	5
F	Service user can take leave (escorted or unescorted) from the ward	12 (92)	1 (8)	3	3	6
G	Staff and service user watch TV and /or sit together	7 (54)	6 (46)	1	2	4
H	Meals are eaten together by staff and service user	10 (77)	3 (23)	1	5	4
I	Informal chats happen between staff and service user	9 (69)	4 (31)	2	3	4
J	Time with staff can be spent off the ward (e.g. walks or in the rooftop garden)	10 (77)	3 (23)	1	3	5
K	Service user's family/friends are allowed on the ward	12 (100)	-	-	3	8
L	Service user can meet with their community workers on the ward	11 (92)	1(8)	-	3	7
M	Ward rounds take place	12 (92)	1(8)	3	1	7
N	The office/nursing station is closed/locked	11 (85)	2 (15)	4	3	3
O	Any other (please state_____)					

4.5: THEMES FROM THE OPEN-ENDED QUESTIONS

The data from Section D of the questionnaires were extracted from the SPSS table and analysed thematically using the six stages of the thematic analysis method developed by Braun and Clarke (2006). For the two closed-ended questions on the questionnaire, it was found that, 53 (73%) of the respondents agreed that the physical environment of the hospital impacts what service users do on the ward with 64 (88%) agreeing that it could be improved.

The following three key themes emerged:

- "Hemmed in": less freedom
- Inadequate resources with limited access and maintenance
- A less engaging environment

These are discussed in the following sections with supporting quotes from staff (S) and service users (SU). The participants are numbered according to the data entry used in SPSS in the order of numbers 1 to 40 representing the staff and 41 to 73 representing the service users. This system was chosen instead of using pseudonyms due to a large number of participants (n=73). However, in the case of the staff quotes, I have included their profession in addition to their staff number. The quotes from staff and service users have been mixed up to support the themes.

4.5.1: "HEMMED IN": LESS FREEDOM

This phrase largely represents the staff perceptions of how service users felt about the wards. The service users used words and phrases like 'no freedom' concerning the acute unit design, its layout and the security measures in place. The layout of the wards was regarded as somewhat inappropriate, with thermal discomfort and the building design not lending itself to modifications. The hospital only had a small roof garden with no additional grounds around it, which is a less common feature in a mental health facility. This theme is further discussed in Chapter 7 in relation to the inner London location of the acute unit. Some illustrative quotes in support of this theme are as follows:

> *"there is no freedom"* (SU 65).
>
> *"heat this summer, wards were really warm, and patients were more agitated"* (SU 66).
>
> *"service user often finds the environment to be claustrophobic and lack of open space"* (SU 73).
>
> *"because of the lack of easily accessible but secure outside garden area, patients do feel hemmed in. … Given the restrictions of limited space of the building's original design, I believe we have used the space to best effect* (S11, Associate practitioner).

4.5.2: Inadequate resources, limited access, and low maintenance

The topics covered by this theme ranged from inadequate or inappropriate furniture in activity rooms, to televisions and computers that were not working. The staff and service users both claimed that it took a long time for things to be fixed when faulty. The following quotes are typical:

> *"there is severe lack of furniture provision in the activity room on all wards - no appropriate chairs for an art activity"* (S14, Art psychotherapist).
>
> *"the beds are hard. No computers, they do not work. The toilets are blocked. The staff should stop hand towels because they block up the toilet"* (SU 43)

There was an indication that the service users have limited access to some available spaces within the unit like the roof-garden:

> *"most service users want unlimited access to the garden which the ward does not have. The only garden in the hospital is on the 6th floor and not accessible by patients"* (S23, Health Care Assistant)

The staff and service users were broadly in agreement, particularly about the limited access to the roof garden for service users. This theme was further explored in the PAR group, while the issues with the locked doors as a security features are discussed in Section 7.3.1 of Chapter Seven.

4.5.3: A LESS ENGAGING ENVIRONMENT

Other factors identified as contributing to the social environment were staff and service user behaviours, in terms of how they interact with each other. Some disagreeable behaviours mentioned included service users making a mess, shouting, becoming violent or even sometimes attempting to fight with others:

> "*shouting and external noise bothers me. I cannot watch TV; people are shouting or crying. Noise has an impact because it is disruptive" (SU 48)*

The shouting by other service users referred to here may be due to them becoming agitated or expressing their frustration about being sectioned under the Mental Health Act. In Table 4.2, 73% of the service user participants indicated that they had been sectioned. The issue regarding external noise is discussed in detail in the discussion chapter (Section 7.3.2) and partly attributed to construction and vehicular noise that is very common in inner London (Roberts, 2017). The service users also felt they should be treated with respect by staff: *"the staff should treat patients with more respect"* (SU 49). Another service user stated that he feels they are:

> *"kept as prisoners and treated like slaves, not allowed to have an opinion, told to speak in a certain way"* (SU 52).

This reflects the perception that the staff behave in a controlling way on the wards, which is supported by the higher score for staff control given by the service users compared to the staff score reported in Section 4.3.1. This finding was also explored in the PAR group discussions with the staff and is discussed in Section 7.1.2 under the triangulation of the finding. In addition, the service users mentioned that there were few activities on the wards that they could engage in, which made them feel bored:

> *"it gets boring for service user. It's the same as any other wards in London"* (SU 42)

> *"it is a boring environment. There could be more activities"* (SU 57).

> *"if you cannot have a leave or access to the garden, it causes greater aggression, there is very little to do"* (SU 56)

'Boredom' was a commonly occurring word in the service users' accounts. However, from the analysis, it was identified that it was used to mean different

things. In one sense, it described how the service users felt when they had nothing to do. However, in the quote below from SU 54, the word 'bored' was used in a different sense. To him, the disruptive behaviours of the other service users such as the excessive noise on the ward, made him feel "bored" and want to escape. The notion of boredom and what it means is discussed in Chapter seven (Section 7.6).

> *"it makes me wants to escape. I am bored, and users want attention"* (SU 54).

The staff also expressed their views about what they would like the ideal ward to be. The key points here were cleanliness, a positive change in staff and service users' behaviour and an increase in activities on the wards:

> *"if the ward is clean, bright and furniture fitting all working, this does encourage patients to engage more"* (S 27, Occupational therapist).

4.6: CHAPTER SUMMARY

This chapter presented findings from Module One of the study, which was concerned with staff and service users' perceptions of the acute unit environment. This was measured in terms of their satisfaction with features of the physical environment and on the 10 subscales of the Ward Atmosphere Scale. Overall, the participants in this study were dissatisfied with the physical features of the acute unit environment. Staff and service users had similar perceptions of the top three physical features that they were dissatisfied with, although in a different order. A statistically significant difference was identified in levels of satisfaction with the physical features of the acute unit between males and females, and between the ward staff and the therapy staff. However, the difference between staff and service users' levels of satisfaction with the physical features was not statistically significant.

Staff perceptions of the ward atmosphere ranked higher in terms of spontaneity, practical orientation, and programme clarity, than those of the service users. The service users, on the other hand, perceived staff control on the wards as being greater than the staff themselves perceived it. The key themes generated from the open-ended questions were that the participants felt restricted in the physical environment, partly due to the lack of adequate resources that they could engage in therapeutic activities with. They also identified that there were problems with access to other parts of the acute unit. Lastly, the participants felt some of the staff behaviours towards the service users were inappropriate and that there were few activities to engage in, which often made the service users feel bored.

Overall, this chapter has helped to partially answer the two research questions that this study posed: What are the service users and staff's views on the acute unit environment in terms of how it impacts service users' engagement in therapeutic activities and the relationships that exist within the acute unit? The aim of exploring the environment of the acute unit from the staff's and service users' perspectives was also fulfilled through the findings presented in this chapter, via the survey which captured the views of 33 service users and 40 staff from the multidisciplinary team. As Module One constituted the first strand of the data collection within the participatory action research cycle, some of the information gathered informed the content of the data collected in the PAR group meetings in Module Two of this study. The data collection for Module Two started in July 2018, half-way through the data collection for Module One. However, the analysis of the data produced in Module Two started in December 2018, long after the analysis of the data from module one. The next two chapters (Five and Six) present the findings from Module Two of this study. In the introduction of Chapter Five, I present a brief overview of both chapters in the same way that I did for this chapter.

CHAPTER FIVE

FINDINGS RELATING TO THE IMPACT OF PHYSICAL ENVIRONMENTAL FACTORS ON THE SERVICE USERS' ENGAGEMENT IN THERAPEUTIC ACTIVITIES

5.0: Introduction to Chapters Five and Six

Chapters Five and Six present the results from a thematic analysis (Braun and Clarke, 2006) of the data from the participatory action research group discussions and mapping activities, key informant interviews and my fieldnotes. I have divided these qualitative findings into two chapters based on a natural separation of the results, as follows:

- The physical environment of the acute unit and how it impacted the service users' engagement in therapeutic activities are explored in Chapter Five.
- Chapter Six presents' themes relating to the relationships that the staff perceived to exist within the clinical team, in addition to the challenges encountered in undertaking their work, and how this impacted on the service users' engagement in therapeutic activities.

Before presenting the findings of Module Two of this study, I explain how some of the activities that were originally proposed to be done in the study protocol changed. This was structured around the recruitment of the participants, data gathering and analysis. However, utilising the PAR methodology offered flexibility (Reason and Bradbury, 2008) for things that were initially proposed to be amended once the appropriate ethical approval was obtained (Wilding and Galvin, 2014). In the study protocol submitted for ethical approval, it was stated that one of the areas that I aimed to gather data on was how the acute unit

environment promotes service users' "recovery and healing" (Study protocol, Appendix X, p. 4). However, after the data analysis, the key themes identified did not include this information. On reflection, I realised that this information could have been collected from the service users if they had shared their lived experiences in a semi-structured interview or participated in the PAR group. The rationale for not including the service users in Module Two of the study is detailed in Section 3.4.1. of Chapter three.

Concerning recruiting participants, I approached approximately 30 staff to invite them to participate in the PAR. This number was arrived at as a result of all the staff who completed the questionnaires being invited to participate in the PAR group and given a participatory information sheet (PIS) to help them decide. I also verbally shared the inclusion and exclusion criteria with them and explained what they had to do if they committed to being part of the PAR group. Some of them responded that they could not commit to being part of the PAR as they were not interested or were leaving the service. Details of the recruitment process are provided in Chapter three, Section 3.4.4.2. However, there was one particular nurse who did not say that she could not commit to the PAR group whenever I met and spoke with her on the ward but simply gave a reason why she had not attended the last meeting. I finally had to stop contacting her by PAR 4 as I realised that she was not going to attend.

The other key challenge was recruiting a doctor to join the PAR group. With hindsight, I realise that my inclusion criteria that staff should have worked at the

acute unit for three months ruled out the junior medical doctors on rotation as they only spent six months at the acute unit. This was a key rationale for the amendment to the ethics protocol to carry out the key informant interviews: I wanted to have an opportunity to talk to them on a one-on-one basis for a short period. However, this did not make it easy to recruit a doctor to participate in Module Two of the study. For example, on 1st July 2019, I was at the acute unit at 7:55 am, intending to meet some of the night doctors as well. By 10:00 am, I had talked to five doctors and one of them assured me that he would call for a telephone interview. My phone number was on the PIS. However, I did not receive any call and I had no way of getting in touch with him.

The final strategy, which worked, was to arrange a short interview with one of the Consultants via an email sent to four of them by the service manager's assistant on my behalf. The inclusion of the key informant interviews after the substantial amendment to the ethics protocol helped to gather the views of an additional four staff whose views would otherwise not have been part of the data gathered. The interviews were tape-recorded and transcribed, following the process described in Section 3.4.4.5 of Chapter three. This involved a theme led analysis (Fereday and Muir-Cochrane, 2006) as the analysis for the PAR group discussions had already started at this point and themes were emerging. The interview participants (referred to by pseudonyms) were as follows:

1. Dr John - Consultant psychiatrist
2. Louisa - Team lead
3. Mercy - NHS Trust deputy smoking cessation lead
4. Peter - Ward manager

Through the recruitment process, I had hoped to get a broad representation of all the professions involved to participate in the PAR group. However, this proved not to be possible as there was no clinical psychologist in post at the time, and the new psychology assistant had just started work, so did not meet the inclusion criteria. With hindsight, I realised I should have contacted the psychology team again and offered to arrange a key informant interview as I had done for the doctors. Therefore, the findings that I present subsequently should be interpreted bearing in mind that there was no contribution from the psychology team, which could be seen as a limitation of the study. Table 5.1 displays a summary of the participants recruited for the PAR group. Participants' characteristics and their record of attendance at the PAR group meetings are presented in Table 5.1 below:

Table 5.1: Staff characteristics and PAR meeting attendance

	PAR group meetings					
Staff	**1**	**2**	**3**	**4**	**5**	**6**
	Data collection					**MC**
	08.06.18	**13.07.18**	**07.09.18**	**09.11.18**	**11.01.19**	**06.09.19**
Elsie, Occupational therapist 1 (OT 1), *female*	√	√	√	√	√	√
Eugene, Therapy staff 1, *male*	√	√	X	√	X	X
George, Health Care Assistant (HCA), *male*	√	X	X	X	X	X
Henrietta, Occupational therapist 2 (OT 2), *female*	√	√	√	√	√	√
Josephine, Health Care Assistant (HCA), *female*	√	X	X	X	X	X
Ulric, Therapy staff 2, *male*	√	√	√	X	√	√
Victor, Nurse 1, *male*	X	X	X	√	√	√
Winfred, Nurse 2, *male*	-	-	-	-	√	-
Nurse 3, *female (30 minutes)*	-	-	-	√	-	-
Trainee therapy staff 2	-	-	-	-	√	-
Other people in attendance						
(Facilitator)-Researcher	√	√	√	√	√	√
Peer researcher (co-facilitator)	√	√	√	√	√	√
Facilitator (induction session)	√	-	-	-	-	-
Total attendance	**9**	**6**	**5**	**7**	**8**	**6**

Key: (MC) – member checking (√) attended (X) did not attend (-) was not expected to attend

I recruited eight staff for the PAR group meetings, at different points in time. I gathered personal information about the participants' ethnicity to ensure a broad representation of the staff group. However, this information is not included in the table to guarantee the participants' anonymity. Pseudonyms are also used to refer to the staff to ensure anonymity and confidentiality (Bryman, 2015). In Table 5.1, the participants are listed in alphabetical order according to the names that I chose for them and not in any way in ranking order of any of the professions. There were an additional two participants who joined the session on a one-off basis. In PAR 4, there was a staff nurse from the hospital on-site, waiting to attend a meeting who agreed to sit in on the session to share her views. She verbally consented for her views to be used but could not commit to attending the other sessions. In addition, a therapy staff trainee was invited by another staff member and he attended as an observer. Two of the group members attended all five PAR group meetings over the eight months duration whilst two dropped out after the first meeting, one due to ill health, and the other for an unknown reason. The two nurses joined the fourth and fifth meetings after a substantial amendment to the ethics approval, detailed in Section 3.4.4.5 of Chapter three which increased the amount required to reimburse the participants. Overall, ten staff participated in the PAR group which meant that I had met the target for the maximum number of staff that I aimed to recruit in the protocol, although there was inconsistency in attendance and two dropouts.

Originally, I had indicated in the protocol that there would be five PAR group meetings, including the workshop, and that they were due to start in March 2018. However, the first PAR group was held in June 2018 due to the extended timeline

for obtaining ethical approval from the NHS REC. I also held one further session six months after the five scheduled data collection sessions. The sixth PAR meeting was for group analysis and member checking of the emerging findings. Regarding the data analysis, I indicated in the protocol that I would start the process by transcribing the data and generating initial themes, after which there would be an opportunity to analyse the data with the PAR group members who were co-researchers, as suggested by Kemmis and McTaggart (2008). I managed to successfully involve them in this but felt that they could have done more. We engaged in different forms of analysis during three sessions, which could be seen as part of the action cycle of the PAR. In PAR 2, we worked through the data to identify key issues that has been raised after we had discussed the main research question. PAR 3 was dedicated to going through some of the emerging findings from the survey data. The rationale was to further explore some of the information generated from the open-ended questions. It also allowed triangulating the data (McNiff *et al.*, 2003) to identify areas where the participants' views overlapped or diverged.

Five days before PAR 5, I sent the group information on the emerging themes that I wanted us to further analyse. However, I soon realised none of the participants had looked at the information as they did not come with any prepared materials and so we had to work through the process together. The staff were supposed to record any ideas for the research on the small notepad that I gave them during the workshop and bring it along with them to each session, as I had indicated in the protocol and the consent form that, by agreeing to participate in the study, they were committing to doing additional work relating to the research

outside of our meetings. Nevertheless, they actively engaged with the emerging themes presented and helped to reword some of the themes and subthemes in the session.

Interpretation of objects used in mapping activities

I completed a mapping activity with the participants during PAR 3 to give a visual representation of the physical environment of the acute unit as perceived by the participants to indicate how the space was used by service users and staff. This was intended to identify areas that may have inhibited or facilitated service users' engagement in therapeutic activities. The selection of the resources that I took along for the mapping activity was informed by my previous readings on mapping as a research method (Huot and Rudman, 2015; Powell, 2010) and the results of other mapping activities I had seen. I got basic items from the craft shop and decided to use a piece of cloth to draw on instead of a sheet of paper because it was more durable. As described in Chapter Three (Section 3.4.4.4), I attended the PAR 3 meeting with the printed pictures of the acute unit environment that the staff had emailed me earlier. I also took along other items like pebbles, dead wood, and toothpicks, which could potentially be used by participants to represent items or spaces within the acute unit environment. A photographic image of mapping activity one is presented in Figure 5.1.

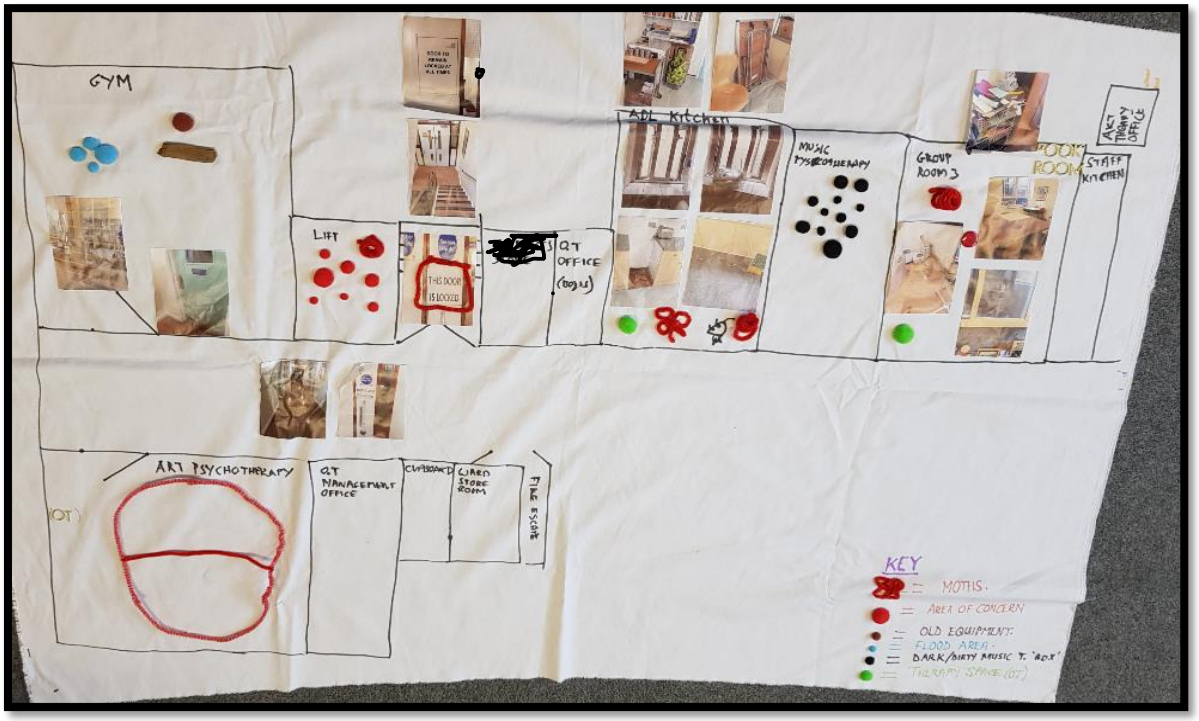


Figure 5.1: Full image of mapping activity 1 completed in the PAR 3 meeting

The participants started the mapping activity by using the marker to outline the basement or the ward. Different people (Ulric and Victor) volunteered to lead both mapping activities. The participants then decided to illustrate the outline of the basement with the various cut out photos of the unit. After that, they wanted to show where the problem areas were on the wards and decided to use the pompoms to do so, as they were in various colours, which were used to represent different things. For instance, the use of red in mapping activities 1 and 2 indicated areas within the spaces that had problems and impacted the staff's work with the service users. The key for mapping activity 1 is shown in Figure 5.2.

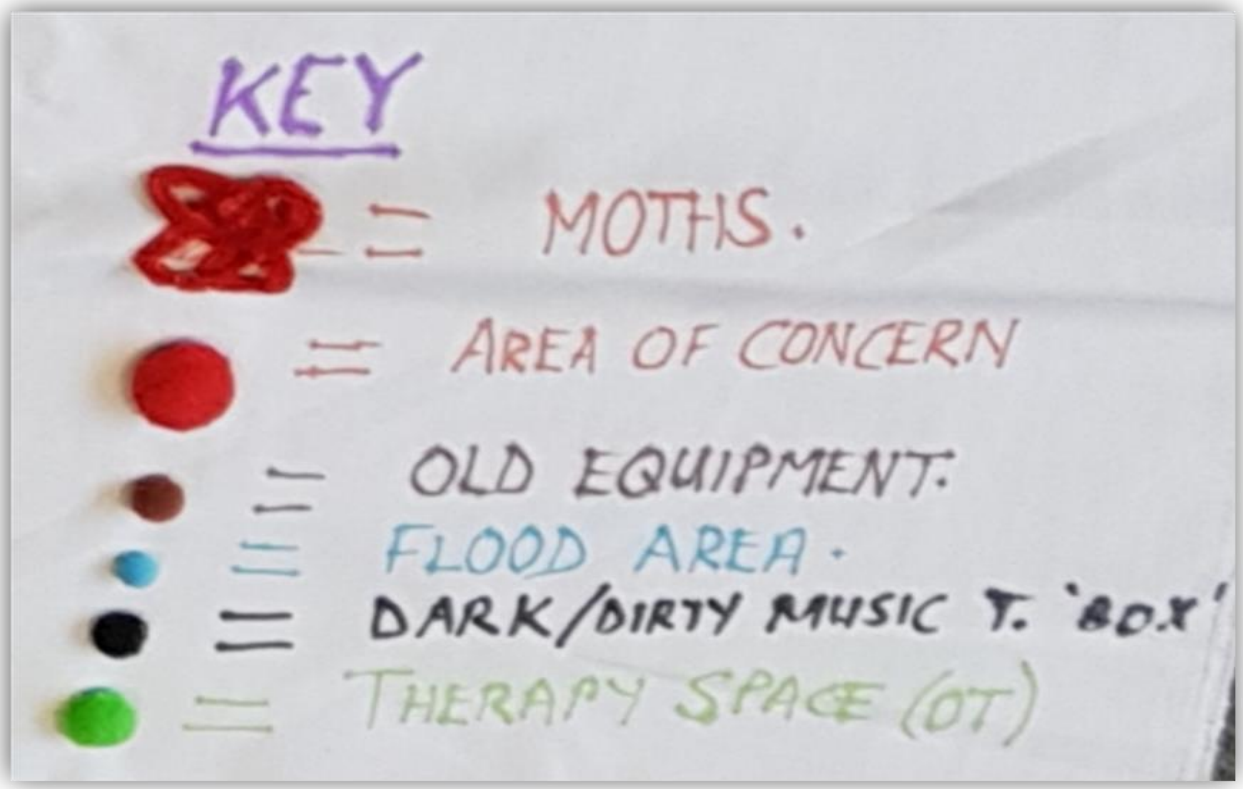


Figure 5.2: key for mapping activity 1

In addition, the dead wood was used to represent the old equipment in the gym. The large red circle with the red line across it represented, 'do not enter', which is discussed in detail in Section 5.3.2 of Chapter Five. Among the art and craft resources available, the one with the alphabets that the staff used to make words on the image happened to be gold in colour, but the fact that the letters were gold does not convey any additional meaning. When we engaged in mapping activity 1, I observed that the three staff present, whom all worked in the basement, although in two different teams, worked well together. This was evident in relation to the items they used to represent things on the map, the colour of the pompoms they used and the printed pictures that best represented the idea that they wanted to convey, for example, the decision to put three different images of the locked door on the map. Each of them concentrated on redesigning the space that they worked in, as they felt they could effectively represent the issues that

needed addressing using the red pompoms. They also went further by identifying where the issues were in the other spaces in the basement.

However, I also observed there was something that Henrietta wanted to put on the map but she could only do so after Ulric had left the session. Ulric always left the session early as he had to attend a group session that overlapped with the PAR group. Henrietta added the 'Do not enter' symbol, discussed in detail in Section 5.3.2. of Chapter Five, which represented a space that she felt needed to be shared by the two teams but had been taken over by the other team. Reflecting on the session afterwards, I was not sure why she only shared that information after Ulric had left but I realised that it was a potentially sensitive issue.

To clarify this further, I brought the issue up in PAR 4 in Ulric's presence and his response was: *"It sounds like you know, that's still a sore point*", which I interpreted to mean that he did not want to discuss it further. Elsie, from the occupational therapy team, attributed the reason to having lost the space in the basement (discussed in detail in Section 5.3.2 of Chapter five). The discussion moved on to the management proposal that the therapy staff should consider spending more time on the ward. This is one example of the participants resolving opposing ideas and working together within the PAR group. They demonstrated a sense of respect for each other's views, providing a communicative space and abiding by the ground rules which was agreed at the start of the group (Kemmis and Wilkinson, 1998; Reason and Bradbury, 2008). In other instances, staff resolved a disagreement about the service users' escort

ratio by deciding that they would go back and check what was stated in the new policy. The full image of mapping activity 2 of the ward layout, not drawn to scale, is shown in Figure 5.3. The image should be read from the point where the initials F.D. are shown, indicating the front door. The key for mapping activity 2 is shown in Figure 5.4.

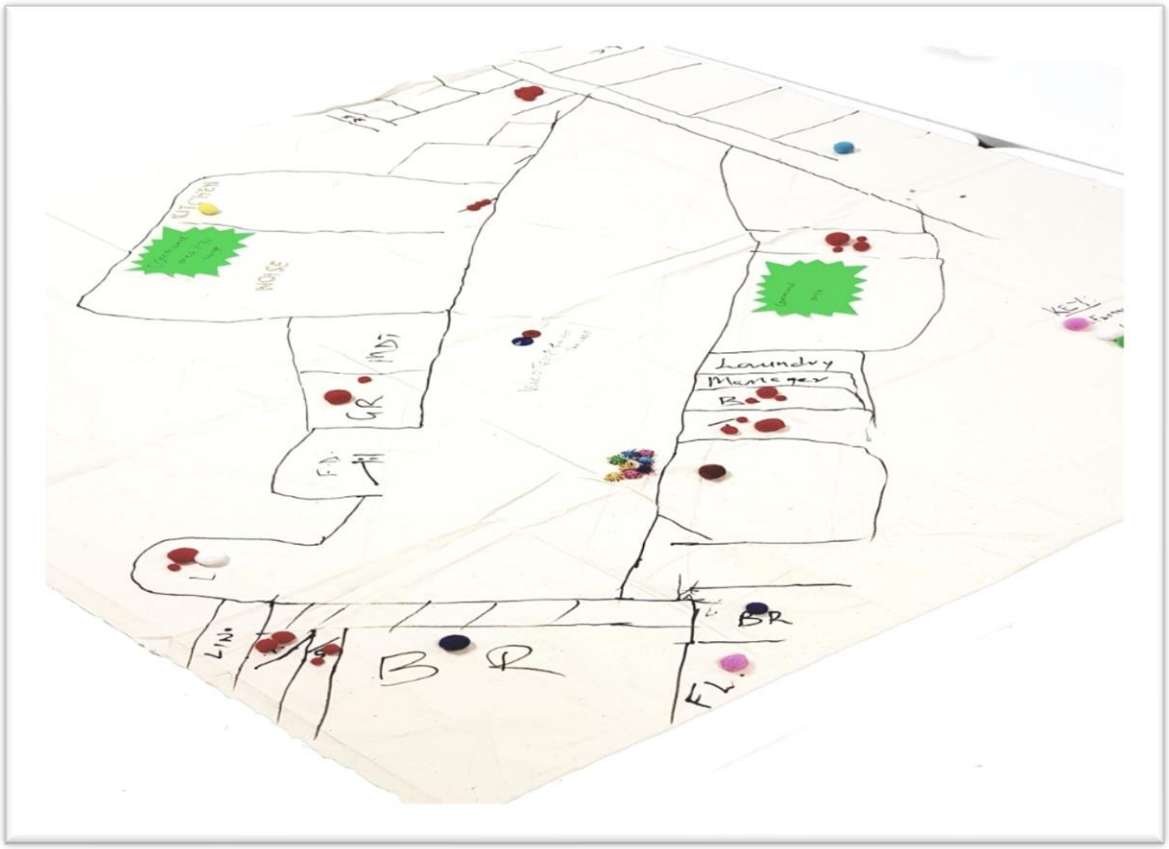


Figure 5.3: Full image of mapping activity 2

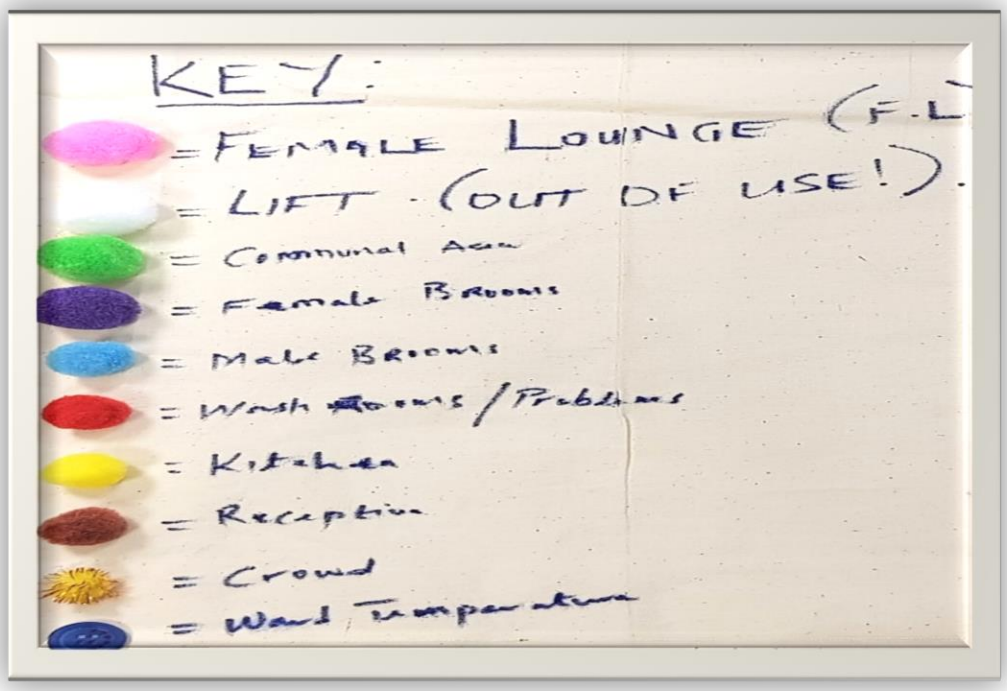


Figure 5.4: key for mapping activity 2

Each of the three wards of the acute unit had a similar layout, with 18 single occupancy bedrooms. Each ward had a separate 'women only' area with four bedrooms, a lounge, and washroom facilities, although some of the women had their bedrooms within the open ward area where the men's bedrooms were also located. People entered the wards and reported to the nursing station, usually from the stairs by going through the front door ('F.D.' in Figure 5.4). As can be seen from the picture, the multi-coloured pompoms grouped were used to represent service users gathering in front of the nursing station. Other rooms included the multidisciplinary team room, the group room, the open communal area, the manager's office, and the shared washroom facilities. Each ward also had a laundry room along the corridor. Due to the challenges and delay in recruiting the ward staff for the PAR group, discussed previously in this section, there was no opportunity for them to bring in the pictures of areas of the ward

environment that they wanted to discuss, and hence no pictures of the ward environment are shown in the image of mapping activity 2.

Chapter Five uses images from the two mapping activities to present the findings of the participant's perceptions of the physical environment and its impact on service users' engagement in therapeutic activities. Within the two chapters (5 and 6), each quote from the PAR groups is followed by details of the participant's pseudonym, profession, the PAR group number, line and page numbers of the quote in the original transcript in parentheses, for example (Victor, Nurse 1, PAR 4, L. 510 p. 26). The six participatory action research group meetings are referred to as PAR 1, PAR 2, through PAR 6. Quotes from key informant interviews are followed by details of the speaker's pseudonym and staff role in parentheses, for example (Louisa, Team lead). The subsequent sections focus on presenting the findings that related to the physical environment of the acute unit and its' impact on the service users' engagement in therapeutic activities.

This chapter details some of the findings from Module Two of the study, which entailed a qualitative exploration of the views of staff and other key informants, elicited through the use of PAR groups and individual interviews, in relation to the impact of the physical environment of the acute unit on service users' engagement in therapeutic activities. The physical environment, as a major area of interest, was discussed at length in both the PAR group discussions and in the key informant interviews, and hence are presented here as a separate findings chapter. As indicated in the section on the method, the group discussion schedule and the interview guide contained questions specifically designed to

elicit the participants' views on the physical environment of the acute unit and its impact on the service users' engagement in therapeutic activities. Five main themes are explored in this chapter, namely participants' perceptions of the following:

- Historical use of the acute unit building
- Impact of the physical layout of the building
- Use and availability of space
- Staff ability to influence the environment
- Staff vision for an ideal working space

These themes are presented in relation to how they impacted the service users' engagement in therapeutic activities within the acute unit. I use images from the two mapping activities of the basement and a ward, and the participants' quotes, to present these themes and their subthemes, as generated from the thematic analysis. The selection and inclusion of quotes in the findings section were guided by Lingard's (2019) suggestion that the quote should be illustrative, succinct, and representative of the participants' perspectives. I completed a "light tidying up" of the quotes by removing words and phrases like "erm", "er", "you know" and "I mean" that impacted their readability (Corden and Sainsbury, 2006, p.18). However, this was done cautiously to ensure the quotes still represented the participants' voices and their intended meaning. Any word inserted into a quote to make it read better appears in a square bracket [-], while ellipses (…) are used to indicate words that have been cut out to shorten the quote.

5.1: HISTORICAL USE OF THE ACUTE UNIT BUILDING

In Chapter Three, Section 3.4.2 in relation to the study site, I described the acute unit building as an old (built in1884) six-storey building with a basement along a major road in inner London (Online from National Archive, 2018). The PAR participants reported that the building had contained a mental health day hospital in the basement and a Psychiatric Intensive Care Unit (PICU) at different times since it was opened for mental healthcare in 1986:

> *"Because this place was traditionally the basement. There used to be the old day hospital and you had the community service users who would be coming here for their therapeutic engagement, would have a meal here"* (Louisa, Team lead).

Louisa recounted the set-up and the services that the building was used for, before its current use as an acute mental health unit. The previous day hospital operated a model of care which was reported to be different from the existing service. For instance, Louisa explained that the acute unit still had the big burners in storage that were used to make the service users' lunch onsite, and that the service users actively participated in cooking sessions which is no longer the case:

> *"That used to be a dining room. Yeah, the food used to be cooked up there. And then of course that was stopped, and we stopped cooking. We still have the big burner and everything there, they're still working".*
> (Louisa, Team lead)

Two participants in the PAR group (Victor, Nurse 1 and Elsie, OT 1), also spoke highly of the PICU in terms of its staff-service user ratio and service users' level of engagement:

> *"The difference was that patients were fewer, and the number of staff were more. Because when we used to work in the PICU, it was about, if you add the ward manager and the OTs, then you were looking at, at least about 10 staff on the ward. In terms of nursing staff, the ratio was like 1:2, so when I come to work, I know I have 2 patients that I have to engage with during my 7.5 hours"* (Victor, Nurse 1, PAR 4, L. 510 p. 26).

However, there were also challenges encountered by the participants in undertaking their work in the acute unit building, as outlined below:

> *"We just continually having a problem with the fabric of the building, … although people try and keep maintaining the building, but there is often a lot of issues coming up with it, and they seem to be increasing"* (Louisa, Team lead).

These issues were described as ongoing and "increasing" and were thus not a new occurrence. The doctor who was interviewed summarised his perceptions of the hospital as being a small facility compared to other facilities that he had worked in:

> *"One thing about the hospital, although is a very good hospital and it has good staff, the hospital is a very small hospital"* (Dr John, Consultant).

The other four themes that I present subsequently each have additional subthemes which are summarised in Figure 5.5.

- **Impact of the physical layout of the building**
  - Access to daylight, ventilation and thermal comfort
  - Impact of the security features of the acute unit
- **Use and availability of space**
  - "Not everything can go on, on the ward"
  - "I have to sort of fight for my space": lost space
  - Designing spaces for specific use
- **Staff ability to influence the environment**
  - "Work with that, the best we can"
  - Meeting necessities: blocked toilets
  - "People have given up" regarding the delayed repairs
  - "Bright lights… on the administrative floor"
- **Staff vision for an ideal working space**
  - Safe space
  - Comprehensive redesign

Figure 5.5: Themes relating to physical environmental factors and their subthemes

5.2: IMPACT OF THE PHYSICAL LAYOUT OF THE BUILDING

The participants perceived that the physical layout of the building had major impacts on the service users' engagement in therapeutic activities. The two subthemes identified within this main theme were:

- Access to daylight, ventilation, and thermal comfort
- Impact of the security features of the acute unit

5.2.1: ACCESS TO DAYLIGHT, VENTILATION AND THERMAL COMFORT

The basement of the acute unit was where the occupational therapy and art psychotherapy department were located, as well as the gym, activities of daily living (ADL) kitchen, group rooms and music studio. These rooms did not have windows that allowed natural daylight in, and the few windows were either very small or fixed glass panels. As a result, the place tended to feel "dark and dingy", as Eugene remarked. In the mapping activity, Ulric represented his workspace, the music studio in the basement, with black dots and described it as follows:

> *"I have spent ten years in an airless box, four days a week, no natural light, no ventilation, treating patients"* (Ulric, Therapy staff 2, PAR 2, L. 69, p. 4).

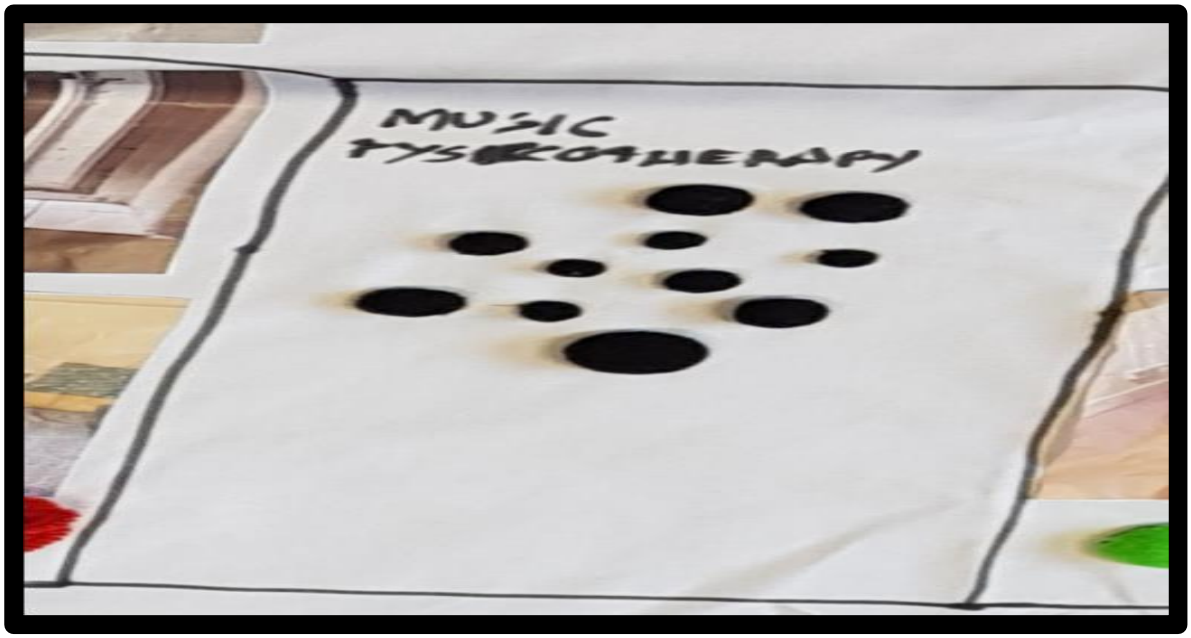


Figure 5.6: Image of music psychotherapy studio from mapping activity 1

To him, these black dots represented how dark the room was because there were no windows and inadequate access to daylight. The staff perceived the artificial lighting in the basement, provided by light bulbs, to be insufficient:

> *"Obviously, there is limited light anyway, some rooms, you don't have windows".* (Elsie, Occupational therapist 1, PAR 2, L. 355, p.16)

The music studio, which constituted Ulric's working environment, had limited access to daylight and inadequate provision of fresh air, hence his use of the phrase "an airless box". His sentiments regarding poor lighting and ventilation were also echoed by the other participants based in the basement:

> *"The basement is really bad, dark, dingy, someday I am just there, I feel lethargic, withdrawn, there is no light that comes from outside"* (Eugene, Therapy staff 1, PAR 2, L. 199 p.9).

From my observations of the acute unit, the lighting and ventilation situation in the basement contrasted sharply with the wards that had direct access to daylight

and were located on the second, third and fourth floor. This reinforced the finding from the survey that 12 out of the 13 participants who worked in the basement were dissatisfied with the access to daylight. The following example was given of an instance where the lights went off at the basement level:

> "*I don't know if you were there, this week,* [referenced that it occurred in the week of 13th July 2018] *where we had this blackout, where everything just went down, at least three or four times in a space of like two hours… also the backup system went as well, [giggles] and all it was, there wasn't enough petrol"* (Elsie, Occupational therapist 1, PAR 2, L. 348, p.16).

She described the impact as follows:

> *"The computers went off and down, the light went out, everything completely came to a standstill. Everyone was running around like helter-[skelter] chicken, trying to find out what the hell was going on"* (Elsie, Occupational therapist 1, PAR 2, L. 350, p.16).

Closely linked to daylight and ventilation was the thermal discomfort experienced by the participants. They said that there was no centralised air conditioning to help regulate the temperature, which was needed especially during the summer. This tended to make the place feel too hot for staff facilitating the therapeutic activities for the service users. For instance, with regard to the breakfast club in the ADL kitchen, the following scenario was recounted:

> *"If you got a group of about six or seven patients, all cooking [using] the two cookers, it can get very stuffy in that kitchen and therefore you do need some ventilation and while there is a fan, it's not enough to ventilate the room"* (Elsie, Occupational therapist 1, PAR 3, L. 324 , p.17).

An examination of Elsie's quotes raises questions that go beyond the discomfort experienced due to the kitchen being very hot during the cooking session. For example, why were there six service users in the kitchen at the same time? The breakfast cooking club might be able to accommodate up to six service users but did the amount of space in the kitchen, the risk assessments and group protocol allow all six service users to be in the kitchen at the same time? These three factors - access to daylight, ventilation, and thermal discomfort – had an impact on the therapy staff in the basement in terms of their working conditions. The quotes reveal that staff wanted to share some of their struggles and their thoughts about what they needed to work with. In addition, they also made inferences about the impact of these things on service users when they engaged in therapeutic activities with them in these spaces, such as during the breakfast club.

From my fieldnotes made on visits to the acute unit, I found the following entry which was recorded during the data collection period of the survey between May and September 2018. The offices that I refer to in the fieldnote were in the basement, in the same corridors as the activity rooms (gym, ADL kitchen, music studio and group rooms):

> "Today at the acute unit, London weather is 29^{o}C and very warm. Have observed a few things in the basement. A manager's office has a humidifier which I learnt she bought herself. Next door, the admin office door is wide open, although she usually does that to see people at the basement door. The first door, which is the staff door on the left was wide open with a box to keep it in place. Staff were in working. I investigated the other staff offices to see what is happening and it turned out that nobody was in. I saw this little fan attached to a monitor". (Fieldnote 2, 25/7/2018).

From the ward perspective, the nurses described the experience of extreme hot and cold temperatures, using the red and blue buttons to represent this in mapping activity 2 (Figure 5.7):

> *"We have to sometimes give patients three, four blankets [at night]. And sometimes, patients have to come out in the day area with blankets, we can't stop them, … meanwhile if it's summertime is unbearable"* (Winfred, Nurse 2, PAR 5, L. 453, p.15).

Fig 5.7: Image of extreme ward temperatures from mapping activity 2

The participants shared their challenging experiences of these three aspects - daylight, air and temperature - of the built environment. The staff appeared to have no immediate solutions to these challenges that they faced in their working environment. However, they did acknowledge that engaging in the mapping activity raised their level of consciousness (Kemmis and Wilkinson,1998) of these

factors within the physical environment, which is a form of positive feedback that characterises participatory action research. This is further discussed in relation to the actions taken by staff in the conclusion chapter.

5.2.2: IMPACT OF THE SECURITY FEATURES OF THE ACUTE UNIT

Staff identified that the security measures in place at the acute unit were inadequate to keep staff, service users and the public safe. The main entrance to the acute unit was locked at all times to monitor people going in and out of the hospital. Each ward or floor also had a main door that was locked all the time. Access to the wards was gained by a key when I started going to the acute unit in July 2017, but this changed to a swipe card in 2019. The basement door was initially open all the time, but was locked after a major incident in the acute unit mentioned in Section 5.2.2.1. Staff had a Red Alert Staff Attack – alarm transmitters that they carried while in the building to call for help when needed. An example of the staff key bundle with ID and swipe card is shown in Figure 5.8.

Figure 5.8: Image of staff keys, swipe and ID used while in the building.

In addition, there was CCTV at some key points in the acute unit which was extended to the wards during the period of data collection. There was no indication of people being searched or scanned at the main reception before entering the acute unit or going up to the wards. However, on the wards, the staff reported that the service users were sometimes searched when they returned from leave. Recent incidents had caused the participants great security concerns:

> *"We recently had the incident where a very unwell patient stabbed a doctor a few weeks ago and you know that was a big risk, …, and we had another one [service user] got into the offices and caused havoc, frightened everyone"* (Louisa, Team lead).

The doctor who was interviewed also confirmed that the security at the acute unit was something that needed to be looked at:

> *Obviously, security has become a huge issue at the hospital after a recent event, we feel the security is probably something that can be stepped up in many ways and reviewed* (Dr John, Consultant).

The ward manager was emphatic that the acute unit did not have security personnel on-site; rather, they just had reception staff in the reception area. He was concerned that whenever there was an issue and they called the police, the police assumed they had security personnel onsite:

> "*I think there is a consensus about [the acute unit] that we don't have security. We have reception staff, they are not security"* (Peter, Ward manager).

Therefore, there was a call for better security measures to be put in place in the reception area:

> *"I will personally hope that there will be better security even in the entrance or reception area of the hospital. That could probably diffuse anything that*

> *could be going up to the wards. Any unwanted things like contraband, weapons and things like that"* (Dr John, Consultant).

5.2.2.1: LOCKED DOORS WITHIN THE ACUTE UNIT

However, the common security feature, the locked doors, was identified as a barrier to the service users accessing groups or activities off the wards. These doors could only be opened by staff members with a key or a swipe card for both formal and informal service users. This was usually an issue for the informal service users who could leave the wards unescorted to attend therapeutic activities in other parts of the building like the basement. The locked doors that separated the various parts of the building meant that they needed to rely on staff to escort them to these sessions. An occupational therapist who shared her experience of working with the service users began by saying:

> *"I was planning to take one of the patients from the ward for an assessment in the breakfast club"* (Henrietta, Occupational therapist 2, PAR 3, L. 108 p.6).

This indicates that it was part of their routine when working with the service users, to get them from the wards to the basement. The occupational therapists had an additional concern about facilitating access for the service user to use the toilet in the basement because it was behind the locked door. The door along the basement corridor had previously been kept open all the time but was now locked and could only be opened by the staff swipe key:

> *"It is not resolved. Because [the toilet] is now blocked by this door. … So, if the patients need to go to [the] toilet especially coming from the gym,*

> *they will need a staff to escort them there* (Henrietta, Occupational therapist 2, PAR 3, L. 400 p. 21).

This was an additional source of disruption to the group sessions as a co-facilitator had to escort the service user to one of the toilets in the basement due to the door being locked. There were two toilets in the basement, and this scenario relates to the toilet at the far end of the corridor. The other toilet in the basement had no locked door and was easily accessible by service users from the gym, ADL kitchen and the group rooms. There was also a group of outpatient service users who attended weekly music psychotherapy sessions in the basement, and they had often found themselves stuck outside the locked basement door:

> *"lock doors to the basement, is still a massive issue, people continue to be affected. It stopped one community group, [a] very popular group now because patients can't get in"* (Ulric, Therapy staff 2, PAR 3, L. 63 p. 4).

The main door to the therapy department historically used to be left open all the time but had to be closed after a service user attempted to abscond from the acute unit using this door. When the participants were asked to bring photographs of features of the acute unit environment showing areas that they were concerned about, all three participants (Elsie, Ulric, and Henrietta) came with photographs of the locked door. These pictures were used in mapping activity 1 as shown in Figure 5.9, representing the basement door.

Figure 5.9: Image of locked basement door from mapping activity 1.

The staff agreed that the locked door was of concern and used the red ribbons in the mapping activity to indicate that it had a major impact on the services that they provided for the service users in the basement. This can be seen as evidence of the longstanding conflict between staff as custodians, delivering treatment and keeping people safe (which was a primary concern for mental healthcare) and staff as therapists, facilitating recovery and creating spaces for people to make profound changes in their lives (Chrysikou, 2019). This forms one of the discussion points in Chapter 7. However, Victor had a different perspective on the doors. He claimed that the wards' main doors were not secure enough:

> *"This door we have, the patients, a female patient can just come and push the door with their hand and the door will open, somebody just use their feet to kick the door and the door open"* (Victor, Nurse 1, PAR 4, L. 531 p. 27).

However, with the introduction of the new swipe card, it was generally felt that the ward front doors were more secure. The new system brought another challenge because staff had to ensure that the door was properly closed after it had been opened. The locked doors across the acute unit also limited service users' access to the rooftop garden on floor 6. Staff were required to escort the service users to the garden, either to attend a session or for a fresh air break:

> *"We used to do a trip to the roof garden, for people who didn't have leave, just for fresh air. We do not do that anymore, … I know like C really wanted to go and get fresh air but there's no one to take you"* (Josephine, HCA, PAR 1, L. 86 p. 5).

Following on from the above discussion, it can be concluded that the main security feature of the acute unit - the locked doors - restricted the movement of the service users within the space, although other factors like the service users' status (voluntary or involuntary) also impacted on their ability to leave the wards. The staff needed to facilitate access, especially to the basement and the roof garden, which was two spaces where most therapeutic activities occurred. This presented a challenge when there was no staff to facilitate access through the locked doors, which is discussed further in Chapter 6 in relation to staff capacity. The tension between being safe and being restricted and the impact on the service users' privacy and dignity is discussed in Chapter Seven concerning the literature.

In this section, the theme of the building layout, the two subthemes of thermal discomfort and the security features were discussed. These were related to how the staff perceived that they impacted the service users' engagement in therapeutic activities. The main factor was the locked doors which, although identified as essential by the staff, limited the service users' freedom of movement within the

unit and ability to access therapeutic activities within other parts of the unit. The next section presents the third main theme, namely the spaces within the building and how they either facilitate or inhibit the service users' ability to engage in therapeutic activities.

5.3: USE AND AVAILABILITY OF SPACE

The findings related to this theme are presented with the following three subthemes:

- "*Not everything can go on, on the ward*"
- "*I have to sort of fight for my space*": lost space
- Designing space for specific use

5.3.1: "NOT EVERYTHING CAN GO ON, ON THE WARD"

The staff indicated that facilitating some sessions in the available spaces, such as music psychotherapy sessions, was very challenging. The music studio was not soundproof so the music could be heard in the other rooms along the basement corridor. A member of the therapy staff had considered holding sessions on the wards but decided against it for the following reason:

> *"The trouble with doing music therapy for example on the ward, is noise. People who don't want to be involved are then assailed by all of this noise pollution, not everything can go on, on the ward"* (Ulric, Therapy staff 2, PAR 3, L. 170, p. 9).

The lack of soundproofed facilities limited how and where music therapy could be provided at the acute unit for the service users who expressed an interest. I observed that the corridor-based layout of the building implied there were no rooms big enough to be used for sporting activities that required a large open space. As indicated in mapping activity 1, the gym in the basement was one of the few large rooms in the unit but the space was filled with exercise equipment. This suggested that activities for which no space provision had been made could

not be offered within the setting. A prime example was green space which evidence-based design advocates for a mental health facility, as outlined in the introduction of this thesis in Chapter one. At this acute unit, the only green space was the rooftop garden which was theoretically available to the service users but limited in terms of access, as discussed previously. The doctor recommended that the acute unit would benefit from:

> *"Safe areas within the hospital like a quad or an outside area that is still part of the hospital so that they [service users] can still go out"* (Dr John, Consultant).

The lack of outdoor space inhibited the service users' engagement in therapeutic activities and therefore highlights the need for a facility to be designed in a way that takes into consideration what it would be used for to ensure all necessary provisions are made. When renovating an existing facility, there should also be a conscious effort made to ensure that the design meets the needs of the new users.

5.3.2: "I HAVE TO SORT OF FIGHT FOR MY SPACE": LOST SPACE

The therapy staff reported they had lost designated spaces in the basement for occupational therapy, art psychotherapy and music psychotherapy sessions. About the use of space in the acute unit, the pottery room was reported to have no sink or tap which made it difficult to facilitate the sessions. According to staff, when they worked with clay they had to use water in a bowl because there was no running water. They mentioned that it had not been the case from the outset, but the situation came about after the room was halved to create an additional office space:

> *"Our creative group room was a bigger room originally, when we had the estate [personnel] coming in, they halved the room …. But also, the space became very cluttered and … there was not much space to manoeuvre, around the room* (Elsie, Occupational therapist 1, PAR 2, L. p. 24).

The staff discussed how they shared their workspace with nonclinical staff from the NHS Trust. This followed a renovation in 2017 in which three rooms were converted into a bigger office space for the nonclinical staff:

> "*Since the administrative group move in, took away an art therapy studio, right and you know is become more difficult for patients to have access and less space to use in more favourable conditions"* (Ulric, Therapy staff 2, PAR 3, L. 85 p. 5).

The participants felt that the environment that they worked in was getting smaller. There was a reduction in the number of rooms available for their use for therapeutic activities as well as for storage space. The phenomenon of NHS facilities being converted or sold for nonclinical use, especially in inner London, is one of the discussion points in Chapter Seven.

The image of the full mapping activity 1 of the basement (Figure 5.1) illustrates the perception that almost a third of the basement had been lost to the nonclinical team. Although the map was not drawn to scale, the blank space, where the map key is, represented space that no longer belonged to the therapy team. The therapy staff felt they had few dedicated spaces which could be adapted and furnished for specific therapeutic activities. The occupational therapists only had two rooms (ADL kitchen and pottery) that were dedicated for their sole use. The other group rooms needed to be booked in advance. Between the two therapy groups, there was a sense of each group claiming rooms solely for sessions that they facilitated for service users. For instance, Figure 5.10 shows one of the

rooms, which was supposed to be ‘bookable’, but one team felt they did not have access to it due to how it had been laid out with tools by the other team, hence the big red circle with a line through, indicating “do not enter”, an image which was added to the mapping activity by one of the occupational therapy staff. After the basement had been mapped, she felt she wanted to tell the story of how she felt about that room, hence this design.

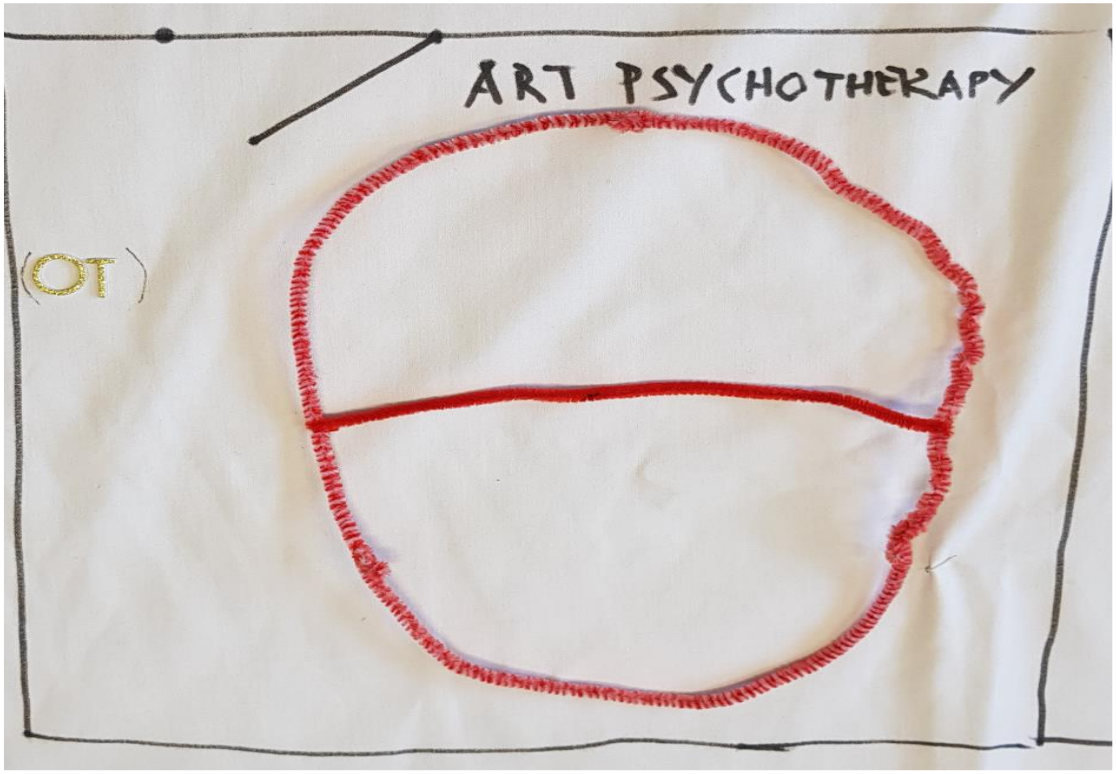


Fig 5.10: ‘Do not enter’ image from mapping activity 1

Elsie explained:

> *“We have no dedicated space, so I am finding like, I have to sort of fight my space with other people just to get a space to work with groups, which is not appropriate, and I think, I don’t want to do that”* (Elsie, Occupational therapist 1, PAR 2, L. 137 p. 7).

Another space that the staff felt had been lost was the storage facilities. The conditions in the basement were such that materials and other resources for

activities had to be stored in the group rooms, which made the rooms cluttered, as shown in Figure 5.11 for group room three.

Figure 5.11: Image of cluttered group room three from mapping activity 1

Although this group room contained basic equipment like the table and chairs, it could be observed that there were also other random items in there. The trolley was overflowing with papers used for creative activities and the window, as can be seen in the image on the lower right, only opened a few inches because of the brick wall. The green pompom indicated that this was one of the rooms that were meant to be for the sole use of the occupational therapy team, but they told me that they still needed to book it if they wanted to use it. On the wards, the doctor agreed that there was not enough space for facilitating therapeutic activities. The

wards had not lost space, as was the case with the basement, but the available space was not big enough for the 18 service users on admission:

> *"Activities that take place on the ward itself for instance are often [crowded]. You do get a sense, there is not enough space, … , it takes up the whole of the available space of the ward sometimes"* (Dr John, Consultant).

He was referring to the weekly community meeting which was held one day a week on each ward. All the service users on admission and the staff on the multidisciplinary team were expected to attend this meeting to discuss any ward issues. Louisa summarised the available space at the acute unit as follows:

> *"Well, there isn't much space to be doing a lot of therapeutic activities. We are all cramped in, squashed in especially now… On the ward, there is only one room to do activities, and down here in the basement there is one room but that is also a bookable space* (Louisa, Team lead).

5.3.3: DESIGNING SPACES FOR SPECIFIC USE

With the loss of space, staff reported that a booking system had been introduced to manage the use of the available rooms for the therapeutic activities. This contrasted with the system previously in place, whereby rooms were always available for use. The challenges of the booking system identified by participants included: available rooms being inappropriate for the session; difficulties making modifications to the room layout; and all year booking of the rooms by some staff. The staff felt that there were few rooms available to be booked due to the high demand for space. The rooms had basic facilities such as tables and chairs in them but were not always equipped with other facilities, for example taps and a sink, which are essential when facilitating activities like pottery. Henrietta commented that it:

> *" is difficult when the room is bookable by a lot of people, because we can't tailor-make it to be like a room that is best fitted for group use*" (Henrietta, Occupational therapist 2, PAR 3, L. 306 p.16).

Here, she was referring to group room 3 as "bookable", in contrast to the art psychotherapy room illustrated with the big red circle in Figure 5.10. Staff reported that some of their colleagues made weekly bookings for meetings or sessions for the whole year, to ensure that these rooms were available when they needed them. However, the bookings were not cancelled in weeks when they did not need the rooms. Hence, a room might be vacant but appear to be booked on the computer system. However, staff said that if they did not book the space for the whole year the rooms might not be readily available. The staff mentioned that this approach limited their ability to be spontaneous in responding to the day-to-day changing needs of service users. Hence, every therapeutic activity/session

that required the use of the bookable space had to be pre-booked. I had a similar experience when booking the rooms for the PAR group meetings. Although it was at a different site, I booked all the rooms in advance in May 2018, even the sessions that would be held the following year in January 2019. However, there was some flexibility when some of the dates changed. Overall, there was a consensus among the participants that the space within the acute unit was small and limited the kind of therapeutic activities that they could provide for the service users. This section has demonstrated, using the findings, that the therapeutic activities were restricted due to the perceived lost space which had led to staff being protective of the limited available spaces. In addition, the new system of having to book the group rooms had limited spontaneity for the staff who were trying to engage the service users in therapeutic activities. The next subtheme concerns the issues of maintenance when equipment or gadgets used for therapeutic activities break down.

5.4: Staff ability to influence the environment

The participants acknowledged that the resources available for therapeutic activities at the acute unit had been provided to the best of the management's ability and that these resources were comparable with other acute units across the country. One of the therapy staff revealed that when a colleague from another NHS Trust had visited the gym, he was impressed by the equipment that the service users had access to. The acute unit had an equipped gym, a furnished Activities of Daily Living (ADL) kitchen, a music studio, pottery with a kiln, computers, televisions on the wards, and table tennis in some of the wards.

However, some of these were deemed old and unreliable by the staff and frequently broke down.

5.4.1: "WORK WITH THAT, THE BEST WE CAN"

The gym was run by Eugene, therapy staff 1 and one of the associate practitioners. In mapping activity 1, the staff used items such as brown pompoms and dead wood to represent the old equipment in-situ at the gym. In addition, they used the sea blue colour pompoms to indicate the flooding that sometimes occurred at the gym. Staff shared that the flood water that got into the basement corridor had a very offensive smell. The representation of the gym from mapping activity 1 is shown in Figure 5.12.

Figure 5.12: Staff image for gym from the mapping activity

> *"That's been blocked, and the sewerage is burst, and is coming straight through the gym, but that is my working environment, is not the best but you know, we try to work with that the best that we can"* (Eugene, Therapy staff 1, PAR 2, L. 234 p. 11).

Staff asserted that the floods were caused by the old plumbing system at the acute unit and from excessive rain draining into the basement. They explained that the flooding was not a new occurrence and it had to be managed as and when it occurred. However, the space still needed to be used for providing essential therapeutic activities for the service users. Eugene acknowledged that it was not the best environment to work in, but he was making good use of it. He also felt that sometimes there were specific exercises that a service user could benefit from, but the right equipment was not available. This limited the provision of current evidence-based interventions for the service users:

> "*But having said that, the type of and methods of exercise and fitness change quite a lot and there are so many methods. Exercising, ways to engage people and I don't think we have kept up with that, I do think we are quite years behind in that respect"* (Eugene, Therapy staff 1, PAR 2, L. 202 p. 9).

Broken equipment and furniture, such as tables and chairs, created additional challenges for staff facilitating therapeutic activities. On the wards, the staff reported that the computers and television were often out of use which impacted on the service users' engagement. They mentioned that a cooker in the ADL kitchen had broken down, which was captured by one of the participants in a photograph used in the mapping activity, as shown in Figure 5.13.

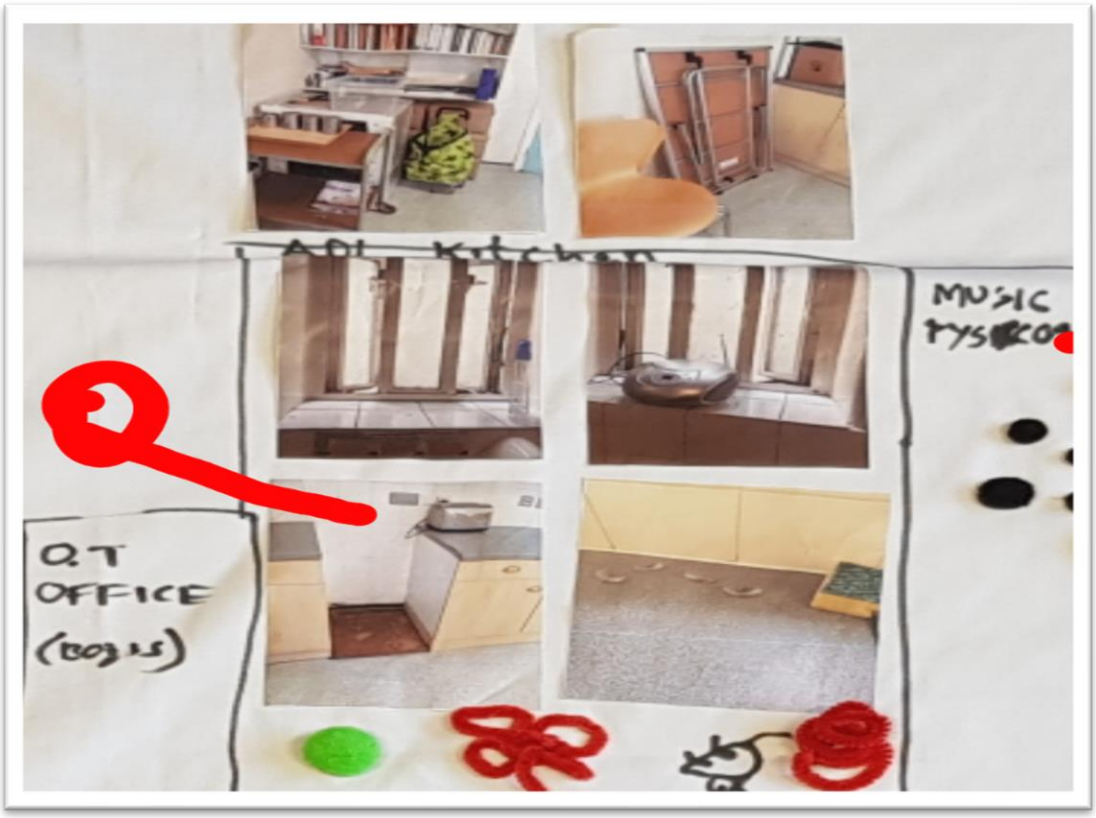


Figure 5.13: Image of empty cooker spot from mapping activity 1

The space with the red line pointing to it is where the cooker should have been. Consequently, the staff reported that the number of service users who could attend the cooking session was limited:.

> "*So, only one cooker is not enough for a group, you need to have at least two. … they are kind of limited in the number of people they can invite to that group now"* (Elsie, Occupational therapist 1, PAR 2, L. 284 p.13).

5.4.2: MEETING NECESSITIES: "*BLOCKED TOILETS"*

It was reported that the service users' toilets on the wards were frequently out of use:

> "*The toilet is blocked for weeks on end"* (Elsie, Occupational therapist 1, PAR 2, L. 532 p. 24).

> *"Oh yes, for example there [have] been times when all toilets have been blocked, we need to escort them [service users] to the female area to use the toilet or escort them to another ward whilst we waiting for maintenance"* (Peter, Ward manager).

The service users on the wards shared the toilets, showers, and bathrooms, as the bedrooms were not ensuite. There were on average four toilets on each ward and staff reported that at least one would be blocked most of the time. These blockages were allegedly caused by the excessive use of toilet paper or the paper hand towels being flushed down the toilet. The ward manager further explained:

> *"At times, we even try to unblock it ourselves by just flushing it … until is clear. Two minutes later, it is blocked again"* (Peter, Ward manager)

This sometimes led to unhygienic and undignified situations for service users:

> *"Most of the time, you have patients defecating in their room … and a lot of the time if you asked the patient why they did it, they will tell you that because I was pressed, and somebody was in the toilet, … toilet is blocked … so is quite a disaster sometimes"* (Elsie, Occupational therapist 1, PAR 4, L. 120, p. 6).

For most of the service users on the wards, being sectioned under the Mental Health Act was very challenging for them but it was also in their best interests to

be cared for. It meant they did not have the luxury of being able to leave the space as and when they wanted to. However, it is more undignified for someone to be in a situation whereby they feel that their only option is to defecate in their room due to factors outside their control, like the blocked toilet. Most of the service users could use the toilet independently on the wards and therefore did not require nursing staff support. The pressure on the toilet facilities because they regularly broke down is one reason a service user could find him/herself in this situation of defecating or urinating in inappropriate places. The staff's concern about the service users' dignity on the wards led to a discussion about meeting the service users' basic needs versus the installation of closed-circuit television (CCTV) on the wards. At that time, there were indications that CCTV was going to be installed on the wards to help with security issues:

> *"Security is supposed to be taken seriously but we have been able to manage to put up until now … but one of the most important things is that the patients have dignity and respect, and you need to have toilets and water. These are the basic needs throughout the hospital … is not rocket science"* (Elsie, Occupational therapist 1, PAR 4, L. 159, p. 9).

The participants felt strongly that the money invested in installing CCTV should be used to provide a permanent solution to the frequent toilet blockages. This is further discussed in Chapter Seven regarding instances where security concerns overrode the dignity of the service users.

5.4.3: *"PEOPLE HAVE GIVEN UP NOW"*: REGARDING THE DELAYED REPAIRS

Clearly, resources could break down or flooding could occur. However, staff were concerned that maintenance and repair work appeared to take an unnecessarily

long time to complete. This included removing broken furniture from the wards, getting the appropriate people to clean up after the basement flooding, attending to gas leaks and ordering and installing a new television on the wards. Staff perceived that the management did not regard these issues as being urgent. One example was recounted by the therapist, Eugene:

> *"To be honest, I was like, let me get a mop out because that morning it had flooded, it wasn't until 3:00 in the afternoon before anybody came…., we had the gas issue as well and … it took a good part of five hours to get a gas man out to resolve a gas leak in the basement"* (Eugene, Therapy staff 1, PAR 2, L. 243 p. 11)

He thought that these incidents were emergency situations that needed to be dealt with immediately. The implication was that, in such instances, the delay to the repairs meant that less could be done with the service users. The following is an extract from the conversation between the therapy staff in the PAR 2 meeting:

> *Elsie: sorry, on our ward, there is also a game of table tennis, which is now completely broken again, and we waited for about eight months for that to be delivered,*
>
> *Henrietta: once it gets broken, is never … is like patient's computer it will never be fixed. I think people have given up now.*
>
> *Elsie: ...there is also a table that is broken in the group room that hasn't been removed for weeks, …, is been passed on to the facilities manager who is aware of it and is still hasn't been taken away.* (PAR 2, L. 503 – L516, pp. 22-23).

This conversation illustrates that some items had either broken, were awaiting repair, or needed to be replaced. The staff seemed to feel that people were expected to make do and put up with what was available because the basic infrastructure of the building was unsuitable. Staff also reported that the

renovation of the basement had caused temporary inconvenience. For example, at one point in time there was only one usable toilet in the basement because the other toilet facility was being renovated to provide an additional toilet. Although the eventual outcome was positive - an additional toilet for staff use - the staff felt that they had been inconvenienced while the renovation work was being carried out.

5.4.4: "BRIGHT LIGHT, BEAUTIFUL OFFICES, ALL CARPETED NICELY" ON THE ADMINISTRATIVE FLOOR

By contrast, the participants perceived differences between the design and furnishing of the administrative staff areas and that of the clinical areas like the wards and the basement. Staff drew unfavourable comparisons between the areas where they worked and the renovations that had been completed in other parts of the building mostly used by the administrative and management staff:

> *" The other day we had a meeting on the first floor and I couldn't believe how bright it looks down there, bright light, beautiful offices, all carpeted nicely and we living in a dungeon in the basement"* (Elsie, Occupational therapist 1, PAR 4, L. 1061, pp. 54-55).

The first floor of the acute unit building was the former psychiatric intensive care unit (PICU) ward that had been renovated for use by the administrative staff of the NHS Trust. This was not a clinical area and hence not available for service users to use. Elsie was concerned about how that space differed from the clinical spaces within the same building. She observed that the space had been redesigned and comfortably furnished to support the staff working there. However, she perceived that the wards and the basement were not equipped to a similar standard that could support the staff to adequately carry out their work with the service users. The staff in the PAR group proceeded to identify potential areas within the acute unit that could improve the service

users' engagement in therapeutic activities as part of the action cycle of the participatory action research. They made recommendations about how the acute unit environment could be improved to support the service users' engagement in therapeutic activities. The staff did acknowledge that, in the case of some of the issues raised, nothing could be done but suggested that a safe space should be allocated for staff and service users on each ward where they could de-stress and de-escalate respectively. It was also suggested that a comprehensive redesign encompassing varied activities to help engage service users should be included in the acute unit environment. This is discussed subsequently.

5.5: STAFF VISION FOR AN IDEAL WORKING SPACE

On reflection after PAR group meeting 2 and scrutinising the data, I realised that the group had only been identifying and discussing the challenges within the acute unit. Therefore, there was a need to start discussing what could be done to effect changes in line with the action research approach. I planned an activity that participants could do which involved imagining the ideal acute unit that they would like to work in. They were asked to give free rein to their imagination and assume there were no limitations on funding or space. From this activity, the two themes that the staff particularly emphasised were safe space and comprehensive redesign of the acute unit.

5.5.1: SAFE SPACE

It was suggested by the staff that the acute unit environment needed to be a safe space for all its users (staff and service users). For them, a safe space did not just mean a secure space, but one with a pleasant ambience, with dedicated spaces for recuperation. They thought the ideal environment should have good lighting and ventilation and should offer thermal comfort with less noise. They

identified the poor access to daylight in the basement and the inadequate ventilation as factors that did not support service users' engagement in therapeutic activities:

> "*Under built environment, natural light, do not stick us in the basement, and then in a room with no window. Need to minimise noise pollution, which is everything from echoing corridors, to people over hearing staff to music therapy on the ward"* (Ulric, Therapy staff 2, PAR 3, L176, L. 179 p. 10)

The therapy staff, most of whom worked in the basement, expressed the view that it was not an ideal place to work and that they would have preferred a space with direct access to daylight with adequate ventilation. To provide a safe space for the service users, the staff suggested that, ideally, the bedrooms on the wards should all be ensuite. However, they did acknowledge that this was not feasible due to the design of the building. The staff perceived that the shared toilet facilities were inadequate, and the fact that they kept breaking down puts more pressure on them:

> *"I think people have to share [toilet] facilities, they need to have their ensuite bathroom and toilet"* (Elsie, Occupational therapist 1, PAR 3, L. 192 p.10).

The participants further acknowledged the stress that staff are under when working on the wards. For this reason, they proposed that a dedicated space should be provided for the staff to de-stress and for service users to calm down:

> *"Those designated places that people go to, so whenever somebody was upset, angry or frustrated about whatever for whatever reason, … a place*

> *where they could go and sit and find comfort and relaxation"* (Victor, Nurse 1, PAR 4, L. 34 p. 2).

They suggested that this space could be on the ward to allow easy access to it, especially for the service users. The concept was linked to the old smoking rooms on the wards where service users could "just go in and chill out". They believed this could be refreshing for the service users and could help prevent incidents escalating to the point where service users needed to be restrained on the ward.

The participants reported that there was no "proper" staff room on the wards where they could go and de-stress, hence their call for an appropriate safe space to be provided. Relating this to a purpose-designed mental health unit, they pointed out that these usually had outdoor garden spaces that were used for these purposes:

> *"Just a space for staff, … you need to have a space where you can go, and de-stress, you know, because is very stressful sometimes being a nurse on the ward, and nowhere to go.*
>
> *Somewhere … people can de-escalate if they are quite aroused, upset, where staff will be able to minimise the amount of restraint that is used"*. (Elsie, Occupational therapist 1, PAR 3, L. 215 p. 12).

The proposal for a separate safe space where people could go to de-stress and to calm down within the acute unit links to the next recommendation, for a comprehensive redesign of the available space.

5.5.2: COMPREHENSIVE REDESIGN

I use the term 'comprehensive redesign' to capture the recommendations concerning the variety of zones, activities and areas suggested by the staff:

> "*I think on a more practical level … I suppose, is not a purpose-built hospital and that is the difficulty"* (Elsie, Occupational therapy 1, PAR 2, L. 59 p. 3).

The participants felt that the physical environment that they worked in was not a purpose-built mental health unit. As mentioned previously, the building was located along the main road in inner London and it bordered other buildings and had pavements on two sides. The locked doors also meant that not all the service users had a leave to go outside the wards as and when they wanted. The proposal for a comprehensive redesign was concerned with how the internal space should be organised. Participants felt that the physical space should be purposefully designed to support different types of use, including creating more dedicated spaces to support service users' engagement in therapeutic activities:

> *"Variety of zones of care and activities…. variety of places that they can go, you know, somewhere with plants, somewhere with a good stock of DVD"* (Ulric, Therapy staff 2, PAR 3, L. 180 p. 10)
>
> *"My ideal ward will have a variety of activities of different things"* (Henrietta, Occupational therapist 2, PAR 3, L. 149 p. 8).

In redesigning the space, the staff suggested that the focus should not only be on the working and living space. By 'working and living space', they meant not asking questions such as, what are the basic requirements for a facility to be used as a clinical space where staff can work with service users and a service

user to be admitted safely, but rather, how could the space help meet the other needs of the staff and service users, such as engagement in therapeutic activities?

Ulric suggested that this could further promote social activities among the service users and offer them opportunities to make choices:

> *"Chance to vote a video which you [going to] watch together, you know, so there is something to look forward to, do the coffee mornings, lunch, these things are really important "* (Ulric, Therapy staff 2, PAR 3, L. 165 p. 9)

Although these therapeutic activities that Ulric mentioned were on offer at the therapy department, he emphasised that they were not engaged in very frequently. He, therefore, thought it was important to think about how the environment could be used to support service users to engage more in these activities. The comprehensive redesign should also include adequate resources to help facilitate sessions when required. For instance, an art room should have the appropriate chairs and a movie room should be properly stocked with DVDs. In these instances, Ulric seemed to be referring to social and recreational activities rather than specifically to therapeutic activities as understood in this context. There is further discussion in Chapter Seven about how these terminologies are sometimes used interchangeably. I gathered during one of the key informant interviews that three bedrooms had been closed on each ward, as part of the acute unit improvement programme. The management was still deciding how these rooms should be used, but the initial impression was that they were going to increase the activity rooms on the wards:

> *"Having closed three bedrooms, we will be using one room for activities on the ward, so you will have your group room and then that room, and then*

> *we will re-evaluate that and see whether patients feel satisfied, if we will have more rooms, more space for the patients"* (Peter, Ward manager).

However, Peter did acknowledge the impact that the three-bedroom closure on each ward was going to have on bed management at the acute unit. What seemed unclear was why those bedrooms had been closed before any agreement had been reached about what they would be used for. This was part of an ongoing discussion before the improvement project was initiated, accompanied by a sense of hope that the therapy staff would have additional space to work with the service users on the ward. However, it was not clear how this reduction in the number of service users on the wards would impact staffing. Details of staffing issues on the acute unit are provided both in Chapter six and Chapter seven. This section on the ideal space helped to bring the participants' perspective into an imagined place, shaped by memories, aspirations and hopes; not just a place where the toilets were in working order but a place where the service users could engage in more therapeutic activities.

5.6: CHAPTER SUMMARY

In this chapter, I have presented an analysis of the PAR group discussions, key informant interviews and my fieldnotes concerning the factors relating to the physical environment of the acute unit identified by the participants as impacting on service users' engagement in therapeutic activities. About the basement, these included the provision of facilities like the gym, ADL kitchen, activity and group rooms. The wards also had allocated spaces for activities including a group room, table tennis, computers, and a rooftop garden. The participants expressed the view that the acute unit was adequately resourced to enable therapeutic activities to be offered to service users during their hospital admission.

However, participants also described the building as old, small, and not purpose-built. They reported that the building layout limited the therapeutic activities in which the service users could engage as the design could not support their provision. Additionally, the main security feature of the acute unit, the locked doors, was identified as limiting the service users' ability to access therapeutic activities in parts of the building. The staff described reductions in clinical areas due to parts of the building being converted to offices for the administrative staff. The age of the building meant that there were more maintenance issues and repairs required, which staff thought were sometimes delayed unnecessarily. According to the above discussion, staff indicated that the design of the acute unit did not adequately ensure the privacy, safety, and dignity of the service users. The basic issue was about the inadequate toilet facilities available on the wards. The two key recommendations made by the participants that would help to achieve their ideal environment within the acute unit, for both themselves and the

service users, were to have a safe space and that the physical environment should be redesigned to include a variety of spaces for activities.

CHAPTER SIX

FINDINGS ON CONFLICT AND COOPERATION WITHIN THE SOCIAL ENVIRONMENT OF THE ACUTE UNIT

This chapter reports the second part of the findings based on the data gathered from the participatory action research group discussions and the key informant interviews. The focus is on the people (staff and service users) within the acute unit. These individuals and their roles in the acute unit are discussed, with the emphasis on how either personal factors or work patterns impacted the service users' engagement in therapeutic activities. From the thematic analysis, I generated three main themes: the service users' personal factors; the social context of therapeutic activities; and the interpersonal relationships that impacted on the service users' engagement in therapeutic activities. These are discussed in detail and supported by verbatim quotes in this chapter. Figure 6.1 provides a summary of the themes and subthemes discussed in this chapter.

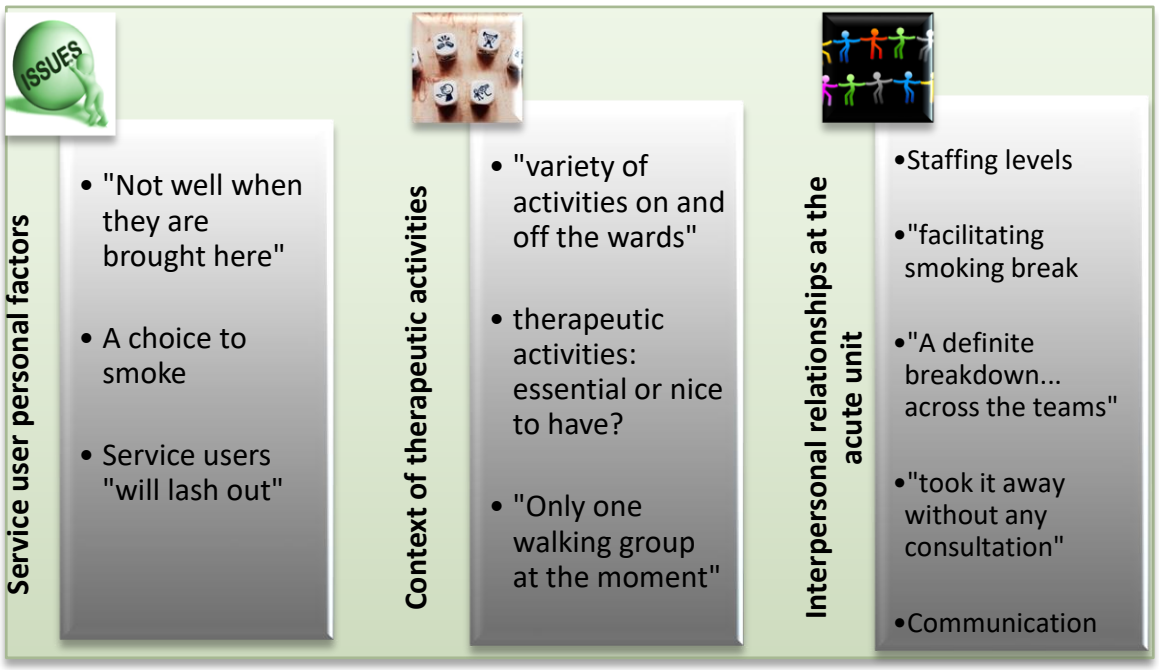


Figure 6.1: Summary of the themes and subthemes relating to the social environment

As in Chapter Five, each quote is followed by the participant's pseudonym, profession, the PAR group number, line and page numbers for the quote on the original transcript in parentheses, for example (Victor, Nurse 1, PAR 4, L. 510 p. 26). In the case of the quotes from the key informant interviews, they are followed by the pseudonym and the profession or role of the staff member. I begin by discussing the theme of the service users' personal factors that impacted their ability to engage in therapeutic activities. This generated two subthemes: the severity of the service user's mental health problem; and the service user's choice to smoke. The findings reported in this chapter are all from the staff perspectives as they were the participants in Module Two of the study.

6.1: Service users' personal factors that impacted their ability to engage in therapeutic activities

This theme is primarily about the service users; the severity of their mental health problems, the choices they make and how that impacts their engagement in therapeutic activities. The Occupational Therapy Practice Framework (OTPF) defines client (personal) factors as, "specific capacities, characteristics, or beliefs that reside within the person and that influence performance in occupations" (AOTA, 2014, p. S7). These factors influence whether a service user chooses to engage in therapeutic activities or not.

6.1.1: "Not well when they are brought here"

The service users on the acute unit presented with varying degrees of mental health problems. The staff perceived most of them to be severely unwell:

> *"A lot of the time, most people you know are extremely not well when they are brought here. Because they are detained against their will"* (Victor, Nurse1, PAR 4, L. 184 p. 10).

As indicated in the literature, different services exist for the management of mental health service users in crisis within the United Kingdom (NHS Long term plan, 2019). Those who get admitted to the acute unit are severely unwell and, most of the time, difficult to manage either at home or by other existing community crisis management services. Victor's perspective confirms the obvious: service users are unwell, which is why they are admitted. However, he emphasised that these people are "extremely" unwell, which connects to the second part of the quote, explaining that they are "detained against their will". According to the UK Mental Health Act, reasons for service users being detained include a statement that the person is "suffering from mental disorder of a nature or degree which warrants the detention" (Mental Health Act, 1983, p. 3), which usually follows an assessment by two registered medical practitioners. Detailed information about the Mental Health Act and service users being sectioned or detained under it are presented in Section 1.2.3 of Chapter One of this thesis. Louisa added that the fact that they are extremely unwell and detained means that the service users will require more support to engage in therapeutic activities at the acute unit:

> *"That the level of acuity of our patients have increased enormously and people come in very unwell. It does make it quite difficult to get people engaging. And you know, [we] try to explain to them the reason why they need to be engaged".* (Louisa, Team lead).

However, a contrasting view was expressed that the service users vary as individuals and in terms of whether they choose to engage in therapeutic activities or not, irrespective of how unwell they are:

> *"Participation and engagement do depend from person to person"* (Dr John, Consultant).

Thus, the individual's factors come into play in terms of whether to engage or not. Louisa further pointed to the importance of the service users' motivation concerning engaging in therapeutic activities:

> "*My experience has been that people who will engage, will engage with anything and everything … and with the ones with very low motivation and they are often like that [even] at home"* (Louisa, Team lead).

This echoes Dr John's assertion regarding the differences between the service users on the wards, even though they are all likely to be very unwell. The service users' personal factors that staff perceived to impact their engagement in therapeutic activities can be summarised as: extreme levels of mental health problems, individual differences, and personal motivation to engage. Related to these personal factors is the service users' choice to smoke despite the implementation of the smoke-free policy.

6.1.2: A CHOICE TO SMOKE

This subtheme centres on smoking-related issues in the acute unit. The hospital grounds were deemed smoke-free areas, which required an absence of smoke from cigarettes, cigars, herbal cigarettes, and pipes (Day and Garnham, 2015), in line with the National Health Service (NHS) smoke-free policy. Smoking cessation was encouraged by the acute unit as a lifestyle change for the service users. However, Victor reported that there were always service users who were smokers on the ward:

> *"Although as I said, I wouldn't promote smoking because is a health hazard and is also a bad habit. Yet, people do it and it is a culture and habit that people develop for years and years and is very difficult for them to stop"* (Victor, Nurse 1, PAR 4, L. 32 p. 2).

Victor's concern was that smoking was a deeply ingrained and longstanding habit for some service users and so their admission to the wards did not mean that they were going to instantly give up or that staff could tell them not to smoke. Thus, the staff acknowledged that some of the service users still wanted to smoke irrespective of the hospital grounds being smoke-free. In Dr John's interview, he agreed that:

> *Obviously, we do not take kindly to drugs and alcohol, but for smoking, I cannot say to someone not to smoke, it causes a problem for us* (Dr John, Consultant).

The acute unit actively encouraged the service users to quit smoking and offered nicotine replacement therapy in line with the NHS policy, but it also made provision for offsite smoking. Informal service users could leave the ward on their own to go outside the acute unit grounds and smoke. Formal service users (sectioned under the Mental Health Act) were given Section 17 leave, either

escorted or unescorted, to smoke when required. Section 17 leave is a formal permission given to a service user who is sectioned to leave the acute unit premises for a period while still under the Mental Health Act (1983). Elsie mentioned that, before the implementation of the smoke-free grounds policy, the rooftop garden used to be the designated smoking space for the acute unit. There were also allocated rooms on each ward for smoking. Frequent "fresh air" breaks throughout the day were offered to the service users:

> *"The roof garden trips were equated with smoking. Because people generally used to go there to the roof garden to smoke"* (Elsie, Occupational therapist 1, PAR 1, L. 92 p. 5).

The service users' choice to smoke meant that the staff had to facilitate the smoking break for them. The staff escorted the service users to the allocated space to smoke outside of the acute unit grounds. This additional nursing duty was identified as taking up too much of the staff's time and impacting how much time they had to engage the service users in therapeutic activities. This is discussed in detail with supporting quotes in the subsequent section concerning staffing levels. The staff reported the service users' reactions when staff were unable to facilitate smoking breaks as very unpleasant.

6.1.3: SERVICE USERS "LASH OUT" WHEN LEAVE IS NOT FACILITATED

Staff also reported that failure to facilitate a smoking break for the service users sometimes meant that minor issues could escalate into major incidents on the wards:

> *"Since the smoking cessation, you know zero tolerance for smoking in the NHS premises, this has made things very very difficult. Because you find that patients are getting more and more aggressive. Because they are not able to go outside and smoke"* (Victor, Nurse 1, PAR 4, L. 36 p. 2).

Victor stressed the difficulty and the aggressive behaviour exhibited by service users towards the staff by repeating the words "very" and "more" drawing an unfavourable comparison with what used to happen before the implementation of the policy. He continued:

> *"If a patient comes to me, and says to me I want to go for a smoke break now and I tell them, look, at the moment I cannot facilitate it, I haven't got staff to facilitate it, … patients will lash out, because for them that is the only way they can get their voice heard … and then when they lash out, the alarm will be activated and this will have to be managed somehow* (Victor, Nurse 1, PAR 4, L. 918 p. 47).

Dr John agreed that:

> *"It has been a huge thorn in our side. Since they stopped people from going out to smoke. Because it does create frustration for a detained patient that you will often see an escalation in aggression and violence behaviour".*

He added:

> "*They [management] should have considered (the environment) before they impose these laws on a unit like this"* (Dr John, Consultant).

I followed up on the smoking-related issues in a key informant interview with the deputy smoking cessation lead of the NHS Trust. She acknowledged the challenges faced by the acute unit in implementing the existing smoke-free grounds policy at the research site. She mentioned that a new smoking policy within the trust had been launched, which was to be rolled out from 27th February 2019. The key components included: no tobacco allowed; vaping to be an option for those who wanted to smoke, and for the staff to stop facilitating Section 17 leave for service users to go out and smoke. Detailed information on the new smoking policy is shown in Appendix AF. However, staff in the PAR group were sceptical about whether the new policy could successfully be implemented in the acute unit. The service users' choice to smoke, the smoke-free grounds policy and the possible outcome of service users expressing their anger is therefore the interactive personal factors relating to the service users that staff perceived to impact on their engagement in therapeutic activities. I next present an overview of the therapeutic activities, to shed light on the social context in which the different activities take place and the roles of the staff at the acute unit.

6.2: CONTEXT OF THERAPEUTIC ACTIVITIES

6.2.1: "VARIETY OF ACTIVITIES ON AND OFF THE WARDS"

The staff agreed that there was a range of different therapeutic activities on offer for service users to engage in. The timetable of the therapeutic activities shared by the occupational therapy team is shown in Figure 6.2.

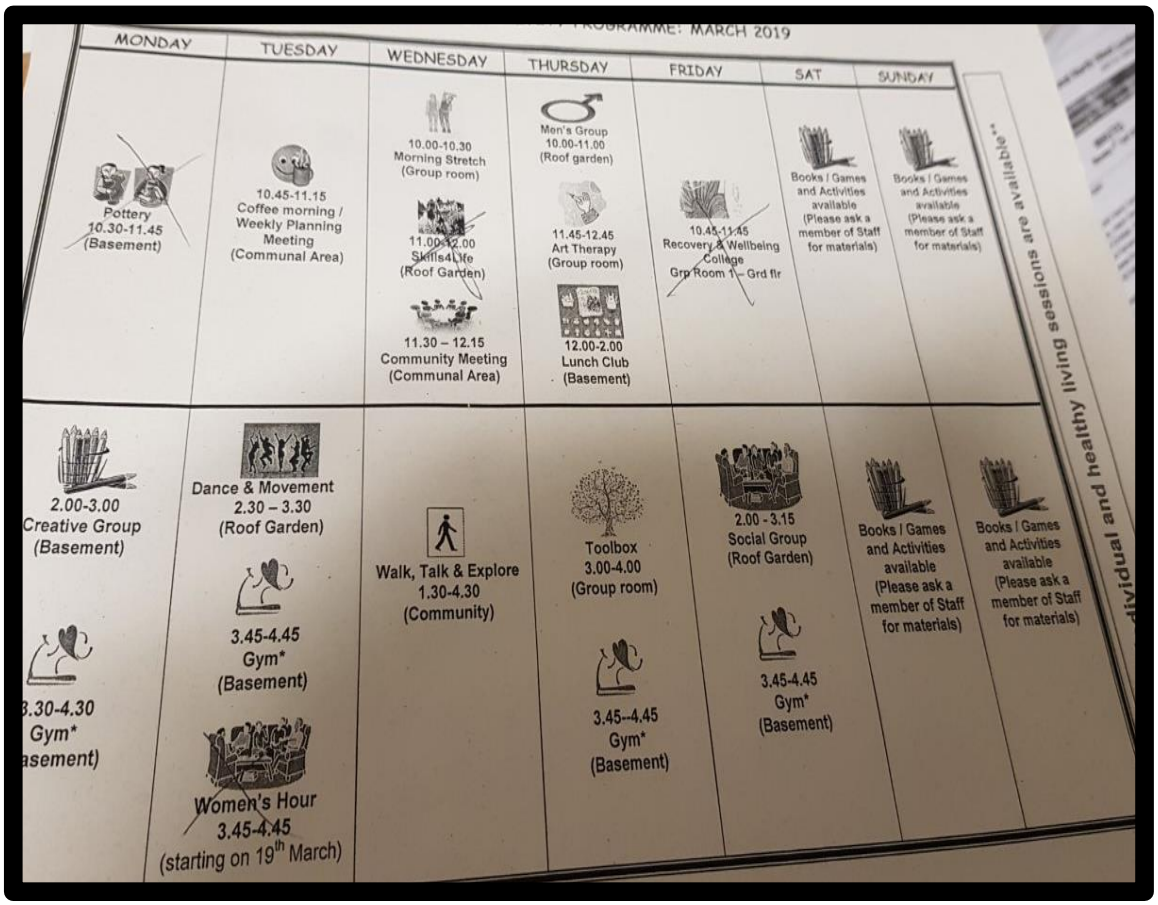


Figure 6.2: Occupational therapy weekly timetable.

According to the timetable, the therapeutic activities on offer included: pottery, coffee morning, morning stretch, skills for life, men's group, art therapy, recovery and wellbeing college, creative group, gym, dance and movement, lunch club, women's hour, walk, talk and explore, and the social groups. At weekends, there were books and games available that service users could ask staff for, if they wanted to. One ward also had a game of table tennis that the service users could

use at any time. Most of the timetabled sessions took place in the basement, communal areas, roof garden and ward group rooms. Figure 6.2 also shows that some of the activities have been crossed out and were thus not on offer at the time that staff shared the copy with me. As discussed later in this chapter, the reasons for this were likely to be due to inadequate staffing. In addition to the occupational therapy timetable, the art psychotherapy group also offered additional sessions of arts and crafts and music therapy to the service users in the basement and the roof garden. The following is a description of one of the music therapy sessions:

> *"Well the group that I run on Friday, … is a three-hour group. Because, what we are trying to do is actually create a studio environment where people can make meaningful choices about the kind of musical education that they engage in and, the product that we create in terms of recording music"* (Ulric, Therapy staff 2, PAR 2, L. 104 p. 27).

The staff deemed the provision of therapeutic activities for service users to constitute an essential part of the treatment at the acute unit:

> *"We are expected to provide some variety of therapeutic activities to engage them [service users] alongside their medication and the other treatment"* (Louisa, Team lead).

Both the ward and therapy staff acknowledged the benefit of therapeutic activities for the service users:

> *"Remember, is not just medication only. Is the key thing for people's recovery… Is spirituality, activities that will help them, activities of their own choice, that will occupy their day*." (Peter, Ward manager).

The ward staff reported that they had received useful feedback from service users after engaging in those sessions:

> *"Obviously, I hear very good feedbacks from patients about some of the activities"* (Dr John, Consultant).

However, the real challenge was the provision of therapeutic activities for the service users at the acute unit. How the various teams perceived their roles with the provision of these therapeutic activities is discussed in subsequent sessions.

6.2.2: THERAPEUTIC ACTIVITIES: ESSENTIAL OR NICE TO HAVE?

As indicated earlier, the therapy staff were responsible for providing therapeutic activities, which was perceived as an expected part of service users' treatment:

> *"The activities on the wards were all provided by the occupational therapists and the associate practitioner*" (Louisa, Team lead).

However, the therapy team explained that their roles within the acute unit involved considerably more than just providing therapeutic activities for the service users. They also completed assessments of the service users, wrote up reports and used this information to plan their interventions with them, using these therapeutic activities:

> *"We do really important assessments for [service users], how people are going to function in the community"* (Ulric, Therapy staff 2, PAR 5, L. 72 p. 3).

The therapy staff reported that, as their working pattern was from 09:00 to 17:00, with few variations, they would benefit from support from the ward staff in facilitating therapeutic activities, especially outside of their working hours. However, it is questionable whether this would strictly comply with the provision of therapeutic activity as defined in the context of this study or the provision of social or recreational activity.

Dr John described his role in the provision of the therapeutic activities as follows:

> *"I often encourage people in ward rounds to engage in activities. And especially, people who are admitted informally* (Dr John, Consultant).

The weekly ward round was a formal meeting between the multidisciplinary team and each of the service users. It was held as a forum in which a service user's progress is discussed, together with changes to his/her care plan and plan for discharge. Dr John indicated that he took the opportunity during this meeting to encourage the service user to attend the therapeutic activities. Some service users were also given leave by the doctor to be able to attend these sessions during the ward rounds. The emphasis he placed on the informal service users was on the fact that they do not require leave to be granted to attend these sessions. However, in his experience, most of them were more likely to choose to do other things than to attend the therapeutic activities.

However, the nursing staff's description of the allocation of their time and duties on a daytime shift indicated that facilitating service users' engagement in therapeutic activities was of relatively low priority to them, especially when working with limited resources, as Victor explained:

> *"In the morning when the shift starts, automatically two people have been taken out of the equation [for medication], if there is a one-to-one, you don't get an extra staff, so you've literally got two people, one person who will be in the office to take phone calls and there is another one serving breakfast"* (Victor, Nurse 1, PAR 4, L. 952 p. 49).

From his quote, it is evident that an "essential duty" of the nursing staff was to ensure that service users get their morning medication at the start of the shift and this took precedence over all other nursing duties. He mentioned that this task required two registered nurses, leaving the other three nursing staff to carry out

all the other duties which included administration, monitoring breakfast (served by staff) and performing close or enhanced observations for service users when required. The way these duties were allocated indicated that, for the first two hours at the start of the shift, there was less scope for nursing staff to be available to facilitate a therapeutic activity for any service user who may require this. The therapy staff who were "expected" to facilitate therapeutic activities for the service users worked at specified hours, as indicated earlier. A glance at the therapy activity programme (Figure 6.2) revealed that most of the group sessions, either on the wards or in the basement, started at 10:00 am. From this analysis, it could be argued that facilitating the service users' engagement in therapeutic activities was not regarded as an essential role of the nursing staff on the ward at the start of the morning shift.

According to the ward routines, the Protected Engagements Times (PET) were scheduled for 15:30 to 16:30. PET are periods when the wards are closed to the public for staff (nurses and therapists) to spend time and engage with the service users (Nolan *et al.*, 2016; McCrae, 2014), a practice common in mental health wards. Elsie said she was the PET lead on her ward and the activities for the designated hour were facilitated by the nursing staff. However, Victor, who worked on the same ward that Elsie referred to, was very sceptical about the effectiveness of the PET programme:

> *"Eugene did mention, they are trying to introduce protected time engagement with the patient but that will never work, they will never work, and I am pessimistic"* (Victor, Nurse 1, PAR 4, L. 219 p.11).

His reservations were based on how the PET conflicted with facilitating smoking breaks for the service users. He also felt that, although the PET was a good

programme, the workload on his ward made it difficult to implement. There are several ways to understand his pessimism, which is explored further in the discussion chapter. It could be due to the impact of the built environment, institutional policies on the staff's day-to-day work, or the priority given to completing tasks other than engaging service users in therapeutic activities. In the box below is an extract from my fieldnotes where a staff expressed pessimism that the information that I would be gathering for this research would not be used to effect any change in their service.

> "One staff asked a question, so after this what is going to happen? [This question was asked after I requested if she would complete the questionnaire]. I attempted explaining with reference to the PAR and how we intend to act with it. She replied, this is what people always come and do and after the study ends, they hear nothing or no change occur".

Fieldnote 3: 11/05/2018

The argument presented thus far reflects why I chose the particular subtheme that I did for this section, by asking whether engaging the service users in therapeutic activities was regarded as an essential role for all the staff or whether it was just seen as nice to have as an 'add-on', if there is sufficient time, capacity or interest. The next subtheme further reinforces this point about the priority that is given to therapeutic activities by discussing the 'walk, talk and explore' community group

6.2.3: "ONLY ONE WALKING GROUP AT THE MOMENT" AT THE ACUTE UNIT

One of the therapeutic activities that were on offer at the acute unit was a walking group. It involved a weekly facilitated three-hour community 'walk and explore'

group that service users from all three wards could join. The aim of the group was described by Eugene as:

> *"to do with the fact that people need to come out of the ward and have fresh air and exercise".*

He continued:

> *"To be honest with you, there is only one walking group at the moment. I facilitate; myself and (…) and it's for three hours on Wednesday, and it works quite well"* (Eugene, Therapy staff 1, PAR 4, L. 650 p. 38).

To elaborate on Eugene's quote, it was commendable that provision was made for the service users to walk and explore the local community to get exercise and have a change of environment. However, at the time of data collection in November 2018, there was only one such group available, for the approximately 54 service users on admission in the three wards. The facilitated walking group had a structure to it, took place in the company of other service users, and could last for up to three hours. It was usually facilitated by the therapy staff and they occasionally got support from nursing students from the wards, implying that the nurses and health care assistants did not participate in the walk. When this was discussed in the PAR 4 group meeting, Victor indicated that he would love to partake in this session, provided the ward was adequately staffed. He acknowledged the health benefits of this activity for the service users but his risk assessment indicated that additional resources may need to be in place to ensure the nursing staff could take part:

> "*If on that particular day…provisions could be made for an extra staff to be booked purely for that purpose… all these things could go a long way in benefiting the patients but again because of funding, you know there is not*

> *even enough staff on the ward"* (Victor, Nurse 1, PAR 4, L. 703, 718 pp. 36- 37).

The nurse's role in facilitating this group at the time of data collection was reported by Eugene to be ensuring that the service users' leave forms were signed by the consultant. This was a pre-requisite for the formal service users before they could join the group:

> *"I mean things got better, when nurses even come upstairs and run around to get leave cleared from consultants, I mean they do what they can"* (Eugene, Therapy staff 1, PAR 4, L. 844 p.43).

Victor was also surprised at the level of risk that the facilitators took upon themselves, i.e. the staff to service users' ratio, while in the community. Eugene and another member of the therapy team were regulars in this group and could have up to six service users (formal and informal) with them. Victor was concerned about what would happen if a service user decided to go back to the acute unit or an incident occurred when the group was out in the community:

> *"How do you expect such people, if, say like crisis breaks out while they are out there, how do you expect them to deal with that and that can be more dangerous, you know that can be quite risky"* (Victor, Nurse 1, PAR 4, L. 709 p. 36).

He expressed concern that the low staff to service user ratio while they were out in the community was not ideal and that the staff numbers needed to be increased. If the session had been held on the acute unit premises and an incident occurred, then the alarms could be activated to summon additional help. However, that would not be possible in the community. Eugene added that they had been working with these ratios for the community walking group for about 18 months and had not recorded any major incidents. This made them feel more

confident in their risk assessment and their approach to engaging the service users. He pointed out that they constantly risk assessed and liaised with the nursing staff to ascertain whether the service users were well enough or posed a sufficiently low risk to attend the session. This point is further addressed in Chapter Seven about the tension between risk, security, and engagement in therapeutic activity in the acute unit.

This section on therapeutic activities at the acute unit has portrayed a setting in which staff provide therapeutic activities for the service users. Although the staff roles varied, they each had a part to play to ensure that the service users were able to engage in therapeutic activities. The evidence gathered which showed that therapeutic activities took place on the wards included the ward activity timetable, the sessions conducted by art psychotherapists, the quotes from staff who attended the PAR group discussion and my observation of facilities like table tennis and board games taking place on some wards. However, the challenge lay in facilitating these sessions for the service users. It was perceived that the occupational therapy staff, therapy staff 1 and the art psychotherapists were responsible for providing these sessions for the service users, although their work pattern of 09:00 to 17:00, Monday to Friday, meant that some additional time needed to be covered by other staff who were present outside of the core hours. I next explore the third main theme: staff working relationships and their impact on the service users' engagement in therapeutic activities.

6.3: INTERPERSONAL RELATIONSHIPS OF STAFF AND SERVICE USERS AT THE ACUTE UNIT

This theme presents the findings related to the staffing of the unit, working relationships, the perceived relationships with the service users, and how these factors impact the service users' engagement in therapeutic activities. The hospital employed both qualified and unqualified staff. As discussed in previous sections, the staff comprised the ward staff with the doctors and the nursing team and the therapy team which constituted the occupational therapy team, psychology team and the art psychotherapy team. In total, there were about 60 staff as of July 2017. The subthemes discussed are staffing levels, teamwork, perceived decision making and communication.

6.3.1: STAFFING LEVELS

As indicated earlier in Chapter 3 concerning the study site, there were five nursing staff (qualified and unqualified) per shift to the eighteen service users on the wards during a day shift, as well as the ward manager, an allocated occupational therapist, and an associate practitioner. The participants in the PAR group discussion perceived that this ratio was sometimes too low and it was more difficult when they had to work with temporary staff (agency and bank staff) to make up the numbers, which happened when a permanent member of staff could not come in:

> *"What actually tends to happen is that, when the ward is short-staffed, … when a bank staff nurse comes, at a time even though they probably will be paid more than I do, I end up having to do all the work because a lot of them don't have a clue."* (Victor, Nurse 1, PAR 4, L. 296 p.15)

Victor's perception was that the temporary staff simply boosted the numbers but did not help to get the work done. Some temporary staff were new to the acute unit and so were unlikely to know the service users and the ward routines, hence they required support from the permanent staff. The ward staffing level was compared unfavourably to what it had been when the Psychiatric Intensive Care Unit (PICU) had existed and staff felt there was a higher staff to service user ratio. As a result, they had more time to engage with the service users. Staff attributed the closure of the PICU to the restructuring within the NHS Trust. In this thesis, I discuss the issue of the closure of facilities within the NHS in detail in the discussion chapter.

The staff acknowledged that, although the two wards (acute and PICU) were different, the level of service users' mental health problems was similar. Therefore, the staffing levels should also be similar:

> *"To be honest, the level of acuity, probably is still the same, like the PICU patients but is just that, we have no PICU, we have forensic patients"* (Elsie, Occupational therapist 1, PAR 4, L. 519 p. 26).

Eugene added:

> *"You can go to the ward and you can feel the atmosphere when you've got new staff in, maybe a bank or inexperienced nurses and you can see the environment"* (Eugene, Therapy staff 1, PAR 4, L. 219 p.15).

The therapy staff also reported having limited administrative staff support and, as a result, spent part of their time on administrative duties like making room bookings and facilitating door access for the service users to attend sessions in the basement. This was because the administrative staff for the therapy team

worked part-time, and so were often not available when needed, as Henrietta explained:

> *"At the moment I rarely see admin staff on the ward, so is the nursing staff sitting in the reception sorting out the cigarettes, answering calls and opening doors for visitors*" (Henrietta, OT 2, PAR 5, L. 714 p. 23).

The therapy team also mentioned having lost associate practitioners (AP) due to job cuts which saw their numbers reduced from six to three, to make savings within the NHS. As a result, they could not organise as many sessions as they used to do:

> *"There were a lot more ward-based groups when the other associate practitioners were around"* (Elsie, Occupational therapist 1, PAR 2, L. 474 p. 21).

Due to the insufficient numbers of the therapy staff, they described struggling to facilitate therapeutic activities when a member of staff was off sick, on training or on annual leave. Henrietta voiced her concern about covering timetabled activities:

> *"Hopefully, we will have a well-organised timetable and when we need covers, we will find someone to cover the groups when you are on holiday*" (Henrietta, Occupational therapist 2, PAR 3, L. 147 p.8).

She explained that it was standard practice at the time, when a member of staff was off, for other members of the team to cover their sessions. If they could not do so, then the sessions were cancelled. Henrietta appeared to be asking for an additional hand when a team member was off, such as using bank or agency staff to help ensure that all the sessions were well covered, a practice that was common among the nursing team, although it brought its challenges, as discussed previously.

In summary, regarding staffing levels, the staff perception was that the staff numbers on each shift seemed inadequate to be able to provide the high level of support required by the service users. This is further explored in reference to the factors that determine nursing staffing levels on an acute mental health ward in the discussion chapter. At the time of the data collection (November 2018), there was an ongoing safeguarding investigation at the hospital that resulted in about six nursing staff being suspended. This may have contributed to the short staffing among the nursing teams on the wards. The staff indicated this was an exceptional case and that it had had a major impact on staffing levels at the acute unit. In the key informant interviews, both the ward manager and therapy team lead reported there was an ongoing discussion aimed at trying to get the therapy staff to be based on the wards to a greater extent to provide therapeutic activities for the service users. The next subtheme explores the interaction between staffing levels and the service users' choice to smoke on the service users' engagement in therapeutic activities.

6.3.2: "HOW ON EARTH ARE YOU ABLE TO?": FACILITATING SMOKING BREAKS

In this section, the majority of the views quoted are Victor's and come from PAR 4 as he was the new addition to the PAR group. He raised the issue of smoking and its impact, which added a new perspective to the factors within the environment that impacted the service users' engagement. The other therapy staff present also contributed to this discussion and I have included quotes from them, as well as the views gathered from participants in the key informant interviews. The effect of the service users' personal factors on their choice to smoke was discussed earlier in this chapter. The focus in this section is on the

issues the staff faced as a result of the implementation of the smoke-free policy with the limited resources available. Victor recounted the challenges the nursing team experienced in facilitating smoking breaks for the service users after the implementation of the smoke-free grounds policy at the acute unit:

> *"A lot of the time, you have like seven patients who have been given leave to be escorted by a nursing staff and how on earth are you able to …, half of them being given escorted leave. How are we able to facilitate all these? "*
>
> *"…Problem is like, is difficult to manage, when you have got challenging people, who want to make smoke breaks, every half an* hour (Victor, Nurse 1, PAR 4, L. 191 p. 10).

Most of the time on the ward where he worked, Victor described that up to a third of the service users may be smokers and would therefore need to be escorted outside of the ward due to their formal status resulting from being sectioned under the Mental Health Act. The greatest challenge, Victor explained, was the frequency with which the service users wanted to be escorted outside the acute unit to smoke. On average, some service users were given up to four escorted leave breaks (15 minutes each) per day by the Consultant, at "nurse discretion", which could be used for smoking. Although the ward teams had suggested sometimes at which the service users could be escorted outside to smoke, the decision usually lay with the nurse in charge. The phrase "nurse discretion" therefore placed the responsibility on the nursing staff to negotiate with service users when it was not possible to immediately grant their request to be escorted to smoke outside.

The other challenge that staff faced regarding leaving the wards to facilitate service users' escorted leave for smoking was the reduction in staff numbers on

the wards. Usually, there was a ratio of five nursing staff to the eighteen or nineteen service users on the wards during a daytime shift. Therefore, if a staff member escorted two of the service users off the ward to smoke, it would leave the ward short-staffed:

> *"If you take somebody out of the building for smoking, even if it is for a period of 10 - 15 minutes, anything can happen while you have left the ward, that means, if say, a fight broke out between two patients, your support has been taken away, from the ward"* (Victor, Nurse 1, PAR 4, L. 40 p. 2).

The other implication is that it would leave a few staff available to engage the other service users in other activities:

> *"And by so doing, reducing the number of staff on the ward. So, if you are talking in terms of having quality time with patient"* (Victor, Nurse 1, PAR 4, L. 218 p. 11).

The staff reported that the implementation of the smoke-free grounds policy changed the culture of how things were done and placed extra demands on them. It was described that, at busy times or when the nursing staffing levels were low, some inappropriate practices had been observed concerning escorting service users to smoke. The following example was shared by Henrietta:

> *"To be honest, I have seen before, when there was an HCA who was taking four or five patients out by themselves, and I have seen that quite often, and I was just like that's so risky"* (Henrietta, Occupational therapist 2, PAR 4, L. 765 p. 39).

Henrietta explained that she witnessed the incident in the reception area and had not been involved in any risk assessment that had been carried out on the ward. However, based on her professional knowledge and experience of having worked at the acute unit for 11 years, she recognised that it was very risky for the staff

member to take several patients out at the same time. Her main concerns centred around what the staff member would do if a service user decided to abscond.

She was also concerned about who had allowed it to happen. Although she did not do anything about the situation, she felt that it was very inappropriate. However, she said she could empathise with the nursing staff on the wards who were probably very short-staffed and had to deal with service users demanding to go out and smoke. This point is further discussed in Chapter Seven about how unsafe practices continued because staff could understand why they were happening. The likeliest explanation was that they constituted a kind of compromise to try to make things better for the service users, and easier for staff, but with potential risk to everyone. Victor agreed that these instances sometimes happened on the wards and suggested:

> *"What is even sad is that a lot of the time some of these staff, as you clearly said, you know may be bank staff, probably do not even get the chance to read any patients notes. Half the time, bank staff don't get a chance to even sit down and read the patients' notes"* (Victor, Nurse 1, PAR 4, L. 825 p. 42).

In summary, the personal factors involved in the service users' choice to smoke conflicted with the resources available and impacted their engagement in therapeutic activities. The next section explores how the teams at the acute unit worked together.

6.3.3: "A DEFINITE BREAKDOWN … ACROSS THE TEAMS"

The participants shared examples of good teamwork within the teams who worked at the acute unit. Henrietta recounted that the occupational therapy team came together to deep clean the ADL kitchen when they felt it was required instead of waiting for the cleaning services. She indicated that they might have had to wait a long time for the cleaning to be done otherwise.

> *"We did as a team, for the kitchen cleaning. It was me, … and …, we did that together"* (Henrietta, Occupational therapist 2, PAR 2, L. 103, p. 6).

Dr John shared he had a good working relationship with the therapy staff, and he valued the useful feedback they provided that fed into the team's assessments of the service users:

> *"I've close contact with occupational therapists and some of the other therapy department" … "[they] also contributes to the assessment process, because is not like I see the patients every single minute that I'm here, I values the feedback I get from the therapists in the groups"* (Dr John, Consultant).

Peter also shared his experience:

> *"I think for Ward B, we've been working perfectly fine and I can attest that because we've got a dedicated occupational therapist. I will go down to the basement floor and ask the OTs to come and base themselves on the ward".* (Peter, Ward manager)

The emphasis he placed on going down to call the occupational therapists and asking them to come to the ward related to an instance when they were short-staffed and felt they could benefit from the additional help of the occupational

therapy team. Despite these examples of collaborative working among the teams, in the PAR group meeting, some staff expressed the view that the MDT did not work together. As indicated earlier, the staff in the PAR groups worked in different wards, and hence they shared different experiences:

> *"So, there is a definite breakdown [of teamwork] within the hospital among the teams, not so much internally in teams but across teams in terms of what OTs, nurses, doctors do. Feel like you are banging your head against a brick wall"* (Eugene, Therapy staff 1, PAR 2, L. 178 p.8).

Eugene had only worked at the hospital for just under a year (he joined in July 2018), and he indicated that he was still getting to know most of the staff from the three wards that he worked on and perceived that the professional groups worked well among themselves in their small teams but not as well with others outside their team. For instance, he constantly had to explain his role to the other staff outside the occupational therapy team. His use of the expression, "banging your head against a brick wall" meant that, if other staff do not know what role he played in the service users' care, how could he get the support he needed and work with them collaboratively. Other participants (Elsie and Henrietta) who had been working at the acute unit for longer also expressed a similar sentiment:

> *"Because they [ward staff] do not understand the role or the reason why we attend that group, ... I think they just often pick people, random allocation or not allowing patients to come*" (Henrietta, Occupational therapist 2, PAR 2, L. 464 p. 21).

The issue identified by Eugene and Henrietta here concerned the multidisciplinary team's understanding of each other's roles which, Eugene felt, could account for why some service users did not get referred for certain therapeutic activities. Within the literature review, I reported similar findings from

two studies on nursing staff perceptions of the role played by occupational therapists and psychologists (Wood *et al*., 2019; Smith and Mackenzie, 2011). The relevant arguments are explored further in the discussion section.

About conflicts among staff, Henrietta shared another experience. According to her narrative, she had planned a cooking session (part of the occupational therapy assessment) with a service user to be held in the ADL kitchen in the basement. The service user she referred to had been motivated to attend the session in the morning when she arrived at the ward. However, it was not clear whether this information was communicated to the nursing team to be put in the ward diary. The service user had to take his medication before he could leave the ward, for which there was already a queue. She interacted with the nurse to ask if the service user could go to the front of the queue, so that he could take his medication and leave for the session, but received the following negative response: *"* if he has to wait, he has to wait*"*. She felt the nurse could have accommodated her request if they were working collaboratively. However, while waiting, she observed the following:

> *"So we stood there and there was someone [a service user] who jumped the queue".* (Henrietta, Occupational therapist 2, PAR 3, L. 110 p. 6).

Thus, the nurse offered another service user the opportunity to take his/her medication ahead of the others, even though it was not his/her turn. Eventually, after a long wait, the service user decided not to attend the session, the impact of which Henrietta described as follows:

> *"Would delay an assessment, which in turn delay the discharge of patients"* (Henrietta, Occupational therapist 2, PAR 3, L. 117 p.7)

In working together to facilitate therapeutic activities for the service users, the therapy staff reported unnecessary delays from the ward staff that could have been avoided. For instance, formal service users on the ward required leave to attend the walking group sessions off the wards, but Eugene explained:

> *"Sometimes is like, we have to wait for the doctors to fill the leave form or do the gym form for patients to access groups."* (Eugene, Therapy staff 1, PAR 2, L. 446, p. 20).

These two examples of other staff delaying service users' engagement in therapeutic activities suggests issues with team work rather than the service users' factors or choices, as discussed with the first theme. As a result, the therapy staff felt their sessions with service users were sometimes undermined. They perceived that the ward staff undervalued their involvement in service users' treatment. However, the doctor and ward manager who were interviewed did not agree and referred to there being a good working relationship with the therapy team. Elsie cited an instance whereby a service user was called out from a ward group session to attend a meeting. The occupational therapy staff facilitated groups with service users on the wards, which usually lasted for an hour. When these sessions were held, there could also be other activities going on such as ward rounds, which meant that usually service users were called away from their session. Elsie expressed the view that it would be helpful if the ward staff could recognise the value of their sessions and wait for the group to end before asking the service user to leave:

> *"So, if there is, for instance the ward round, and that person is in the music therapy session or a group of some sort, they are not to actually call people out of groups because that is part of their treatment, so is about*

> *valuing that treatment* (Elsie, Occupational therapist 1, PAR 3, L. 268-270 p. 14).

The two scenarios of Henrietta getting the service user off the ward in time for the cooking session and the ward staff taking service users out of the group to attend the ward round were used as evidence by the therapy staff to conclude that the nursing staff could get the service users to engage with them at any time but the same could not be said of the therapy team. This provides another example of the conflict that the staff experienced in working with the service users in the acute unit that impacted their engagement in therapeutic activities.

This section has explored the theme of the working relationships between the staff at the acute unit. This can be characterised as a mixture of sometimes working together and at other times not. It should also be noted that most of the issues raised are from the therapy staff's perspective. The challenges in recruitment partly accounted for this as some of these issues were not further discussed when the nurses attended the PAR group meetings. Therefore, this constitutes one of the limitations of this study.

From my experience of conducting this research at the acute unit, I observed a similar pattern regarding the working relationships between staff, especially across the team. It was known at the acute unit that the study was led by the occupational therapy team. The therapy team were very supportive and volunteered to complete the questionnaires as well as sign up for and commit to attending the PAR groups (refer to Table 5.1 for PAR group attendance). However, it was very challenging to recruit from the wards, especially for the PAR group, which resulted in the amendment to the ethics approval. On the positive

side, the staff that I recruited did work well together within the PAR group meetings, for example completing mapping activity 1 and showing respect to each other. Like any group, I observed differences in perspectives between the therapy staff on some issues, like the locked doors in the basement, which is discussed in the decision-making section. However, in one session where only staff from the occupational therapy team were present (towards the end of PAR 2), I observed that staff were more open in their discussions, due to a sense of having a communicative space (Kemmis and Wilkinson, 1998) in which they could talk freely. The next subtheme explores the perceived decision-making processes used by the teams in the acute unit environment from the participants' perspective.

6.3.4: "TOOK IT AWAY WITHOUT ANY CONSULTATION": DECISION-MAKING PROCESSES

During the recruitment and data collection stages, I attended various staff meetings including profession-specific team meetings, handover and ward rounds, as described in Chapter 3, Table 3.1. These forums discussed service user care and the service provision at the acute unit, indicating that there were opportunities for staff to discuss ideas and make decisions. The ward manager confirmed in his interview that the staff meeting took place once every fortnight on his ward. In the PAR group discussion, however, there was a perception that some teams took decisions without considering the implications for other teams that worked within the environment. Two examples were used to illustrate this point. The first related to how a decision was made that the basement door was

to be locked all the time. It concerned the two team leads who worked in the basement.

Ulric described the sequence of events as follows. There was an incident with a service user absconding from the ward and the escape route he/she used included the main basement door and others. After the service user's unsuccessful attempt to abscond, Louisa and the occupational therapy team decided that the door needed to be kept locked and access was only to be granted by a key that the staff had already. As the team lead for the other team, Ulric felt they should have been consulted to suggest possible solutions as they were also users of the basement, as he explained in the following excerpt:

> *"I think as a knee-jerk reaction, she wanted the door closed, locked, they took away the little key which can allow you to put the thing on the latch, they took it away without any consultation"* (Ulric, Therapy staff 2, PAR 2, L. 86 p. 4).

He alleged that Louisa had a "knee-jerk reaction" in terms of her decision making, by immediately presenting what she saw as a solution in response to an adverse event, without consulting others sufficiently. He described how the door closure had a knock-on effect on his team and they decided to temporarily suspend a group held in the basement on Fridays because the service users could not get into the basement without the staff facilitating access. They did not have the staff capacity to manage access via the door. He concluded that issues were discussed, and decisions were taken within teams, but there was not enough discussion between teams.

The second example was the management decision to partition the pottery room to create an additional office space for the estate personnel to move into. The

therapy staff felt their views were not taken into consideration and that led to the loss of the use of the sink and tap, as described in relation to the physical environmental factors. They felt that the management simply took the decision and went ahead and implemented it:

> *"When they [management] decided to put the door there, I think there was suggestion about having a door instead of having a full wall, have a door in between…, if people want to have access to the sink, they can* (Henrietta, Occupational therapist 2, PAR 2, L. 566, p. 25).

The staff that used the pottery room indicated they were not against the room being divided into two. However, the difficulty for them was how they could access the sink and the water if they were running pottery sessions, hence the recommendation that there should be a door instead of a solid wall. With regard to the ward environment, Victor revealed that he struggled whenever he was on a ward round with one of the consultants because his suggestions were not taken into consideration:

> *"I believe that, ok, like most of the time the main decision-making lies in the hands of the consultants … but we are supposed to be working as a team, as a multidisciplinary team and because of that everybody's view is important"* (Victor, Nurse 1, PAR 4, L. 891 p. 46).

As a result, he had stopped attending the ward round, if he knew that the consultant was going to be the chairman. The ultimate decision-making power regarding service users' care was perceived to lie with the consultants at the acute unit. This was confirmed by the consultant:

> "*Yes, I mean I do have to give the final say, if someone can go on the walk*" (Dr John Consultant).

This situation whereby the therapy staff were waiting on the doctors for a final decision, as described above, made them feel they had no part in the decision-making process, adding to the feeling of being undermined and ignored. It could impact on the service users' engagement in therapeutic activities too, for example if they were waiting for a service user to be given leave before joining the community 'walk and explore' group. The final issue relating to decision making was bureaucracy, which was discussed in terms of the processes for requesting repairs and replacement of broken resources.

> *"I did actually put maintenance, getting things repaired and equipment and [the] bureaucracy in fixing equipment"* (Elsie, Occupational therapist 1, PAR 2, L. 432 p. 19).

Elsie explained that the length of time it took for a maintenance request to be actioned and implemented was unnecessarily long, and involved making an initial online request, plus follow-up calls, which was time-consuming. Eugene discussed the bureaucracy in terms of who was allowed to do what within the environment concerning the health and safety policies. He believed there were some repairs that he could easily have fixed but the acute unit policy did not allow him to do since he was not a certified person to carry out the work:

> *"As I said, if you give me a hammer and a tool, I will probably go around and fix half of the problem, is that easy, then the bureaucracy will set in that, you can't do that, you not [allowed], health and safety"* (Eugene, Therapy staff 1, PAR 2, L. 324 p. 15).

The other staff present (Henrietta, Elsie and Ulric) smiled in response to this statement, especially the suggestion that he would have loved to fix the oven. That seemed to be their first instinct too, as most of them would have done so in their own homes, but they were aware that this was an institution, which meant

that they had to follow set policies. The underlying issue of who was authorised to carry out maintenance work is largely related to the health and safety concerns and the division of labour within the acute unit. Staff are employed with specific responsibilities and are expected to work within the scope of their contract, although they may have other skills too. Following further discussion of the institutional measures that were in place to address maintenance issues, Elsie stated:

> *"Even for a little electrical appliance, you have to get it tested by some random person"* (Elsie, Occupational therapist 1, PAR 2, L. 327 p. 15).

From these discussions, it was clear that the staff were dissatisfied with the organisational structure and the processes that had to be followed to get equipment fixed when it was broken, from the time it took after a fault was reported, to the various people who needed to approve. This could also be looked at from a financial perspective and the impact of scarce resources because usually obtaining authorisation meant getting financial approval. From my analysis as an outsider researcher, these factors could be summarised as constituting some of the institutional restrictions common in organisations like the NHS, which sometimes come into conflict with staff trying to do their work. It also demonstrated signs of the neoliberal capitalist perspective adopted in healthcare management which was mentioned as a major policy change in the healthcare context after deinstitutionalisation (Gooding, 2016), for example the privatisation of an aspect of healthcare such as maintenance. I address these institutional restrictions, the perceived excessive bureaucracy and the influence of neoliberal capitalism in the discussion chapter.

6.3.5: COMMUNICATION WITHIN THE ACUTE UNIT

The final sub-theme on the interpersonal relationships within the acute unit explores the communication within the social environment. Communication was identified as a key issue within the acute unit and was perceived as a factor affecting the decision making and collaborative work within the MDT. In this thesis, I have reported staff discussions on communication through the ward community meetings and other channels through which staff receive information. This section ends with a brief overview of how some staff communicated with the service users:

> *"There is no team meeting on my ward, the team meetings kind of occur ad hoc, so I never know when it is happening, is usually just the nursing team"* (Elsie, Occupational therapist 1, PAR 3, L. 261–263 p. 14).

Elsie suggested that communication among the MDT and with service users could be improved if the MDT prioritised attendance at the ward's community meetings. Recorded in September 2018, her quote expressed her frustration about not being able to get the staff on her ward together to pass on information from the ward community meetings. The community meeting is a forum where staff and service users of the ward come together to discuss issues and take action. Staff in the PAR group reported that this meeting was usually attended by the service users, occupational therapy staff and some nurses and health care assistants. The doctors and management staff rarely attended. Elsie, who usually facilitated this meeting on her ward, said the service users always requested other team members to be present, so that they could directly address issues:

> "*the community meeting is supposed to be for the whole community, and sometimes we don't get representatives from each [of] the other*

> *disciplines. It just us [occupational therapy staff], and we think we cannot answer all the questions*" (Elsie Occupational therapist 1, PAR 3, L. 228 p. 12).

It was standard practice at the community meeting for notes to be taken by the occupational therapy staff present and later communicated to other MDT members who needed to be aware of the issues and act on them. Henrietta expressed her views about the perceived poor attendance at these meetings:

> "*I feel some of my ward staff will be avoiding going to the meeting because of the [complaints], I mean, they might just come in, sit down, try and get involved and get all kinds of complaints from the patients*" (Henrietta, Occupational therapist 2, PAR 3, L.242 p.13).

Henrietta explained that this meeting was characterised by the service users reporting things not working on the wards and the acute unit. The absence of other MDT members and the ongoing issues raised compounded the problems. To her, the acute unit environment could be much improved if staff attended these meetings, took the complaints as and when they were made and actioned them. However, in his key informant interview held in April 2019, Peter (ward manager) provided a different perspective on the non-attendance of other MDT members at the community meeting. In the case of doctors, he said that, in the past, service users had raised their confidential treatment issues at the community meeting and expected them to be addressed:

> *"Also pushing for doctors to come in but it becomes kind of argumentative"* (Peter, Ward Manager).

Peter also added that the acute unit bed managers' meeting was scheduled at the same time as the community meetings, which explained why other key staff could not attend. Regarding his ward, he explained that there had been an

improvement and that staff meetings were held every fortnight, although the details of therapy staff's attendance were not shared. From the discussions and views gathered from the various staff, I realised that, although the community meeting is an important forum, many factors combine to determine its success or failure.

Concerning communication channels, I gathered that the acute unit had various forms of communication for the staff other than organising face-to-face meetings. In the case of the wards, the ward manager identified that sometimes staff did not make use of the other communication channels available to acquire information themselves, but instead just waited for the staff meeting to receive this information. He also mentioned the NHS Trust and the acute unit newsletters, which were sent by email, and the ward diary as other forms of communication:

> *"So yes if you check your emails, the newsletter is there, good things coming up. The division, whatever they are planning as an organisation, if you don't check your email you wouldn't know, until you wait for two weeks at a staff meeting"* (Peter, Ward Manager).

6.3.5.1: COMMUNICATION WITH SERVICE USERS

This section provides a brief overview of how the staff reported that they communicated with the service users. On admission, the service users were given an information pack about the ward that included the ward schedules and activities. Louisa (Team lead) said that they sometimes had to modify the initial information to make it simpler, taking into consideration that some of the service users may be very unwell during the initial assessment. There was usually information about the therapeutic activities on offer so that the service user can choose which ones he/she would like to attend:

> *"We might just identify some things [therapeutic activities] and maybe give [it to] them. Write on a separate sheet and just give them a sheet with it so they can remember*" (Louisa, Team lead).

However, Josephine thought that there was limited information available to service users on her ward:

> *"We don't even have the information leaflets available on the ward anymore. It seemed to be ripped off and it never been replaced. So, all the medication leaflets are not freely available on the wards, so stuff are not even there"* (Josephine, Health care Assistant, PAR 1, L. 83 p. 5)

In her view, the posters in the open access area provided useful information to the service users about their medication. Those service users who could read were directed to them to gain a deeper understanding of what medication they were on. She, therefore, suggested that such information could be made available on a poster or small leaflets and left in an accessible part of the ward for the service users. She wanted to work on this project as part of her actions to come out of participating in the PAR group meeting, but sadly she became unwell

so she dropped out of the PAR group, which provides an example of the challenges involved in conducting participatory action research.

The other communication issue affecting the service users involved passing on information to them about the self-directed occupation box containing board games, cards, colouring activities, and books. These were usually kept on each ward and the service users had to request them from the nursing staff if they wanted to use them. The therapy staff felt that if the service users were made more aware of these items, it could reduce the number of complaints about being bored in the evenings and at weekends. However, there was also a concern that some of the nursing staff were not even aware of the existence of these activity tools on the wards:

> *Despite how many times you say, there was something that you can ask the nurse, you go, you get it. It depends on who is at the ward reception and who know they are there …. or remember the box* (Henrietta, Occupational therapist 2, PAR 2, L. 496 p. 22).

6.3.6: CHAPTER SUMMARY

This findings chapter has focused on the social environment of the acute unit. It helped to address the aim of exploring the social relationships that existed among the users of the acute unit and how this impacted the service users' engagement in therapeutic activities. In summary, there were instances of co-operation and conflicts among the staff working in the acute unit. The personal factors and choices of the service users were sometimes in conflict with policies and the extent to which staff could support them. This also impacted their ability to engage in therapeutic activities, for instance, if service users chose to smoke, they had to be escorted by staff, which impacted staff time. The national smoke-free grounds policy placed extra demands on the ward staff's time when facilitating smoking. Staffing levels were also identified as an issue about the staff to service users' ratio necessary for engaging in therapeutic activities. This was also perceived as impacting adversely on sessions like the walk and explore community group. The chapter also examined relationships within the multidisciplinary team and found that the communication and decision making of the staff tended to impact each other, which sometimes led to conflicts between the teams. Finally, it was suggested by the staff that improved communication between themselves could help enhance some of the interpersonal challenges that impacted service users' engagement in therapeutic activities. In the next chapter, I have an introduction section that summarises the main findings from the two modules of this study, as reported in Chapters Four, Five and Six of this thesis.

CHAPTER SEVEN

DISCUSSION

7.1: INTRODUCTION

7.1.1: SUMMARY OF THE INTEGRATED FINDINGS FROM MODULES ONE AND TWO

As described in Section 3.4.3, the explanatory sequential design of mixed methods (Creswell and Clarke, 2018) was adopted to structure the data collection. Creswell (2014) suggested that after the quantitative and qualitative data have been collected and analysed in a mixed methods study, they should be integrated and reported together. This helps the researcher to form a complete picture of the findings gathered from the study. For example, it helps to know whether a finding from the quantitative data is supported by or contradicts those reported in the qualitative data, especially when the same participants were sampled. I present the three key findings from the survey, the PAR group discussions and the key informant interviews from Chapters Four, Five and Six of this thesis in Table 7.1. The complete table with the selected quotes, confirmed hypotheses and additional evidence are shown in Appendix AG. In Table 7.1, each key finding is listed, followed by three columns showing the relevant themes and subthemes (in a different font) and a number indicating the findings chapter that each one has been drawn from.

Table 7.1: Three key findings with subthemes from the three findings chapters

1. **Service users' engagement in therapeutic activities was limited by the building not being purpose-built and designed as an acute inpatient mental health unit**

Historical use of the acute unit building (5) Dissatisfaction-access to garden, outdoor facility and noise (4)	Impact of the physical layout of the building (5) Access to daylight, ventilation and thermal comfort (4) Hemmed in (4) Claustrophobic	Impact of the physical layout of the building (5) old equipment and breakdown Staff vision for an ideal working space (5)

2. **Service users' access to spaces within the acute unit to engage in activities was compromised by the formal systems and policies in place such as: locked doors, booking systems, and the smoke-free grounds policy.**

Impact of the physical layout of the building (5) Impact of the security features of the acute unit Staff control (4) perceived as high	Use and availability of space (5) lost space "Hemmed in": less freedom (4) Interpersonal relationships at the acute unit (6) [smoking facilitation & choice to smoke] Service user personal factors (6)	Use and availability of space (5) Designing spaces for specific use Staff vision for an ideal working space (5) no locked door, no booking

3. **Staff assigned profession-specific roles and responsibilities impact the facilitation of therapeutic activities for the service users.**

Staff ability to influence the environment (5) Context of therapeutic activities (6) Staff assigned roles Interpersonal relationships at the acute unit (6) [smoking facilitation & choice to smoke] Service user personal factors (6)	Interpersonal relationships at the acute unit (6) staffing levels Context of therapeutic activities (6) Therapeutic activities: essential or nice to have	Interpersonal relationships at the acute unit (6) Decision making and communication (teamwork) Context of therapeutic activities (4) Ward staff versus therapy staff on WAS

7.1.2: USING TRIANGULATION

This table (7.1) was developed through methodological triangulation which compared the findings from the different strands of the data collection. Triangulation is one way in which the trustworthiness of a research study can be assessed by looking at how data was drawn from multiple sources (McNiff *et al.*, 2014). The fact that I commenced the data analysis immediately after the completion of the survey and after each PAR group helped to notice patterns in the data. It also indicated any additional data that were required to help meet the aims of the study. For instance, after PAR 2, I realised that data from the doctors and the nurses were missing, hence the amendment to the ethics approval of the protocol to allow for the increase in payment to the PAR participants and the inclusion of the key informant interviews.

Utilising methodological triangulation (Young and Piggot, 2014) also allowed the themes generated from the survey to be further explored with the PAR group to establish whether the views of the participants were similar or contrasting. In this regard, I found the staff still maintained that they were less controlling of the service users on the wards and that they only worked according to the acute unit's policies and guidelines. As an additional cycle within the PAR process, the PAR group members' views on smoking and the impact on the service users' engagement in therapeutic activities were further explored in the key informant interview with the NHS Trust deputy smoking cessation lead and the doctor. The doctor confirmed in his interview that he believed the service users have the right to smoke despite the implementation of the smoke-free grounds policy. The

smoking cessation deputy lead confirmed that the policy was difficult to implement, and also revealed that there was a further updated policy that was yet to be rolled out. I, therefore, take the aforementioned three key findings from Table 7.1 forward to indicate how they relate to the literature and to clearly this study's original contributions.

7.2: Overview of the discussion of the findings

In this chapter, I discuss the knowledge generated from this research study about the service users' engagement in therapeutic activities within the acute unit. This is presented as three sets of findings:

I. A building not purpose-built and designed as an acute inpatient mental health unit.

II. Engagement in therapeutic activities were compromised by the formal systems and policies in place such as: locked doors, room booking systems, and the smoke-free grounds policy.

III. Staff assigned profession-specific roles and responsibilities impact the facilitation of therapeutic activities for the service users.

This discussion enriches previous understandings about service users' limited engagement in acute units due to the impact of the physical and social environment, given that, within the literature, researchers have not exclusively focused on how the physical environment of a relatively old non-purpose-built facility impacts on the service users' engagement in therapeutic activities. The

discussion further highlights the occupational alienation experienced by the users of the acute unit due to the restrictions and challenges within the physical and social environment. In addition, I discuss the originality of the methodology used while critically appraising the strengths and the limitations of the study design concerning the quality criteria of PAR presented in Section 3.5 of Chapter Three.

Overall, this study has identified that the service users' limited engagement in therapeutic activities within the acute unit is a result of the incongruence between the physical environment provided and the model of care currently adopted for use in the setting. In this thesis, a 'model of care' is defined as: "an overarching design for the provision of a healthcare service that is shaped by a theoretical basis, evidence-based practice and defined standards" (NHS acronyms-glossary of terms online, 2020). It includes the systems, policies and guidelines that informed the practices within the acute unit. Regarding the three key findings, the incongruence is discussed first, from the perspective of the building's design as an acute unit and its fitness for purpose. The model of care adopted and how that impacts on the service users' engagement is then addressed. This is explained using the second and third key findings, namely: (i) the use of formal systems such as locked doors and booking systems, and (ii) the impact of staff assigned profession-specific roles and responsibilities, respectively.

Many perspectives lend themselves to the discussion of the integrated findings that emerged from this research study. The moral perspective, for example, examines how vulnerable people (mental health service users) are cared for

within society, taking into consideration the environment in which they receive care and how it is delivered. However, I did not interpret the findings through this lens as it would involve departing from the aim of this research, which was to explore how the acute mental health inpatient unit environment can impact the service users' engagement in therapeutic activities. Instead, I combine five different perspectives to understand the findings:

- evidence-based design
- pragmatic
- occupational
- political and economic
- organisational behaviour

I use a pragmatic perspective to explore the practicality of mental healthcare provision in urban areas like inner London. This includes contrasting the provision of care closer to service users' homes (Wood *et al*., 2013) with acquiring places that meet recommendations from the evidence-based design of a healthcare facility (Ulrich *et al*., 2008; Alfonsi *et al*., 2014). From an economic perspective, I examine the impact of neoliberal policies (Pollock and Price, 2011) within healthcare management to try to understand why the building was in its current state. I explain the neoliberal capitalist policy in further detail in Section 7.4.3 of this chapter. Meanwhile, a political lens facilitates the exploration of the impact on mental health services of government policies that were in place at the time of this research, with a focus on capital expenditure within the NHS. Using an organisational behaviour lens helps to gain insight into the rationale for the behaviours and the actions of the staff and service users in the acute unit. Finally,

the findings are interpreted from an occupational perspective, discussing mental health problems and occupational (in)justice.

The originality of this study resides with the findings and the methodology, specifically the use of PAR which enabled data to be gathered from various participants to gain a deeper understanding of the topic under investigation. For example, among the people who participated in the study were the service users and the MDT staff, while the use of mixed methods of data collection ensured that their diverse views could be captured. In addition, the fact that the research was conducted as a PhD study offered the luxury of time for the data collection to be spread over more than a year, from May 2018 to September 2019, to ensure adequate representation of all the prospective participants from the acute unit. Overall, the data gathered for this research over the stipulated period constituted the views of approximately 80 participants, 33 service users and 47 staff and students. As well as the study participants, various people were also involved throughout the different stages of this collaborative research. The study commenced with the establishment of a steering group of staff on the acute unit, several service users, and a university lecturer, but it was completed as a piece of research for a PhD. One benefit of this arrangement was the constant supervision that I received from the OT Consultant within the NHS Trust (Figure 1.1) throughout the research period until she vacated her post.

Figure 7.1 shows a schematic representation of the three key findings with the relevant themes and subthemes, which are discussed in detail in this chapter.

The base of the diagram, the triangle and the tilt bar represent the service user's engagement in therapeutic activities. This is impacted by the two main factors, the physical environment that is not up to the required level considering the demands placed by the model of care.

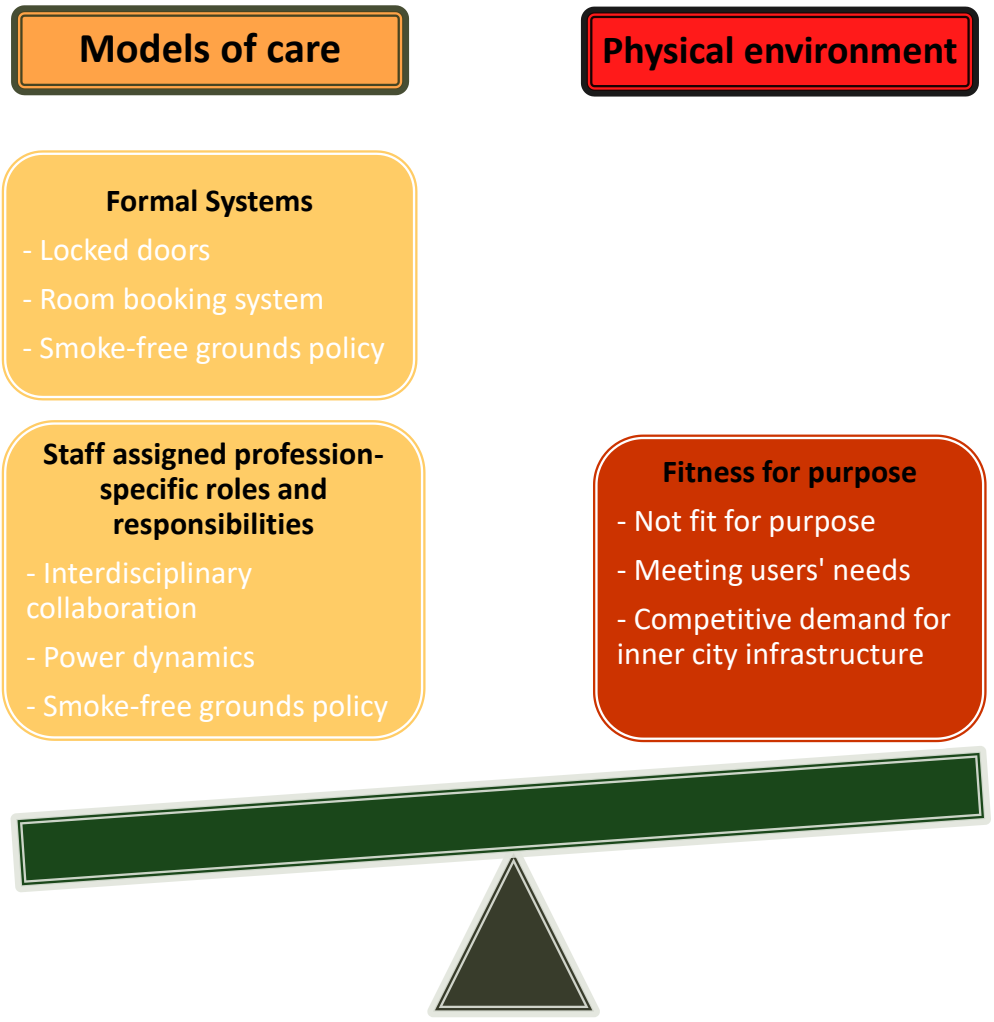


Figure 7.1: The incongruence between the two main themes and subthemes

7.3: Fitness for purpose of the physical environment

This section discusses the conditions of the physical environment, as reported in the findings, focusing specifically on whether it helped to meet the needs of the users (both the staff and the service users). In particular, I was interested to find out what the current state of the physical environment was like and why. I interpreted this finding from the evidence-based design, political and economic, and pragmatic perspectives. The rationale for including the staff as well as the service users as users of the acute unit was because it was found that the service users who participated in the survey spent an average of 30 days on the wards during admission, whereas the staff worked in the acute unit for 60 months on average, demonstrating that the latter spent a substantial amount of time in the building, thus making them users of the facility. I first explore how the physical environment met the needs of these two groups of users, as shared mostly from the staff perspectives focusing on the building layout and design. The discussion continues using the pragmatic lens to shed light on the challenges involved in finding facilities within inner London to meet the demands for the provision of services closer to service users' homes. Finally, I unpick the impact of the adoption of the neoliberal capitalist policy in the management of healthcare services, with the emphasis on privatisation and reducing public expenditure. These are presented using the following three subthemes: meeting users' needs; fitness for purpose; and competitive demand for inner-city infrastructure, represented in pictorial form in Figure 7.2.

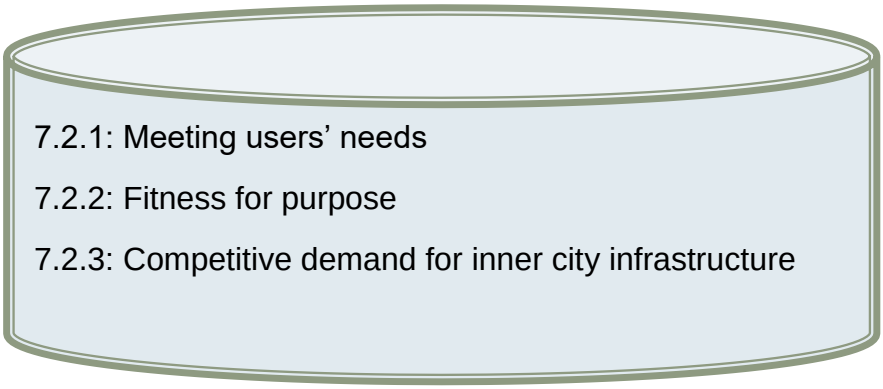


Figure 7.2: Three subthemes of the fitness for purpose of the physical environment

7.3.1: MEETING USERS' NEEDS

This study has revealed that the physical environment of the acute unit helped meet the service users' needs for intensive care in terms of the medication regime and the provision of a safe environment, as recommended by the Mental Health Network NHS Reconfiguration (2012). However, the limitations identified were concerning the physical environment not meeting the service users' needs for engaging in therapeutic activities, which were characterised by dissatisfaction with access to the garden, outdoor facility, and the loss of therapy space. In the Standard of Mental Health Inpatient Care (Perry *et al.,* 2017), the care and treatment of the service users includes medications, talking therapy, and the service users' engagement in activities. The standard also mentions the provision of an environment to support the service users' treatment and management, although it does not explicitly state that there should be a provision of space for therapeutic activities, which I argue is a limitation of the document.

Viewed from an evidence-based design perspective regarding the recommended features of mental healthcare facilities, the acute unit fell below the recommended

standards. The design of the building that housed the acute unit and its location was such that there was no available space around it that could be used for expansion. It was surrounded by pavements, roads, and private properties. Within the evidence-based design literature, the importance of outdoor facilities and gardens to the service users and staff and its impact on the service users' ability to engage in therapeutic activities is highlighted (Connellan *et al*. 2013; Sheehan *et al*., 2013; Shepley *et al*. 2017). Shepley ***et al.'s*** (2017) study that investigated the perceptions of staff from the USA, Australia, Canada and the UK identified that the design of mental and behavioural health settings needs to recognise the importance of aesthetics and ensure that these are taken into consideration. They recommended an environment that offers physical access to the outdoors, and pleasant gardens and landscapes, as these were rated significantly higher by the participants than the presence of pleasant street life, with easy access to shops and transport as was the case in the acute unit. The findings from this study are therefore in direct contrast to the recommendations by Shepley *et al*. (2017), although the aforementioned study considered different settings as well as the acute inpatient unit that formed the focus of this study. Also, Shepley *et al*.'s (2017) findings were exclusively obtained from staff, with no service users' input, whereas the findings from this study included information provided by service users.

Additionally, the findings from this study indicated that the lack of access to a garden is something that both the staff and the service users were dissatisfied with, which aligns with previous research on mental health and architecture by Connellan *et al*. (2013): the latter reported that the common issues discussed

concerning a garden were access, design, varied used and its function as a space that staff could retreat to when they felt overly stressed as a result of working with the service users. About availability and access to the garden, the staff recommendations for the ideal environment within the acute unit, reported in the current study, concurred with this view as they proposed a similar space that they could retreat to, for de-stressing when they felt overwhelmed by working on the ward. This reiterates the significance of a garden within the acute unit, preferably as an outdoor space. The healing effects and the therapeutic benefit of green space are well known (Marcus and Sachs, 2013; Gesler, 1993) but will not be considered in detail here as it is beyond the remit of this thesis. Historically, mental health facilities were situated on the outskirts of towns or located in places with grounds available that could be used for activities by the service users and staff (Borthwick *et al.*, 2001). Although the practice subsequently changed, with no large mental health facilities built on the outskirts of towns following the implementation of deinstitutionalisation, evidence-based design of hospital facilities still advocates the inclusion of a garden and outdoor facilities (Connellan *et al.*, 2013).

As previously mentioned, gardens offer green space, fresh air, adequate ventilation, the opportunity to be closer to nature, and space to exercise, all of which contribute to the service users' recovery and wellbeing (Sachs, 2013; Shepley *et al.,* 2017). Therefore, the implication regarding the study site, which is discussed in detail in the next chapter, is that staff were working around this limitation to help meet service users' needs. Similarly, the lack of such resources prevented the occupational therapy staff from achieving their full potential in terms of providing care to the service users. Staff have the skills to provide these

kinds of therapeutic activities for the service users, but the physical environment did not support their delivery. Low staff morale and failure to recruit staff into the NHS has been linked to the poor environments that are currently being used to provide care for service users due to the constraints on capital spending (Moore, 2019). However, the staff charter of the NHS Trust stated that staff should be provided with a good working environment that is safe and supportive (NHS Trust Staff Charter, 2015). According to the findings, it can be argued that the physical environment was not supportive, especially to the therapy staff, in terms of working with the service users. This, therefore, leads onto the next subtheme, in which I argue that, in the past, when the building was in a better state, it probably was able to support the service users' care more effectively, but the deterioration in its physical state meant that it was no longer able to do so.

7.3.2: FITNESS FOR PURPOSE

The findings from this study align with assertions made in the CQC (2017) report that acute units in old buildings used for the care of service users in the UK are not fit for purpose. According to the survey findings of this study, both staff and service users were dissatisfied with the overall features of the physical environment of the acute unit. However, this is in contrast to the findings of Sheehan *et al*. (2013) which claimed that 41% (n=623) of the MDT staff rated the overall design of the inpatient wards as average, while an additional 34% (n=521) rated it as well. In Sheehan *et al*.'s (2017) study, the participants' satisfaction was associated with the non-corridor design and provision of personal bathrooms, which were not features of the physical environment in this study. This, therefore, provides an example of how the acute unit was not meeting the service users' needs as a result of the design failing to comply with the evidence-based design recommendations. As explained in earlier sections of this thesis, the acute unit had a corridor design, while single room occupancy with shared washroom facilities was with toilets that were constantly blocked, thus constituting evidence of why such facilities are deemed not fit for purpose.

A novel contribution of this study to the literature is the extension of Sheehan *et al*.'s (2013) argument that objective measures could be used to assess the features of the built environment. The scale developed by the study team, the SOFTEN (Appendix E and F), can be utilised by other researchers to measure staff and service users' satisfaction with the physical features of a mental healthcare facility. The scale's 16 items are close-ended and scored on a Likert

scale ranging from 1-5, which makes it easy for staff to complete in less than five minutes, and 15 minutes in the case of service users requiring support. Although, this scale needs to be used in a study with a larger sample so that the items can be factor analysed, which was not possible in this study as discussed in Section 3.4.3.4 of Chapter three. The study also highlighted that relatively old buildings of this type may be noisy, with poor ventilation, and thermal discomfort, similar to Muir-Cochrane *et al.*'s (2012) findings, in which the service users perceived their space to be crowded, noisy and subject to extreme temperature fluctuations, although the temperatures experienced in the State of Victoria, Australia, might be expected to be more extreme than those experienced in the UK. However, recently built healthcare facilities that have utilised current technology can easily overcome the problems associated with ventilation and thermal discomfort that may be peculiar to the design of the old facilities. However, with Muir-Cochrane *et al's.* (2012) study, the current study extends the argument about the person-place encounter from an occupational perspective, that, concerning these encounters, what people do within the space and how the space supports or inhibits these engagements, also needs to be considered.

On the earlier point about the importance of a garden, as recommended by evidence-based design, Dzhambov and Dimitrova (2015) indicated that green space plays a significant role in mitigating noise in urban areas. This could explain why the staff and service users reported dissatisfaction with the level of noise in the acute unit, as there were no green spaces that could help to minimise the effects of the noise (Dzhambov and Dimitrova, 2015). In this study, both internal and external sources of noise were identified on the wards. The external

sources included the vehicular noise from the adjacent London Road and construction work from within the acute unit. Roberts' (2017) report on noise levels indicated that the study site was situated in the Borough that ranked among the top three in London for reported noise incidents. Despite being opened relatively recently (1986), the acute unit had no external soundproofed spaces to limit the impact of the types of noise that could be controlled, such as from the music therapy sessions.

If the building had been purpose-built for use as an acute mental health unit, considering the benefits of music psychotherapy for people with mental health problems (Lale and Ntourntoufis, 2020), a soundproof space could have been created. In using a renovated facility like the acute unit, the service has provided a space with the necessary equipment to be used for music psychotherapy. However, the therapist who ran this session referred to the space as "*an airless box*", while the other staff in the basement complained about the noise from the music sessions. In contrast, when I worked in the medium secure forensic unit, there was a soundproof music studio located in the therapy wing of the building that had limited impact on other users of the space, which provides a good example of a purpose-built facility, specifically designed for use by mental health service users. In addition, the internal noises reported in the acute unit included screaming and shouting from agitated service users, televisions on at high volume, electronic alarms and noise from the ongoing routine maintenance work at the facility (which was common in the acute unit during the data collection period). For instance, on some days while I was working in the basement, I found the consistent buzzing of the electronic alarm very distressing and distracting to

the point where I enquired each time which of the wards had activated it, as in Fieldnote 1 in Section 3.4.3.3. These noise levels could therefore have a similar impact on the other staff and the service users. People with symptoms of depression, mania, psychosis, and any anxiety or stress-related illnesses could be assumed to be negatively impacted by distressing noise. The staff would also have been subject to this, which could have exacerbated levels of stress and burnout. Urban and social noise were identified to have adverse effects on the verbal and the working memory of both people with schizophrenia and healthy control participants in a pilot study by Wright *et al*. (2016).

In relation to the fitness for purpose theme, the staff demonstrated in mapping activity 1 (Figure 5.1) that they had lost almost a quarter of the original basement space that was allocated to them for use as office spaces and therapeutic activities. They shared how, over the past few years, the clinical area had been reduced, due to space being allocated to the administration and maintenance staff, which was confirmed in the Estate report for the study site for 2018/2019. The report indicated that 2,400m^2 of the space was reserved for non-clinical use, while 3,412m^2 was for clinical use (Estate Related Information Collection, 2018/2019). According to the Estate report, 60% of the space at the unit was deemed *not functionally suitable – occupied floor area* (Estate Related Information Collection, 2018/2019). The report was written within the data collection period of this study, thus providing additional authentication for the findings. This figure was very high compared to other facilities that were listed in the report, with some recorded as 0% *not functionally suitable*, and the majority recorded as less than 20%. This non-functionally suitable floor area could be due

to the building being old and the problems associated with that, including the plumbing issues which led to the flooding of the gym and basement and the blocked toilets discussed in Chapter Five, Section 5.4.2.

This, therefore, raises the question of why resources for direct service delivery were being restricted rather than expanded? O'Connor *et al*. (2012) suggested that the capital work of health services and architectural design are influenced by economic and legal factors within an organisation. The potential reasons why the resources within the acute unit were not expanded is discussed through the political and economic lens that informs service delivery in the NHS. One possible explanation could be the limited funding allocated to mental health services compared to physical health services, which the NHS Five Year Forward View (2014) aimed to address. Through the implementation of the NHS Five Year Forward View (2014) policy, the government aimed to redress the funding gap by providing adequate funding together with greater integration of mental health crisis services (The NHS Five Year Forward View, 2014). The policy that superseded this - the NHS Long Term Plan (2019) - also aims to increase funding and staffing for mental health services. However, the spending of this additional funding has to take place within the NHS Cost Improvement Programme (CIP), whereby services are expected to make targeted savings each year. While the additional money dedicated to these services is welcome, what needs to be carefully considered are the service management systems that control how the money is spent.

Mahomed (2020) argued that, when funding increases are considered, efforts should be made to ensure that services are targeted at addressing the human rights of service users and contextually relevant issues, instead of repeating the mistakes of the excessive emphasis on the biomedical model of care. Dawson *et al.* (2020) reported that a major shift in Australian mental health policy that occurred after the deinstitutionalisation of the 1980s and 1990s involved a "broad political and economic focus on market principles that emphasised deregulation, efficiency and profit-making" (p. 277). Gooding (2016) designated this as the adoption of neoliberal thinking in the management of healthcare services. This policy is guided by three principles, namely: reduced public expenditure on social infrastructure; privatisation and competition; and freedom of choice (Barnette and Bagshaw, 2020). The footprint left by reduced public expenditure on social infrastructure and the privatisation of services were two main effects of this neoliberal thinking on the management of the acute unit observed in this study. Economically, there is an emphasis on services finding ways to save costs, accompanied by a drive for efficiency and improvement of services delivered. Participants in the PAR group shared the information that the cleaning and maintenance services had been privatised, as has been the case throughout the NHS since 1983. In the UK and Australia there is evidence to suggest that mental healthcare facilities that were deemed old and not meeting the needs of the service users, were either renovated or new facilities were built in the period immediately following the implementation of deinstitutionalisation to date (Nicholls *et al.*, 2015; Cleary *et al*., 2009; Urbanoski *et al.*, 2013 and Wood *et al.*, 2013). This leads to the discussion of the last subtheme within the theme of fitness for

purpose of the physical environment of the acute unit, which explores the competing demands for infrastructure in inner cities.

7.3.3: COMPETITIVE DEMAND FOR INNER-CITY INFRASTRUCTURE

From an economic perspective, I further argue that the competing demands for the available resources in inner cities are another reason why the acute unit building was still being used despite being deemed unfit for purpose. The difficulties that may be encountered in acquiring spaces for use as NHS facilities in inner London need to be acknowledged, as such sites are hugely expensive. Within market economies, the price of infrastructure is influenced by demand and supply (Keane *et al.*, 2018). In contrast to the limited funding available to the NHS, there have been suggestions by NHS England for Trusts to use money generated by the disposal of "surplus assets" (https://www.england.nhs.uk/five-year-forward-view/next-steps-on-the-nhs-five-year-forward-view/funding-and-efficiency/#44) as a possible solution to cost-saving. Two examples of this are the part sale of Edmonton hospital in 2019 and St. Ann's hospital in Haringey in 2018 (London.gov.uk). Moore (2019) speculated that these transactions may have taken place as part of an attempt by the hospital to raise funds to either renovate the remaining part of the building or redevelop the facilities and/or enable the organisations to meet the savings demanded annually by the government as part of the NHS Cost Improvement Programme.

The sales of NHS facilities imply are that services could become more centralised with less local provision available in the wider community. Concerning the acute

unit, the building had not been sold yet but as explained earlier, 60% of it was deemed to be non-clinical space. Although the administration and maintenance staff who occupied these areas of the floor were also contributing to the healthcare service provision, the expectation remained that a larger proportion of the space would be designated for clinical use. In addition, mental health service user should to be admitted to healthcare facilities closer to informal and family carers (Wood *et al*., 2013). Generally, the current trend for out of area placements for mental health service users is a downward one (2019/2020), although the trends were high in 2018/2019 (NHS dashboard).

Acute mental healthcare is a specialist service and there are few within each NHS Trust catchment area. As a result, the available facilities are organised in such a way that there is a good geographical spread, with the primary aim of ensuring that service users are admitted to a facility relatively close to home. For this reason, although some of these facilities are old and not fit for purpose, as stated in the CQC (2017) report, they are still used to provide services for service users. For instance, the study site had been in existence for use as a mental health facility since 1986. At the time it was opened, it met the required standard for service delivery. However, as pointed out by O'Connor *et al.* (2012) in the literature, models of care used in mental health have changed over the years, but the facilities used are still trying to catch up with these changes. The location of this acute unit was very strategic in terms of serving people within that area and its closure would have meant the service users would be admitted to facilities that may be much further away from their families. A quick Google map search

revealed that the facility to which they could be admitted as an alternative was 5.2 miles away from the acute unit.

In conclusion, the findings relating to the theme of the physical environment of the acute unit not being purpose-built and specifically designed as an acute unit were presented in this section, demonstrating that it did not adequately meet the needs of the service users and staff, especially, about the provision of and engagement in therapeutic activities. In terms of meeting the users' needs, the lack of a garden and outdoor space was discussed, leading to the conclusion that the design and existing features of the acute unit did not meet current standards recommended by the evidence-based design of mental healthcare facilities, which, in turn, limited the extent to which the occupational therapy staff working with the service users could achieve their full potential. I further argued that the physical environment and its design was not fit to be used as an acute mental healthcare facility. This argument drew on the literature which indicated that a non-corridor type of design with en-suite bathrooms was preferable, yet the study site was not designed in this way. The facility was also deemed not fit for purpose, especially for the therapy staff, in terms of meeting the service users' needs for engaging in therapeutic activities, due to the loss of internal spaces. In this regard, I put forward the view that it was potentially the impact of the adoption of neoliberalism in the management of healthcare services that had led to funding cuts and the privatisation of services within the acute unit. Finally, within this section, I demonstrated how this study has built on the existing literature by developing a simple scale measure (SOFTEN) with good validity that can be

used to measure staff and service users' satisfaction with features of the physical environment of a mental health facility.

The effective provision of therapeutic activities for service users' engagement within an acute unit undoubtedly requires a physical environment that has been built and designed to support this. However, as discussed in the preceding sections, a renovated facility like the acute unit falls short of supporting this aspect of the service users' care. Although the physical environment may be inadequate, the service provision should still adhere to the minimal standards for the provision of these services and work in line with government and wider NHS policies. It is in this regard that I highlighted the incongruence that exists between the physical environment provided and the model of care that guides the service provision for the service users. I now move onto the next theme which also relates to the physical environment but in terms of the formal systems that have been put in place as part of the model of care adopted. The model of care adopted is examined via two different themes, in Section 7.3: formal systems in place; and Section 7.4: staff assigned profession-specific roles.

7.4: Model of care: formal systems and policies

This theme explores the formal systems and policies that have been put in place and adopted in the management of the acute unit physical environment, and that has an impact on the service users' engagement in therapeutic activities. These are discussed using the following subthemes: room booking systems; locked doors; and the smoke-free grounds policy. The room booking system is linked to the issue of the lost space within the non-purpose-built facility of which a large proportion is designated for non-clinical use, as discussed in the preceding section. In addition, the findings from this study serve to challenge the dominant approach of using locked doors as a key security feature within the acute unit. It is argued that the need to ensure the collective safety of the service users is achieved at the detriment of the individual rights of other service users. Finally, this study found that, within the NHS, when it comes to the implementation of national policies, like the smoke-free policy, there is a need to first consider whether the physical environment in which the service is delivered could support the policy's implementation. Subsequent sessions discuss these three subthemes which are represented schematically in Figure 7.3 from the perspectives of the evidence-based design of mental health facilities, and organisational behaviour.

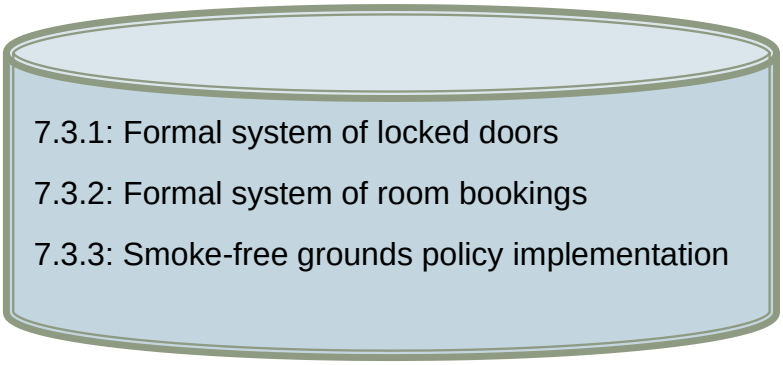


Figure 7.3: Three subthemes of the formal systems and policies adopted

7.4.1: FORMAL SYSTEM OF THE USE OF LOCKED DOORS

This study found that the use of the locked door system as a key security feature of the acute unit adversely impacted the service users' engagement in therapeutic activities, concerning the service users accessing parts of the building such as the basement, rooftop garden and the first floor to attend the Recovery College groups. This agrees with Curtis *et al.*'s (2013) findings, according to which the service users could not access the ADL kitchen to make a cup of tea due to a locked door that the staff attributed to the presence of a ligature point within the space. In Connellan *et al.*'s (2013) literature review on mental health and architecture, in which they identified key features, although security was a key theme, the issue of locked doors was not specifically highlighted, which constitutes a limitation of the study that future literature reviews should consider addressing.

In contrast, in an ethnomethodology study of an acute unit that was purpose-built, Simonsen and Duff (2019) pointed out that the physical layout and the design of the ward facilitated the service users' engagement in activities, movement and interactions within the space. The aforementioned study reported that the way the ward was designed, with more open space, made the maintenance of ward security more straightforward as service users were highly visible to the staff at all times. Within the acute unit, there were at least two doors that were locked, leading from each ward to the basement, where most of the therapeutic activities took place. The number of locked doors increased if users attempted to access the rooftop garden or leave the acute unit through the main reception area. However, it was only the ward doors and the main reception doors that could be

controlled by the remote door locking system, which implied that, in most cases, the service users had to rely on the staff to move from one space to another.

While the locked door constitutes an important symbolic representation within the physical environment, it also relates to the lack of freedom experienced by the service users, which is another key finding of this study. In the survey, the service users reported that they had *"no freedom"* on the wards, a finding similar to that reported by Muir-Cochrane *et al*. (2013) and Gilburt *et al*. (2008). The service users in Gilburt *et al.*'s (2008) study spoke about their freedom to be outside being limited concerningtheir inpatient unit experience. The freedom to move around, as and when an individual wants and/or needs to, is fundamental to all humans (Human Right Acts, 1998). However, for the service users detained under the Mental Health Act (1983) this freedom is restricted. This is an example of Foucault and Fanon's idea about psychiatric facilities constituting a restrictive environment (Faramelli, 2017) which, in the case of the acute unit in this study, was exacerbated by the use of locked doors.

From an organisational behaviour perspective, it is necessary to explore what freedom meant for the service users as this can be complex. For instance, although a service user may be detained, he/she can still have a leave of absence from the hospital, either escorted or unescorted. Faramelli (2017) presented an analysis of 'The Decolonised Clinic', in which he drew on the work of Fanon and Foucault. From Fanon's work at Blida-Joinville – a mental health institution in Algeria - he concluded that the only way to enhance therapeutic practice was to limit confinement among the service users within the space.

Faramelli argued that Fanon's work gave us "a tool to continually resist enclosed spaces of discipline and to create new and open spaces of liberation" (Faramelli, 2017, p. 128). This, therefore, raises the question of what measures could be used instead of the locked doors to ensure people's safety within the acute unit. The participants did not suggest that all the doors should be removed or left open; instead, the debate centred around adopting systems like remote locking and cameras that allowed doors to be opened from a central point, without requiring a staff member to be physically present by the door, which was negatively impacting on staff time.

Within the acute unit, the key issue, therefore, is how the collective safety of the users (staff, service users, visitors, and carers) within this environment can be maintained while protecting the individual rights of the service users. Chamber *et al*. (2014) reported that the limitations on their freedom badly affected the service users' dignity and respect in the case of the 19 previously detained service users who participated in their study. In this study, 27% of the service users were not detained under the Mental Health Act, so how did the design of the acute unit ensure that they had the 'freedom' to move around despite the locked doors?

Lack of freedom was also identified by Muir Cochrane *et al.* (2013) as a factor that increased the risk of service users absconding. With this in mind, and even with the locked doors in place, I recorded an incident in my fieldnotes whereby a service user planned to escape from the acute unit through these same locked doors, although the person was not successful. The collective need to ensure that all the users are safe within the acute unit has led to the adoption of a system under which it is accepted that doors that have been put in place should be

locked. However, this impacts the rights of individual service users who do not require those kinds of safety measures. Curtis *et al*. (2013) argued from a Foucauldian perspective that, within inpatient units, the institution controls not only the service users but also the staff who oversee the service users. Accordingly, the environment is locked for all those within it, including the staff, although they can open the doors.

The impact of the locked doors, discussed above as impacting on the service users' engagement in therapeutic activities within the acute unit, is outside of the service users' control. The restrictions they face that prevent them from participating in a meaningful activity is regarded as a matter of occupational injustice (Durocher, 2016), and more specifically, occupational deprivation, which is defined as: "a state of prolonged preclusion from engagement in occupations of necessity or meaning due to factors outside the control of an individual, such as through geographic isolation, incarceration or disability" (Christiansen and Townsend, 2004, p. 278). It is commonly experienced among people who find themselves in restricted environments where there are safety concerns and containment issues, such as prison services and forensic mental health units (Cronin-Davis and Sainty, 2017). Baillard *et al.* (2020) described this subtle way of targeting ways of 'doing and being' among a group of people as micro-occupational injustice. The impact of this occupational deprivation, and another form of occupational injustice that the service users experienced within the acute unit (occupational alienation), is discussed subsequently in Section 7.3.4 from an occupational perspective.

Ensuring the safety of service users, staff and visitors in the acute unit are usually paramount, meaning that adequate measures are put in place to achieve this. The study site claimed that they had an open ward system, but the doors were all locked and access was by swipe card and key. The ward layout, shown in figure 5.3, consisted of the service users' bedrooms, the open lounge area, the group room and the long corridor which was accessible to the service users. Wood *et al.* (2013) identified that it is not ideal for the service users and carers to depend on staff for access to areas beyond a locked door within an acute unit, stating that it did not make the environment a therapeutic landscape. Cleary *et al.* (2009) also highlighted that features like locked doors continue to cause dissatisfaction among service users, even in newly built facilities, due to the restrictions on their freedom.

Based on medical architecture theories linked to the evidence-based design perspective, it was proposed that a building's design could theoretically be positioned within the three-dimensional problem space, consisting of: safety and security; competence; and personalisation and choice (Chrysikou, 2019). Chrysikou (2019) argued that models of care have evolved over the years from a jurisdictional model, via a medical model, to the current model which places more emphasis on psychosocial rehabilitation. However, the type of environment that exists within some hospitals, like the acute unit in this study, does not suggest that the psychosocial rehabilitation model is necessarily being put into practice. I further argue that the physical environment and the security features (locked doors) within the acute unit were based on the jurisdictional model of care, whereby the emphasis is on safety and security. This, therefore, impacts the

efforts being made by the staff to offer rehabilitation services to the service users. Unless there is a complete shift in thinking or a conscious effort to redesign the environment to facilitate more rehabilitation, while reducing the emphasis on security, then the service users will continue to experience limited levels of engagement in therapeutic activities resulting from the impact of the acute unit design. The next subtheme to be discussed is the implementation of the smoke-free grounds policy which has also been affected by the locked doors within the acute unit.

7.4.2: IMPLEMENTATION OF SMOKE-FREE GROUNDS POLICY

From an organisational behaviour perspective, the approach that was adopted towards the implementation of the smoke-free grounds policy within the acute unit was having a significant impact on the nursing staff's time. This was largely attributed to the incompatibility between the design of the physical environment and the stipulations of the smoke-free grounds policy. According to this policy, all NHS sites are deemed 'smoke-free', meaning that people are not allowed to smoke within these premises. However, this study found that some service users chose to smoke while on admission, as discussed in detail in Chapter Six, Section 6.1.2. This was identified as impacting on the staff's time as they had to escort the service users through the locked doors each time they wished to go outside for a cigarette. It was an issue predominantly faced by the nursing team as they were usually the ones who facilitated smoking breaks for the service users.

There are currently no guidelines for safe nursing staffing levels in mental health services, despite plans being outlined by NICE in 2015 for their development in mental health units. Nursing duties are grouped into either ongoing nursing care activities or one-off care activities (NICE, 2018). These two categories have an impact on staffing levels. One-off nursing activities that affected the demands placed on nursing staff included admissions, care after death, discharge planning and escorting service users. Escorting of service users by nursing staff is deemed a one-off nursing care duty that requires an additional member of staff whenever it occurs within a shift. However, in this study, it was observed that staff escorting the service users to smoke outside the acute unit was not a one-off activity. Rather, it was more of an ongoing nursing care activity that placed high demands on staff time, leaving them with less time to engage the service users in therapeutic activities, although the participants shared that a new smoking policy was soon to replace the old one, with a focus on preventing service users from using tobacco and reducing the need for staff to escort service users outside, under the Section 17 leave to smoke.

Within this second discussion theme on the formal systems and policies adopted within healthcare management, this study makes two original contributions to the literature on acute mental healthcare, namely: the provision of detailed knowledge about the challenges experienced by staff following the implementation of the smoke-free grounds policy; and the limitations imposed by the use of locked doors as a security feature. The key issue to emerge from this is the impact on ward staff time and reducing staffing strength whenever they escort service users to smoke outside the hospital building. This study has helped

to explain the practical difficulties that Ratschen *et al*. (2009) identified as accompanying the implementation of the smoke-free policy. I have shared the lived experience of the staff who work on the wards and facilitate these smoking breaks, unlike Ratschen *et al*. (2009) who surveyed the views of non-clinical executives of the NHS Trust from the Human Resources department. The next subtheme to be discussed is the booking system for the group rooms that had been put in place to enhance the effective use of the remaining space, following the loss of part of the previously available space. The therapy staff highlighted that this had significantly affected their capacity to engage the service users in spontaneous activities.

7.4.3: FORMAL ROOM BOOKING SYSTEM

From the discussion of the fitness for purpose and design theme earlier in this chapter, it was established that 60% of the floor space within the acute unit was allocated for non-clinical use. This corroborated the findings revealed by the therapy staff that they had lost space within the basement. The staff explicitly stated that the new booking system which had been adopted to manage the effective use of the available space by staff had reduced their capacity to spontaneously engage the service users in therapeutic activities, especially those activities that require the use of group rooms that have to be booked in advance. I realised that this booking system was not only used within the acute unit, as I had to follow a similar system to book the room where the PAR group meetings were held in another building owned by the NHS Trust.

Regarding the rooms that could be booked, the participants reported that it was difficult to design those spaces for specific therapeutic use. While it was perceived as a good idea to have space within the basement that had multiple uses, the design and the layout of these rooms was not flexible enough to support this. Within the basement, there were dedicated spaces that were furnished to support the provision of specific therapeutic activities like the ADL kitchen, pottery, gym and music studio. In contrast, the room that was used for the art and craft group required booking, and the therapy staff were expected to clear away all the items after each session so that other activities could take place. This approach to holding the arts and craft group in a non-purpose-built facility with limited space is in direct contrast to the example of a purpose-built occupational therapy department reported in Birken and Bryant's (2019) study. In the report on the photovoice research, the service users appreciated being able to see the paints and the craft materials that were ready to choose from when they attended the arts and craft group. Simonsen and Duff (2019) reported an example of a flexibly designed ward that was based on the principles of healing architecture, suggesting that such designs allow for spatial ordering by staff to support different events occurring within the space.

The three subthemes discussed in this section about the model of care related to factors that prevented the service users from engaging in therapeutic activities either because they could not access the space, a room was unavailable, or there were no staff on the ward to facilitate the session due to staff having to escort other service users outside to smoke. Thus, the foregoing discussion provides a clear indication of how these factors impact the service users' engagement in

therapeutic activities. The ward staff's time was predominantly impacted by the facilitation of smoking breaks for the service users, whereas both the therapy staff and ward staff had to facilitate access to other parts of the building for the service users due to the locked doors. Although staff within the acute unit were busy most of the time doing different tasks with or for the service users, there is a need to investigate further to establish whether they considered what they were doing meaningful, from their profession-specific perspective. In other words, did they regard the duties that they primarily engaged in as constituting the best use of their time? If not, then, technically, it can be argued that the staff were experiencing occupational alienation. Occupational alienation is defined as, a "sense of isolation, powerlessness, frustration, loss of control, and estrangement from society or self as a result of engagement in an occupation that does not satisfy inner needs" (Wilcock, 2006, p. 343). In the subsequent section, I discuss the third theme and its relevant subthemes, namely the impact of staff assigned profession-specific roles and responsibilities on the service users' engagement in therapeutic activities. Following that, from an occupational perspective, I develop the issue of occupational alienation, as experienced by both staff and service users within the acute unit, drawing on elements of the three key themes.

7.5: Impact of staff assigned profession-specific roles and responsibilities

This study found that the staff assigned profession-specific roles and responsibilities within the MDT were impacting the extent to which non-therapy staff could engage the service users in therapeutic activities, which could be attributed to the challenges presented by interdisciplinary working, power dynamics, and the fact that engaging service users in therapeutic activities were

not always regarded as a priority by all the MDT members. The model of care adopted for use within the acute unit stipulates that staff each have their roles and responsibilities which, together, all contribute to the service users' care. Staff roles differ between the various professional groups and grades and are defined before recruitment, along with associated responsibilities to the public, service users and colleagues. The NHS Constitution for England (2015) identifies the following values as important: working together for service users; respect and dignity; commitment to quality of care; compassion; improving lives; and everyone counts. In addition, as is the case across the world, each professional group is guided by standards of professional practice set by their regulatory bodies to which they must adhere (NHS Constitution for England, 2015). It is with these in mind that the findings relating to staff assigned profession-specific roles and responsibilities are discussed, based on the three subthemes shown in Figure 7.4.

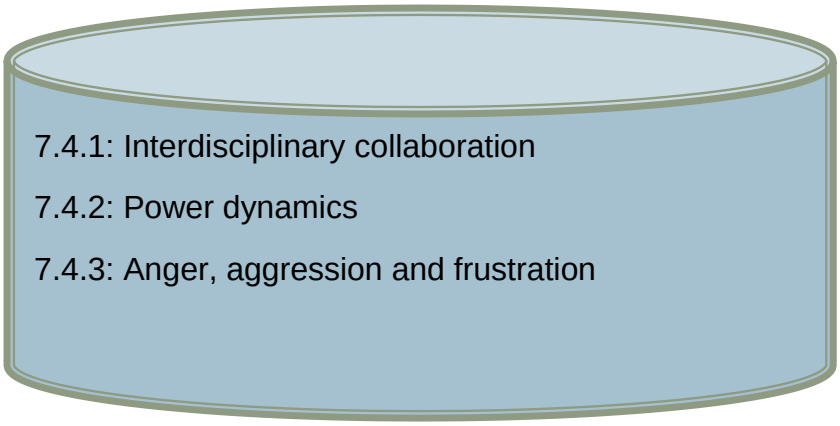


Figure. 7.4: Subthemes of staff assigned profession-specific roles and responsibilities

7.5.1: INTERDISCIPLINARY COLLABORATION

The findings of this study revealed a challenge related to the way that staff within the MDT worked at the acute unit, which impacted the service users' engagement in therapeutic activities. Following on from the theme of the building design and fitness for purpose, it was identified that the ward staff and the therapy staff had two different types of experiences regarding the use of the space. The therapy staff, who mostly worked with the service users in the basement, reported being dissatisfied with access to daylight, which was not an issue for the ward staff. Within the acute unit, it can be argued that the different staff groups worked according to different models of care. Whereas the doctors and the nurses were influenced by the biomedical model of care with a focus on diagnoses and the medication regime, the therapy staff used the biopsychosocial model to inform the therapy sessions that they ran (Onyett and Campling, 2003). The provision of therapeutic activities, which formed part of the psychosocial interventions, were the core responsibility of the therapy staff at the acute unit. This staff group are usually referred to as Allied Healthcare Professionals and, in the acute unit, included the occupational therapist and assistants, the art, music and drama psychotherapists and trainees, the fitness instructors, the clinical psychologists and their assistants.

From a broader perspective, reviewing the purpose of the acute services provided by mental health services more generally could provide some answers. The Mental Health Network NHS Reconfiguration in 2012 stated that the focus of the acute mental healthcare inpatient unit should be, the provision of care with

"intensive medical and nursing support for service users in periods of acute psychiatric illness" (p. 9). The document further adds that there is a full range of professional disciplines, including pharmacists, psychologists, occupational therapists and housing and social care colleagues in the acute mental health inpatient unit who provide evidence-based care. This suggests that all the MDT members identified are expected to contribute to the service users' care, from whichever professional perspective is appropriate. Their roles should therefore complement each other rather than being oppositional, as is the case in all instances of MDT working.

The findings from this study uncovered that there are challenges to effective inter-disciplinary working. An example presented earlier (Section 6.3.3 in Chapter Six) was an incident involving a member of the nursing staff not enabling a service user to attend his scheduled occupational therapy sessions due to a delay in dispensing medication. From an organisational behaviour perspective, collaborative working within the MDT is key to the effective functioning of the acute unit, as in other healthcare facilities. West *et al*. (2014) identified the potential benefits of the MDT working together as: increased service users' satisfaction; consistent communication with service users; and effective healthcare delivery. The staff participants in West *et al*.'s study were also found to have low levels of stress, absenteeism, and turnover when the team worked well together. In the book -*The unconscious at work: Individual and organizational stress in the human services*, Roberts described nursing staff's relationships with the other professionals on an older people's ward as "antagonistic" (Roberts,

2003, p. 77) and competitive rather than collaborative, which he attributed, amongst other factors, to the lack of a cohesive model of care.

It is notable that, despite the challenges to collaborative working between the various professions in the unit, participation in my research was good, as demonstrated by the staff response rate of 55% (n=40) in the survey. Leading this research required a considerable commitment from me in terms of time, perseverance and resilience, as described in Chapter 3, Section 3.4. The three ward managers also supported my recruitment of both staff and service users to this study. I have no way of knowing if this would have been the case if I were an insider researcher (Herr and Anderson, 2015) and the difference between being a researcher and a clinician on a ward needs to be acknowledged. As an outsider, I had to overcome the initial challenge of establishing relationships with the various professional teams and the ward staff, which was achieved by informing them about the research and how they could contribute to it. As the topic was 'relevant' to most of them, staff were more receptive to supporting the study. The good relationships that I established with the staff were also enhanced by my being present frequently and regularly at the acute unit, although I had to commute from Colchester to London. In addition, I appeared friendly, confident and presented a professional demeanour, which I think helped to build trust with the staff. Finally, on reflection, I think my background as a person from the Black and Minority Ethnic (BAME) community also helped to establish good relationships with the staff as most of them were from this community. There was one instance where a male member of the nursing staff said that he was pleased to know that "one of their own" was leading the research and was pursuing a PhD degree. The way

that the PAR group worked together during the data collection process was a good indication that collaborative working between the staff could be achieved.

The participants in the PAR group, especially the occupational therapy staff, felt that their roles were not entirely understood by other staff and they felt less valued as part of the MDT. These findings, therefore, shed light on the possible feelings of a staff group whose roles are not well understood by colleagues and build on the finding by Smith and McKenzie (2011) that nursing staff did not fully understand the occupational therapy staff role. However, in their study, the positive aspect was that, although the nursing staff did not fully understand the occupational therapy staff roles, they nonetheless valued the presence of the occupational therapy staff and what they contributed to the service users' care (Smith and Mackenzie, 2011), which is in contrast to the participants in the current study who felt less valued within the MDT.

In an ethnographic study investigating the challenges of interdisciplinary collaboration, it was identified that respect and the understanding of each other's professional philosophy were key elements to staff working together (Fortune and Fitzgerald, 2009). The host organisation for my research have a staff charter which states that the clinical teams are to work collaboratively, "within and between teams, recognising the range of expertise and performance that exists" (NHS Trust Staff Charter, 2015, p. 15). It elaborates that this collaborative work could take the form of supporting someone in one instance and receiving support in another. However, it was evident that a knowledge gap existed in terms of some staff being able to fully identify and understand the roles and responsibilities of other staff members across the professional groups. The study

findings support Kivak's (2020) assertion that each professional role should be clearly defined, and that staff should know their specific responsibilities and how their duties relate to those of other team members in the workplace. A recommendation for how this can be achieved is made in the concluding chapter of this thesis.

Two recent job adverts on the NHS jobs website of the NHS Trust were reviewed for references to inter-disciplinary roles to find out how the NHS makes it a responsibility for staff to understand each other's roles. The clinical duties of the occupational therapy (OT) band 6 post included: "to provide OT consultation to other professionals within the team". It was also the responsibility of the post holder, "to promote the role of OT within the treatment ward and represent an OT clinical perspective in all clinical meetings" (NHS Jobs website). In contrast, the job advertisement for a band 6 nurse did not list such responsibilities to the other team members. Schot *et al*. (2020) argued that there is evidence to suggest that professionals actively contribute to interprofessional collaboration and they do so by bridging gaps in their roles, negotiating overlaps and creating space.

As discussed in relation to the physical environment's fitness for purpose theme, other factors like the physical environment were identified as impacting interprofessional collaboration. Within a primary healthcare setting, the allied health staff identified that working in proximity with other health professionals facilitated interprofessional interactions to a greater extent than when they worked with them in a geographically separated location (Seaton *et al.,* 2020). This could partly explain Eugene's feelings about staff not working well across the

multidisciplinary team, as his work environment was in the basement which was separate from the wards. However, some findings suggested the opposite was true, as staff who worked in the same environment reported less collaborative working between them, perhaps indicating that there were other factors also operating, including professionals working from a medical versus a psychosocial perspective (Onyett and Campling, 2003), as explained in the introductory part of this section. The next subtheme, which is also closely related to interdisciplinary collaboration, involves the power dynamics reported by the PAR participants within the acute unit. The staff reported feeling that some of their colleagues had more power and authority than others about decision making within the acute unit.

7.5.2: POWER DYNAMICS

Questions relating to authority and power were raised by the PAR participants who reported instances where they felt uncertain about which staff members were responsible for acting when serious incidents occurred or reporting building maintenance issues. In this study, there was an acknowledged power differential among the staff working within the healthcare services. The PAR group participants shared their experiences, and it emerged that some MDT members had more power than others and, consequently, their needs were usually met, whereas others lacked this kind of control and authority. This assumption relates to Max Weber's conceptualisation of "power being a finite commodity to be seized" (Masterson and Owen, 2006, p. 21), which thus resides with a group of people and needs to be shared. This description applies to the PAR group participants' perceived sense of having no agency; a sense of agency can be

defined as a “feeling of control over actions and their consequences” (Moore, 2016, p. 1). Onyett and Campling (2003) claimed that the power relationships within mental health teams are complex in the sense that leadership may reside in more than one person and may “vary with the domain of activity that is being led” (p. 168).

Onyett and Campling (2003) developed ideas about four sources of power that staff within an MDT may have, originally suggested by Richards (1998), namely: personal, instrumental, projected, and official power (Richards 1998 cited in Onyett and Campling, 2003). Although the publication was based on work done with UK Community Mental Health Teams (CMHTs), some of the ideas apply to acute mental healthcare services. Richards (1998) described personal power as that which comes from knowledge, experience, skills, or personality. This is a type of power that all the MDT members have, irrespective of their grade or profession, but it cannot be drawn on to influence major decisions. He described instrumental power as arising from what one owns or control, such as money or other resources, while projected power is that which is attributed to someone by others. Finally, official power was defined as that which is linked to roles and responsibilities within an organisation, providing someone with the autonomy to make decisions, and increasing in line with higher grading within an organisation. Usually, these are the kinds of powers that a manager or a director wield and which allow them to take major decisions and actions. Oynett and Campling (2003) therefore argued that, in an organisation, a member of staff can have both personal and projected power, but the instrumental and official power may lie with another team member, in which case it impacts on what he/she can do.

In contrast, Foucault argued that power does not reside with a few individuals who exercise it over the many but is something to which everyone is subjected. Masterson and Owen (2006) offered the view that the normalisation of power makes us want to do what we want to do. For instance, within the acute unit, the roles and responsibilities set out by the employer for the employees were equally matched by the responsibilities of the employer to the employee, indicating that power is normalised within the environment. As appealing as Foucault's perspective is, in this research study, within the acute unit, it was clear that power resided with some staff but not others. Under the Mental Health Act 1998, the psychiatrist is named as the 'responsible medical officer' for the service user who is sectioned, which means that the psychiatrist has more power than the other members of the team when it comes to making decisions that concern the service user. This argument supports Dr John's (Chapter 6, Section 6.3.4) assertion that ultimate responsibility for the service users lies with him.

Therefore, the question that remains is why did some staff feel they did not have the power to act or get things done but instead had to depend on others? From an organisational behaviour perspective, the acute unit, as part of the acute services within the NHS Trust, had set out procedures for getting things done. The staff in the PAR group (except one) did not directly manage a budget and had to rely on their team leads for resource allocation, which is typical of the situation in most organisations. The team leads act as 'middle managers' who report to the 'executive management', as they are designated in the services'

organisational structures (Currie and Procter, 2005), a situation that exacerbates the bureaucracy within health services. Difficulties arise when actions taken at higher levels are not well communicated to the staff who need to know or the person who originally reported an issue. The staff indicated that this led to them feeling frustrated due to the impact on their work. I link this feeling of frustration with the discussion of the high levels of anger and aggression among the service users that were reported in the survey findings.

7.5.3: ANGER, AGGRESSION, AND FRUSTRATION

Both staff and service user participants in the survey component (Module 1) of this study perceived high levels of anger and aggression on the three inpatient wards, as measured by their scores for the four questions relating to this issue in the WAS (Manual on WAS, 1974). The samples did not make it possible to determine whether specific characteristics were linked to levels of perceived anger and aggression in the ward environment. In addition, the study did not investigate actual levels of anger and aggression, as indicated by the frequency and severity of reported incidents, using the mandatory reporting system. However, the high levels of perceived anger and aggression on the wards recorded in this study could have impacted on the delivery of care as and when incidents occurred.

Within the acute unit, when the alarm was triggered in response to a service user displaying high levels of aggressive and violent behaviour on a ward, staff from other wards came to assist, as part of the unit's 'incident response team'. Although the study did not explore the frequency or severity of incidents that took

place during the research period, it can be assumed that even low numbers would have an effect on staffing levels for the duration of the incident, when the response team staff would have been absent from their workplace. As explained in Chapter Six, Section 6.2.2, there were five nursing staff, both qualified and unqualified, on each ward per shift and it is from this pool that the incident response team were drawn: one from each ward and the therapy teams. Removing a member of staff from one ward would therefore be likely to have a negative impact on the service users' care, as suggested by Victor's (Nurse 1) description of how challenging it was already with the existing nursing staff numbers in the morning during medication rounds.

A possible explanation for the high levels of anger and aggression that have emerged as one of the findings of this study lies in the discrepancies between the staff and the service users' perceptions of the ward atmosphere. This study found that differences in staff and service users' perceptions existed on five subscales of the WAS (Manual on WAS, 1974), which were: support, spontaneity, practical orientation, programme clarity and staff control. The staff generally had higher mean scores for these factors, indicating more positive perceptions, while the service users had lower scores except in the area of staff control, where a higher score indicated more negative perceptions.

Although the staff who completed the survey generally had positive perceptions of the ward atmosphere, in contrast, the PAR participants, who had experienced a reduction in staffing numbers, working with inadequate numbers of staff on

some shifts, and a lack of material resources, all expressed feelings of frustration about working within the acute unit. The occupational therapy participants reported having lost three associate practitioners, which reduced their numbers from six to three. Although it was not clear precisely when the changes occurred, one of the healthcare assistants who completed a questionnaire in May 2018 divulged that she had been an associate practitioner but subsequently had to reapply for a job as an HCA after she lost her post. The nurse participants reported instances of shifts having begun with less than the required number of staff, due to staff sickness. They reported high usage of short-term bank or agency staff which has been linked to a lack of continuity of care by the CQC (2017, p. 43). Participants also reported feeling tired and frustrated due to their increased workload.

Pollock and Price (2011) expressed the opinion that the long-term staff cuts and limited numbers of staff working in the acute unit can be linked to the adoption of a neoliberal capitalist policy in healthcare management within the UK. This is a highly contested and debatable position, but one to which I adhere. Neoliberal capitalism has been described as a system that “uses people as workers to resource the cycle of production by exchanging time and energy for money and promoting models of consumerism and consumption through global markets” (Clouston, 2015, p. 12). Barnett and Bagshaw (2020) identified the three main strategies of neoliberalism as: privatisation and competitive markets; reduced public expenditure on social infrastructure; and deregulation to enhance economic activity and ensure freedom of choice. In this study, there was

evidence to suggest that saving had impacted the staffing levels at the acute unit and led to staff feeling frustrated.

This feeling of frustration could also have contributed to the low staff morale, in addition to events that were happening at the acute unit at the time. About nine staff had been suspended from clinical duties due to ongoing disciplinary investigations, and undoubtedly this had a detrimental effect on the morale of those staff remaining at work. For instance, I struggled to recruit staff to complete the questionnaires from this ward as well for the PAR group and the key informant interviews. The remaining staff probably were wary of being seen as being critical of the work practices. The acute unit at this time was going through an improvement programme halfway through my data collection period. The attitude of the staff is similar to that reported by Blacker *et al*. (2017), who observed that the nursing staff on the acute unit appeared "fearful of engagement with patients" (p. 15) and that the acute unit environment felt repressive. This finding was reported from a qualitative study in which the researchers sought to understand staff behaviour from a psychodynamic perspective, although the study steering group that engaged in the reflective processes only included external participants with no staff from the ward.

To summarise, in this section I have argued that the model of care adopted for use within the acute unit concerning people's interpersonal relations and professional perspectives impacted on the service users' ability to engage in therapeutic activities. I explored the interdisciplinary collaboration within the acute unit and the working relationships which I observed in the PAR group over the

period of the data collection. The power dynamics within this context were also discussed, linking these to theories on how power and authority reside only with some staff, which gives them greater control over decision making. It was also noted that the issue of power within healthcare settings can be complex and that each team member works according to his/her specific professional knowledge and the roles and responsibilities assigned to staff all confer some degree of power. However, a failure to respect the profession-specific knowledge of some team members by those responsible for making final decisions could cause other professionals to feel that their voices were not heard and they were less valued within the team. These assigned roles and responsibilities also encourage staff to do what is required of them and not to work beyond their remits, especially if they are already struggling to complete their core responsibilities as a result of working with limited resources and reduced staff strength. In the next section, I bring these three themes together to discuss the impact of the physical and social environment of the acute unit on the staff's work and the service users' engagement in therapeutic activities. This is discussed through the concept of alienation.

7.6: THE ACUTE UNIT: AN ALIENATED THERAPEUTIC LANDSCAPE

Within this study, the conclusion drawn from the findings is that the models of care adopted for use and the state of the physical environment of the acute unit were both negatively impacting the service users' engagement in therapeutic activities. As a result, when viewed as a therapeutic landscape, the acute unit took the form that Wakefield and McMullan (2004, p. 299) described as one that can "simultaneously hurt and heal" the users, as detailed in Section 1.1.4 of Chapter One. The 'hurt' component in this instance could be regarded as a shared experience of alienation by both the staff and the service users. Bryant (2016) suggested that people experience alienation in different ways, such as intrapersonal, social and occupational alienation. In terms of the acute unit as a therapeutic landscape, this study found that the safety and the medication need of the service users were being met to a good standard, but there were limitations on the service users' engagement in therapeutic activities. The service users' references to being bored on the acute unit provide an example of how the therapeutic landscape can 'hurt' the service users. Similarly, the staff felt occupationally alienated when they spent time engaging in activities like opening locked doors and facilitating smoking breaks, in addition to the frustrations they expressed about the lack of collaborative working across the teams.

In Section 7.3.3, the definition of occupational alienation that was referenced included the following elements: powerlessness, frustration, and loss of control resulting from engagement in occupations that do not satisfy a person's inner needs (Wilcock, 2006). All three elements of alienation were experienced by the

staff, according to the findings reported in Chapter Six and further discussed in relation to the third key theme in this chapter. The service users' experience of being bored on the wards is similar to that reported by Gilburt *et al.* (2008), who identified that the service users' lack of freedom led them to feel lonely, isolated and bored in the inpatient unit. Marshall *et al.* (2020) also found that boredom among the service users in the inpatient unit is a recognised problem.

From an occupational perspective, occupational therapists believe that all people have an "innate need and right to engage in meaningful occupations", irrespective of the environment (AOTA, 2011 p. S65). Generally, on admission, the service users have specific tasks that they have to do, want to do, and are expected to do (WFOT, 2012), These include, for example, selfcare routines, taking medication, having breakfast, attending therapeutic activities, and using their leave. There were also times that they may be seen having a 'downtime' - doing nothing and would either be in their rooms or sitting with peers in the communal areas watching TV. These routine activities are health-promoting activities that contribute to their health and wellbeing. In this study, the participants in the survey perceived high levels of service user involvement in their care on the wards in terms of how active and energetic they were (Manual on WAS, 1974). This is a facilitating factor that indicates that the service users could engage in more therapeutic activities given the right opportunities and taking take into consideration the severity of each individual's mental health problem.

By contrast, in response to the open-ended questions, the service users reported not having enough to do on the wards and being bored. This was corroborated by the staff in the PAR group discussions who shared that they felt the service users were engaging in fewer therapeutic activities due to the impact of the formal systems that had been adopted and the limitations within the physical environment, as discussed previously. There was a difference between the meaning of 'involvement', as a subscale on the WAS, and 'therapeutic activity' which was used in this study, indicating that these could be seen as two different constructs. In this study, therapeutic activities were conceptualized as those structured activities organised by the occupational therapy team, either in collaboration with the service users or not. These activities were used as therapy and formed part of the service users' treatment, either for assessment or as an intervention, hence the use of occupation both as a *means* and an *end* (O'Brien, 2017).

The concept of therapeutic activities in this study was found to be understood differently by the various professionals within the acute unit. For instance, the ward community meeting was referred to as a therapeutic activity by Dr John in the key informant interview. From a critical stance, Dr John was not wrong in referring to the ward community meeting as a therapeutic activity, as it was a session that occurred once a week in which the service users had the opportunity to voice what they felt was not going well on the wards and to have 'access' to different professionals in the same space. The idea of the ward community meeting originated from the concept of a therapeutic community (Jones, 1953) which posited that the service user's everyday life when on admission forms an

intrinsic part of his/her care. As a result, those with similar experiences need to be together to offer support to peers, thus giving more autonomy to the service users. The Henderson Hospital in London, which was closed in 2008, was noted for its therapeutic community (https://ezitis.myzen.co.uk/henderson.html; Norris, 1983). What requires further exploration is whether the ward community meeting in its current form at the acute unit was in line with the ethos of the therapeutic community approach.

Dewis and Harrison (2008) proposed that occupational therapy as a profession should explore what 'boredom' meant when it was referred to by service users. They argued that it is not simply a lack of occupation, but a feeling experienced when an occupation lacks meaning and is not perceived as adding quality to life. Although there were therapeutic activities on offer at the wards and the basement, as discussed in the findings, the service users still complained of being bored on the wards, suggesting that engaging in those occupations was probably not satisfying an inner need. Engagement in meaningful occupation is regarded as a key feature of, and is strongly emphasised within, the occupational therapy profession (Dewis and Harrison, 2008; Christiansen and Townsend, 2004).

The service users in the acute unit may have been experiencing a sense of disconnectedness with the therapeutic activities that they engaged in or they may have found them unfulfilling (Christiansen and Townsend, 2004), which Bryant (2016) referred to as intrapersonal alienation. For instance, Dr John shared instances in which he had granted service users leave on the condition that they

attended therapy sessions. In this case, the service user may have only attended the sessions as a means of ensuring that their leave of absence from the ward would be granted, rather than because they would have chosen to. Others would sometimes sit in a therapy session on the ward as there was nothing else that they considered meaningful for them to do. Sadly, this could explain why a service user may not protest when called out of an occupational therapy session to attend a ward round, as referred to by Elsie in the findings reported in Chapter Six, Section 6.3.3. Bryant (2016) suggested that one way this problem could be addressed would be to involve the service users in deciding on the occupations that they would like to engage in, thus giving them a choice of the activity that would be used as the therapeutic medium. About the staff who worked in the acute unit, Baillard *et al*. (2020) suggested that only their explicit orientation to occupational justice issues like occupational alienation (as discussed in this section) and articulation would help them to "achieve their full potential in enhancing the participation and the quality of life of the service users" (p. 145). I end this section with a reflection on my experience with the academic supervisory team in this research study.

Reflective Box 4: My experience with the academic supervisory team in this research study

I worked with different individuals on this PhD research study and this reflection is on my experiences with my academic supervisory team. I started off with two named supervisors in January 2017 and within the first three months, due to unexpected circumstances, my primary supervisor (Wendy) who was the lead investigator of the research programme that this study was nested in changed. After Wendy's departure I therefore gained a new supervisor, Fiona. However, in 2020 the personal circumstances of my two supervisors (Fiona and Simone) prevented them from offering me the consistent supervision that was required, hence the introduction of a fourth supervisor (Anna). The initial challenge when Wendy went off was taking the research forward in its original form and working with the expertise of the new primary supervisor, a mental health nursing Professor who had extensive quantitative research experience in mental health. This, I thought could be a hindrance to the progress of the study but acknowledged that it was still in the early stages of the PhD research.

Supervision in a PhD research study is key and more importantly consistent supervision is that which was required to help complete the research study and the thesis write up. These gaps and changes in the supervisors then made me struggle in those instances especially when I had to wait for a long period of time for feedback on sections of the thesis in order to progress. These were frustrating but I was empathetic to my supervisor's situation and acknowledged that an alternative provision needs to be made. Through talking to the occupational therapy programme lead and the PGR director within the school, Anna was appointed as an interim cover. However, she stayed on and supported with the supervision through to my viva and the final submission on a voluntary basis. I continued to progress with the write up of the thesis and as and when I received feedback, I worked on them to effect the changes. Also, I utilised additional support that were available. For example, Wendy reading chapters of the thesis and providing feedback as and when she could.

These supervisors support was key throughout the research process and more importantly during the data analysis and the write up of the findings. Participatory Action Research, like other qualitative research methodology, has been criticised for the researcher's subjective views reported on as findings from the study. To mitigate this critiques, my supervisors were key in helping to ensure that, the themes generated were 'bottom up' from the PAR group discussions and the key informant interviews. These were discussed in depth to ensure that, as a qualitative researcher, I was not only presenting aspects of the findings that reinforced my subjective views. More importantly, having a supervisor within the study team who had no experience of working in the acute unit helped to ensure that, the findings are clearly articulated for the wider audience.

My biggest learning experience from working with my supervisors over the past four years is that, within the PhD journey, the personal circumstances of your supervisors can significantly impact on the supervision processes. How this is managed also can have impact on the progress of the PhD research study but in all, I learnt to work with the available support. Also, I asked for the additional help by talking to the PGR director within the school. If I am to be in a similar situation in future, I will request for the additional support on time instead of dealing with the fear that I had to start all over with a new supervisor who is not familiar with the research project. Working with the four different supervisors, I adapted how I engaged with each of them to ensure that I get the best from the supervision. For instance, working with Fiona was mostly online using skype even before the COVID-19 pandemic and the locked down that resulted transitioning to more online supervision via zoom. As I complete this PhD study, looking forward to taking on own PhD students, I plan to include in their induction discussions around the supervision process, how this could be impacted on and as students how they can best manage such situation such that the impact on the progress of their research study is minimal. As a prospective supervisor, I have learnt that I could be drawn upon to be a supervisor for a PhD student to 'fill in a gap' for a colleague if I have the requisite knowledge and expertise. This could be an additional workload on my time but have learnt that such support is useful for the student who require it. In supervising the BSc and MSc Occupational therapy students in current role, I have not had to support any student halfway in the Modules but have had one-off meetings with students to discuss their research topic, literature review or the research proposals. These approaches I believe help us as a team within the school to support our students effectively and timely.

7.7: LIMITATIONS

This section outlines where the research study encountered limitations that might impact the dependability and the transferability of the outcomes. First, there is a need to recognise that the study site building and design is not a typical example of acute unit design within the UK. Secondly, within this unit, a small sample of staff and service users contributed to this study and are thus representative of a tiny percentage of all NHS staff and service users. In addition, more therapy staff comparatively were recruited for the PAR group compared to the ward staff with no involvement of staff from the psychology team. The PAR methodology used in this research study is a qualitative research design, which means there is a lack of power in the survey data that limits the ability to make any generalisations from the survey findings. In addition, the SOFTEN, as discussed on page 107 was not factor analysed due to the limited number of people who completed the questionnaire. Although, it had good internal consistency, its robustness to adequately measure the features of the physical environment of the acute unit still needs to be worked on. This study is therefore the first pilot study that has been trialled and subsequent studies should continue to work towards reliability and validity.

However, the recommendations from these findings would still apply to another context if the environment were similar to or the same as the acute unit that I investigated. In Section 3.4.2. of Chapter Three, I provided detailed description of the acute unit which can enable transferability (Bryman, 2015) of the findings to similar settings. In hindsight, I would have used a recently validated standard questionnaire instead of the Ward Atmosphere Scale used, taking into

consideration feedback on the challenges of completing the questionnaires gathered from both the staff and the service users.

The study's democratic validity, defined by Herr and Anderson (2015) as the extent to which all the stakeholders participated in a study, could have been improved. This relates in particular to limiting the service users' involvement in the survey and the PAR group participants' involvement in the data analysis. Ideally, in PAR, the people with lived experience should be involved in all the stages of the research processes. However, the service users' involvement was very limited in this study which is attributed to this study being part of a wider research programme. A decision was arrived at, after identifying that participants in the previous studies within the research programme were mostly service users (Bryant et al., 2019). This, however, skewed the findings from this study more towards the staff perspectives than the service users. One, therefore, needs to be cautious in interpreting the findings. The impact on the findings is also observed where there is no information within the findings from the service users on how they felt changes had occurred or not occurred as a result of their involvement in this study. A finding that is key in studies that ascribe to the emancipatory perspective. Reflective box 5 captures my reflection on the nominal involvement of the service users in this study.

In addition, with hindsight, I realised I should also have gathered the views of the administration staff within the acute unit, to ensure that the opinions of all the users of the space were captured, so that any recommendations or changes suggested by the study would apply to everyone. Finally, it would have been

useful to explore the views shared by the key informant interviewees in the PAR group but this was not possible due to the limitations of keeping within the PhD study timeline.

Reflective Box 5: Impact of the nominal involvement of service users in this research study

This reflection was necessitated after the study findings chapters were written up. I realised that the service users' views as reported in the study were very limited, only from the survey components and on hindsight did I realise I could have included them more. Considering the aims and the proposed working study title at that point, I realised that I should have made the provision to involve the service users in the module two of the study. In this research study, 33 service users completed the questionnaires for module one of the study that addressed the aim of exploring their views on the acute unit environment. This decision was arrived at after a review of the literature and the initial discussions with staff that confirmed that, the service users were on admission at the acute unit for approximately 30 days. The service users limited involvement, I felt, was a major limitation to the design of this study. A decision that was arrived at based on the justification that; this study is nested in a wider research programme that previous studies had investigated the issues from service users' perspectives.

This became prominent when I struggled to trace the changes that might have occurred within the environment as a result of this study from the data from the service users. From the PAR perspective, I had proposed that, this research study was approached from an emancipatory perspective such that, at the end of the study, the changes that could occur would help emancipate the participant. However, limiting the service user involvement to only Module one of the study, I found that this objective of the study was not achieved. In reassessing where things had gone wrong, I could trace to the study design and the wider research programme that this study was nested in. The previous studies in the research programme had focus on the service users, although in a different environment. However, as a standalone PhD research study, this was a limitation. This realisation of the limited data from the service users halfway in the data collection informed the decision to add the section E; to the service users' questionnaires when I applied for the amendment to the study protocol. However, after the analysis I realised it was not the best approach to gathering that data. Also, on hindsight I felt more engagement with the service user prior to developing the study protocol would have helped to facilitate their involvement and perspectives. Nothing much could have been done at that point, but going forward, there are lessons that I have learnt.

The research design, especially the data collection, should have included opportunity for either key informant interviews with the service users and/or one-off PAR group meetings with a group of service users on the ward. An approach to the data collection that would not be limited by the length of stay of the service users on the wards. This was key as PAR at its core is to engage and involve the perspective of marginalised service users in order to achieve transformation and the desired change. Also, whenever I am involved in a study that forms part of a wider research programme, I need to carefully evaluate how the aspect I will be leading, although forms part of the bigger project can also be standalone research study.

7.8: CHAPTER SUMMARY

This chapter has discussed three key findings from this study concerning the literature. Generally, it confirmed findings from other studies about the limited freedom experienced by the service users detained in the acute unit, and in relation to them not having enough activities to engage in. However, this study has generated new knowledge through the finding that, when the physical environment provided for the care of mental health service users is not purpose-built, an essential element of care – the service users' engagement in therapeutic activities - suffers unnecessarily. In addition, the use of locked doors as a key security feature limits the service users' access to other spaces within the building where they could access therapeutic activities, with a considerable impact on staff time as staff are required to facilitate this access. On the social environment, the challenges to MDT working and the impact of this on the service users' engagement in therapeutic activities were discussed. The implications of these issues and recommendations for the relevant stakeholders are presented in the concluding chapter.

CHAPTER EIGHT

CONCLUSION

8.1: INTRODUCTION

This chapter summarises the study and highlights the key findings and the new knowledge that has emerged from it. This is followed by the implications and recommendations for research, clinical practice, policy and education. The chapter ends by making suggestions for further areas of research.

8.2: OVERVIEW OF THE RESEARCH

This research aimed to explore the staff and service users' perceptions of the impact of the acute unit physical and social environment on the service users' engagement in therapeutic activities and this was examined through the following objectives as stated in Chapter two.

- To explore the environment of the acute mental health inpatient unit from the staff and service users' perspective.
- To explore staff and service users' perspectives on how the environment of the acute unit affects mental health service users' engagement in therapeutic activities.
- To examine the potential of the acute mental health inpatient unit environment and how it could contribute to the service users' engagement in therapeutic activities.

This research study proved to be challenging to undertake with the staff and the service users who were in an environment that was not typical of most acute units. Although I worked with the peer researcher, I still had to organise the processes and manage the logistics involved in researching within this environment. I could have abandoned the research or cut short the cycles of action research planned in the protocol, but instead, I returned to the NHS REC to apply for an amendment to the ethics approval. Which allowed the inclusion of an additional cycle of data collection to ensure that all identified stakeholders' views were gathered.

The findings of the lived experience of the staff and the service users have been shared in this participatory action research, which predominantly builds on studies that have explored service users' engagement in therapeutic activities. The findings confirm that the study participants were perceived as not having enough to do when they were admitted to the acute unit, which has been discussed from the perspective of the impact of the physical environment of the acute unit, the service users' experiences, mostly from the staff perspective and the social environment. This study has provided evidence that, when the physical environment provided for the care of service users in an acute unit is not purposely designed and built, the staff encounter problems in implementing evidence-based interventions, such as the effective provision of therapeutic activities and the implementation of a smoke-free grounds policy.

This study has therefore contributed to the idea that the provision of an appropriate environment can help to enhance the service users' experience. In

addition, it found that, within a challenging environment, the MDT staff may feel overwhelmed and struggle to work according to their profession-specific roles and responsibilities, which adversely impacts the interdisciplinary collaborative working necessary to facilitate the service users' recovery. It is therefore recommended that the physical environment allocated for the care of the service users should be congruent with the model of care adopted to inform practice. Thus, current evidence-based interventions and policies are most effective if they are provided and implemented within a physical environment that has been specifically designed and built to meet these needs.

8.3: IMPLICATIONS AND RECOMMENDATIONS FOR RESEARCH, PRACTICE, POLICY AND EDUCATION

While these findings may not be easily transferrable across different settings due to the limitations outlined in the previous chapters, they can still serve as a basis for making recommendations for policy, practice, research and education.

8.3.1: RESEARCH

This study has contributed to an emerging area of knowledge on architecture and mental health, particularly from an occupational therapy perspective. In Connellan *et al.*'s (2013) literature review, it was found that the professionals and academic experts who contributed to the area of mental health and the physical environment (architecture) excluded occupational therapists. Therefore, this study is among the few that has been led by an occupational therapist. Research focusing on the environment (or 'space', as it is described in some studies) is still emerging and this study adds to the discourse, especially in the sense that it examines an under-researched area: the acute inpatient mental health unit. In addition, this study contributes to the literature on studies that have utilised the PAR methodology, demonstrating that the participatory research approach can be used with an MDT within an NHS facility to generate knowledge of direct benefit to the service. Those who participated in this study comprised service users, front line staff, and managers, and the research also received support from the NHS Trust as a whole. This was achieved through collaborative working between staff from the University of Essex and the acute unit, as outlined in Figure 1.1. The provision of funds by the acute unit in support of the study was

very useful and helped with staff recruitment, peer researcher involvement, the provision of refreshments and lunch during the PAR group meetings, as well as travel expenses. It should however be acknowledged that the funding of £6,000.00 received from the acute unit to support this study in no way influenced the findings of this study. It however demonstrated the interest that the senior managers had in the research and the other opportunities they provided for the dissemination of the study findings as listed in Appendix Y. This study has further shown that there can be challenges associated with recruiting staff, particularly in terms of enabling staff to take time away from their clinical duties to participate in the data collection. However, this difficulty was overcome and it was proven that it could safely be done with no impact on clinical care. This study, therefore, makes a significant contribution to the literature as there is currently a dearth of published research that involves interdisciplinary participants and outlines the physical and social environmental challenges faced in acute inpatient mental healthcare settings.

8.3.2: PRACTICE

The acute unit is a traditional occupational therapy practice setting - a micro level where occupational justice-oriented practice can be enhanced (Baillard *et al*., 2020). One possible way to address the service users' and staff's dissatisfaction with the lack of access to a garden and outdoor facilities would be to promote indoor gardening on each ward in addition to facilitating easier access to the rooftop garden for the service users. There is no space for an outdoor facility to be added to the acute unit grounds but therapeutic activities available to the service users on admission could be designed to utilise community resources with gardens and outdoor facilities. However, these recommendations would require dedicated space to be made available on each ward, as well as adequate staffing for escorting service users into the community and effective use of the leave system already in place. The closure of three bedrooms on each ward, which has already taken place as part of the improvement programme, is an initial step in the process.

In addition, it is expected that, a substantial financial commitment would be required to allow a full renovation of the study site to be carried out. The renovation conducted in the 1980s before its use as an acute unit is currently not sufficient to meet the needs of the users. Therefore, comprehensive renovations would need to be conducted more frequently than every thirty years, to bring it up to the level required to support the staff's work and promote the service users' engagement in therapeutic activities. However, the PAR participants explained that minor renovations have occurred during this period, and that the original plan

shared with them by the management had involved the closure of the acute unit, which they perceived as being influenced by cost savings, although this had been part of an ongoing discussion even before I started the research at the acute unit. In the final meeting held in September 2019, the PAR group members were very keen to take the ideas forward to help improve the acute unit and to promote service users' engagement in therapeutic activities. However, when COVID-19 was declared a pandemic by the World Health Organisation on 11th March 2020, the NHS Trust decided to close the acute unit and transfer staff and service users to other Trust sites. This confirms that the study was conducted at a time when the provision of services at the acute unit was in its last stage. A further discussion with management could have shed more light on the rationale behind some of these decisions. Recommendations regarding the locked doors as security features are presented in Section 8.3.3.

8.3.3: POLICY

The tension between keeping people safe, service users feeling restricted and the impact on the service users' engagement in therapeutic activities can be addressed by trying to balance these factors equally. A macro-level change needs to occur to effectively address the issues regarding the use of locked doors as key security features within the acute unit. There is a need to utilise current technology so that the service users can have more freedom and do what they value while still maintaining their safety and dignity. Such a recommendation could be part of the policy adopted within the local acute unit, the NHS Trust and within the NHS more widely. The occupational therapist and the staff who have become aware of this knowledge through participating in this research could start advocating for the change. They could use the designated channels within their organisations for this purpose and further widen involvement by engaging in policy-level decision making.

The professional bodies and unions which act as spokespersons for the therapists could also take on these issues and try to bring about changes in policy on the design and building of acute units. For instance, in the UK, the Royal College of Occupational Therapists (RCOT) could look into these injustice issues within the inpatient units resulting from the locked doors and the service users not having sufficient activities to engage in. This process had already been started by the World Federation of Occupational Therapists in 2006, by promoting the idea that people's engagement in occupation is a fundamental human right. The occupational therapists could therefore argue that the rights of the service

users are being violated by their limited engagement in therapeutic activities, which is impacted by the problems identified within the acute unit environment. An alternative solution to locking the doors needs to be found, one that considers both service users' safety and supports their access to other spaces like the garden and the basement, with limited staff involvement. This would promote the service users' autonomy and increase their sense of freedom. Regarding the issues of the loss of space and the acute unit being sufficiently close to service users' homes and family, it is recommended that town and country planners should be made aware of such needs and ensure that spaces are always allocated for such use, irrespective of the rapid expansion taking place in urban areas. Additionally, key documents like the Standards for Inpatient Mental Health Services document produced by the Royal College of Psychiatrists (Perry *et al.*, 2017) should clearly articulate the need for space to be allocated for the provision of therapeutic activities on the ward/unit of the inpatient environment.

Regarding the staffing issues, it is recommended that there should be clear guidelines on staffing levels within the acute unit, appropriately informed by the demands on the staff within the unit. The acute unit management needs to review how they determine ward staffing levels and, in particular, to take into consideration the escorting duties involved in facilitating smoking breaks for the service users who smoke. Until the new smoking policy is implemented and staff are competent in enforcing it, staffing numbers should be maintained at a high enough level to cover these additional staff duties. Finally, working relationships across the MDT could be enhanced by staff learning to share and understand each other's professional philosophy better. Although they work according to

different professional philosophies, staff members still depend on each other to accomplish the task of providing effective care for the service users. To promote professional collaboration among future healthcare practitioners, Bridges *et al*. (2011) recommended the use of a threefold model comprising: a didactic programme; community-based experience; and interprofessional simulation.

8.3.4: EDUCATION

The findings from this study imply that occupational therapy education should place more emphasis on the impact of the environment on people's occupational performance. The Health and Care Professions Council and the Royal College of Occupational Therapists could include in their standards for pre-registration Occupational therapy education clear guidance that, the curriculum should have a section with a focus on the environment. It is recommended that educators, both in universities and practice settings (placements), need help students to become more aware of the broader scope of the environment and the various ways that it impacts people's engagement. In addition, it is recommended that health and social care departments in universities should review and, if necessary, amend the interprofessional training they offer to ensure it fosters a better understanding of different professional roles and responsibilities, role overlaps and collaborative working within the MDT. Interprofessional education has been defined as, an "occasion when members or students of two or more professions learn with, from and about each other to improve collaboration and the quality of care and service" (Statement of Purpose CAIPE 2016, p. 1). Although there may be difficulties, especially within universities, in terms of how departments are structured, it is still essential that these opportunities for interprofessional education continue to be made available. The emphasis in this case, has been on learning with, from and about each other, as highlighted in the CAIPE's definition.

It is also recommended that education about the various professions' roles and their contribution to the service users' care should continue within the practice

setting. The provision of this information should not be a one-off activity, for example communicated in a staff induction session, but rather a more regular activity undertaken when job roles change or the service changes. A more inclusive approach that gives all MDT members an equal opportunity to participate and contribute is also recommended, which has been referred to as cooperative learning (Day, 2013). Cooperative learning sessions should be repeated as and when necessary, for instance when a new staff member joins a team. As services continue to find new ways to improve service users' care, new roles are created, and staff are recruited, but their job titles may not clearly specify their role. For instance, during this research I came across peer support workers on the wards for the first time in my career. Peer support workers are people with personal lived experience of mental health problems who work on the wards to support other service users in their recovery journey (Health Education England, 2019). Longer serving staff members on the wards could easily have a similar experience of mistaking them for therapy staff because they were managed by the occupational therapy team lead. Hence, aside from induction sessions for new staff, other opportunities need to be created by the ward staff and the various teams to help each other understand their roles, identify how these roles overlap and understand how to work collaboratively to support service user care.

8.4: AREAS FOR FURTHER RESEARCH

This study was limited by the resources that were available to support the recruitment of the service users and the timelines of the PhD study. In future studies, the views of all the users of the building, including administrative staff, managers, social workers and hospitality staff, should be gathered via a survey instead of limiting it to the clinical staff, as was the case in this study. This is to ensure that all the users' opinions are captured so that, when action is taken, the needs of everyone are met. This study has generated baseline findings and it is recommended that future research builds on this knowledge by conducting a quantitative study that explores the relationships that exist between the acute unit environment, the service users' engagement and the health outcomes of the service users. Other studies could also compare multiple sites of purpose-built and non-purpose-built acute mental health units to identify the impact on the service users' engagement in therapeutic activities. Finally, this study had intended to explore the cultural environment of the acute unit but findings relating to this aspect did not clearly emerge. It is therefore suggested that a future study could utilise a research methodology best suited to studying the cultural environment.

8.5: CHAPTER SUMMARY

In this chapter, I outlined what this study set out to explore and the findings that emerged. The study aimed to explore the staff and the service users' views on the impact of the environment on the service users' engagement in therapeutic activities. This aim was achieved, and the findings showed that an environment not purposely designed and built presents significant challenges in terms of supporting the provision of care for the service users. At best, some aspects of the service users' needs, such as medication and safety needs, could be met, but other aspects of care, like the engagement of the service users in therapeutic activities, could be hampered. The implications of the findings for research, practice, policy and education have been clearly articulated with suggestions of areas for further research.

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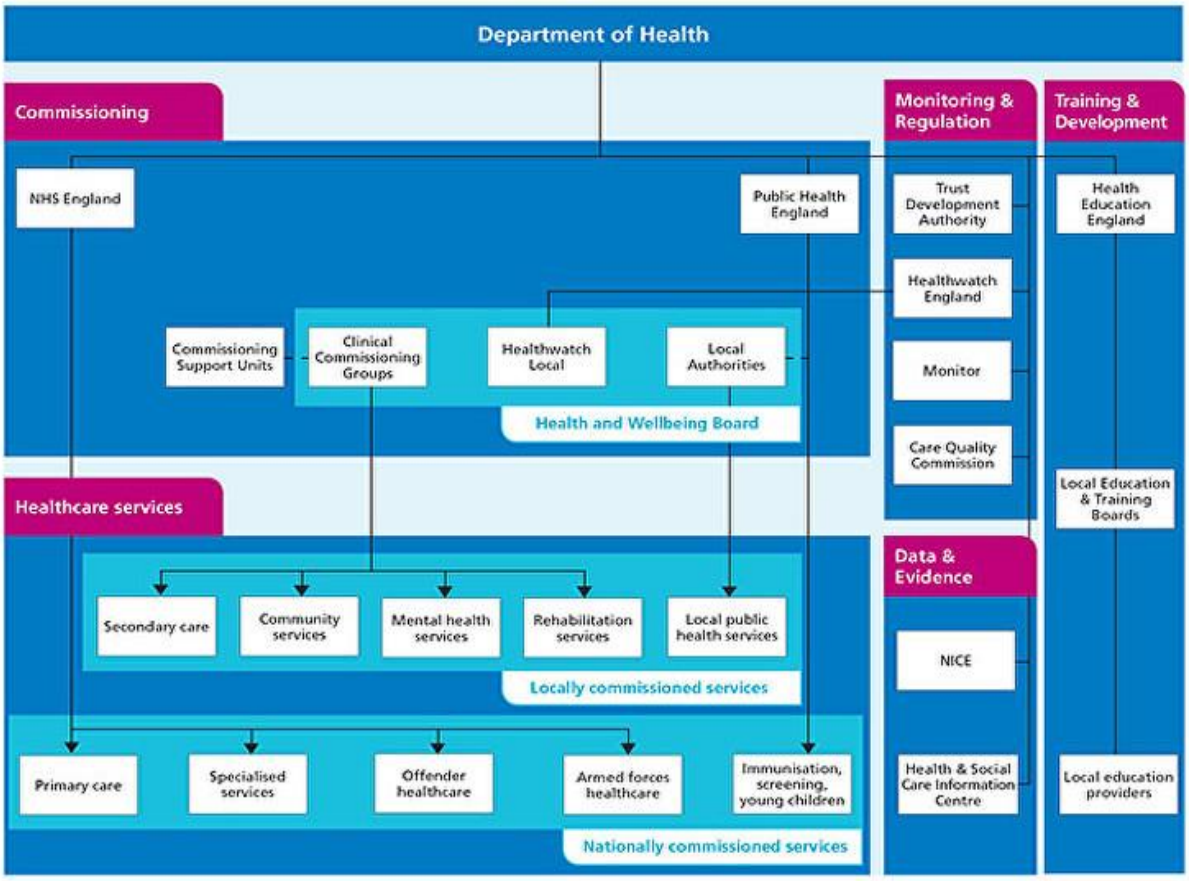
APPENDICES

Appendix A: Structure of the NHS in England.



Adopted from google images.

Appendix B: Honorary contract with CNWL NHS Trust

Central and North West London NHS
NHS Foundation Trust

Recruitment Team
Stephenson House
75 Hampstead Road,
London
NW1 2PL

Tuesday, 21st March 2017

Private and Confidential

Ms Ellen Serwaa Adomako
WM/0/6/7 William Morris
University of Essex
Wivenhoe Park
Colchester
Essex
United
Kingdom
CO4 3SQ

Your Ref: 333-J-HON-AHP-001

Dear Ms Ellen Adomako,

APPOINTMENT OF HONORARY STATUS

Dear Ellen Adomako

I am pleased to offer you an honorary appointment with Central and North West London NHS Foundation Trust as an Honorary Honorary Occupational Therapist/ Researcher (Jameson) within Eating Disorders and CAMHS from 16-Jan-2017 until **16-JAN-2020,** with an option to renew the contract for a further period. You will normally be based at Acute unit Hospital but may be asked to visit/work at other sites within the Trust, which would be negotiated with you in advance.

The appointment and duties

This appointment is without remuneration and covers your duties as they affect patients and/or services and equipment on NHS premises. As you are employed in an honorary capacity no employment rights are conferred by this appointment.

You will be required to complete a medical questionnaire or to allow our Occupational Health Department access to your medical details via your own Occupational Health Department. For some staff a medical examination may be necessary on appointment.

The duties relating to the appointment are determined by Suzie Wills (CNWL) & Dr Wendy Bryant (Essex University) to whom you are responsible.

Confidentiality

During the course of your employment you may have access to data and information (computerised, written or oral) of a confidential nature. You are expected to maintain confidentiality about information relating to all aspects of your employment both during and after your period of employment with the Trust.

Disclosures of information in whatever way it is held relating to patients e.g. diagnosis, treatment, personal data; staff e.g. personnel records; business sensitive or commercial information e.g. contractual and rental agreements, financial arrangements; or that which you acquire during the course of your employment e.g. computer software, research projects, inventions and designs; may only be disclosed with the agreement of your manager. All employees have a responsibility for ensuring security of information and to comply with the Data Protection Act, Access to Health Records Act and Computer Misuse Act. Disclosure of personal, medical, business sensitive or commercial information, systems passwords or other information of a confidential nature to any unauthorised person or persons will be considered as gross misconduct and will lead to disciplinary action which may include dismissal.

Moreover the Data Protection Act 1998 also renders an individual liable for prosecution in the event of unauthorised disclosure of information, or an action for civil damages under the same Act.

As an employee you have a responsibility to ensure you maintain a high quality of data and record management.

No unreasonable restriction is placed on staff in talking to the media on general matters relating to clinical or non-clinical issues except matters, which are confidential. Disclosures of confidential information to the media should only to taken following authorisation from the Chief Executive or their delegated representative.

Health and Safety

You are reminded that, under the Employment Rights Act 1996, you have a joint obligation with the Trust in ensuring good physical working conditions and that health and safety standards are maintained throughout the organisation. You must have regard at all time to your own health and safety and that of your colleagues and visitors to the Trust's premises. Any hazards or accidents must be reported immediately to your manager (or duty manager out of hours) and this should be documented on the appropriate form.

Personal Property

Central and North West London NHS Foundation Trust accepts no liability for loss by theft, fire or other means of personal property. It is therefore recommended that you take out an insurance policy to cover your personal property.

NHS Indemnity

You will be indemnified by the Trust for all NHS work undertaken as part of services provided to the Trust. You are advised to take out adequate defence cover for any work, which does not fall within scope of the indemnity scheme.

You should fully co-operate with the Trust and its legal advisors in the investigation of any patient complaint/incident including but not limited to any allegation of negligence or misconduct. You are required to provide the Trust on request a full written statement concerning any patient complaint/incident. This obligation will continue after this appointment has ceased.

Smoking and Alcohol Consumption

Smoking is not permitted on the premises. Consumption of alcohol is not permitted whilst on duty.

Notification of Actual or Intended Criminal Proceedings

You must immediately notify your Executive Director if you are charged with or convicted of a criminal offence. If in any doubt you must seek the advice of your manager.

Registration

It is a condition of the honorary appointment that you maintain registration with your recognised professional association/General Medical Council. You should present a copy of your certificate to the HR Directorate on an annual basis. Failure to maintain registration could lead to your honorary appointment being withdraw.

Equal Opportunities

You are expected to comply with the Trust's Equal Opportunities Policy and to ensure that no individual (patient, member of staff, visitors etc) receives less favourable treatment on the grounds of their gender, sexual orientation, marital status, disability, religion, creed, colour, race, ethnic, national origin, HIV status, age, social background, trade union membership or non-membership and is not placed at a disadvantage by requirements or conditions which cannot be shown to be justifiable.

You are expected to comply with Trust standards, in accordance with Trust Policies and Procedures at all times. This includes notifying your manager should you be unable to carry out the duties of your appointment for any reason. Should any of the terms of this contract be breached your appointment with the Trust may be affected and your appointment may be terminated.

If you wish to accept this appointment on the foregoing terms, please sign the form of acceptance at the end of this letter and return it to me. Please sign and retain the copy letter for your records.

Yours sincerely,

Mr Chris Thorn
Recruitment Advisor
Tel: 02032145997

Signed on behalf of the Trust

I Ellen Adomako hereby accept the position of Honorary Honorary Occupational Therapist/ Researcher (Jameson) on the terms and conditions as set out herein.

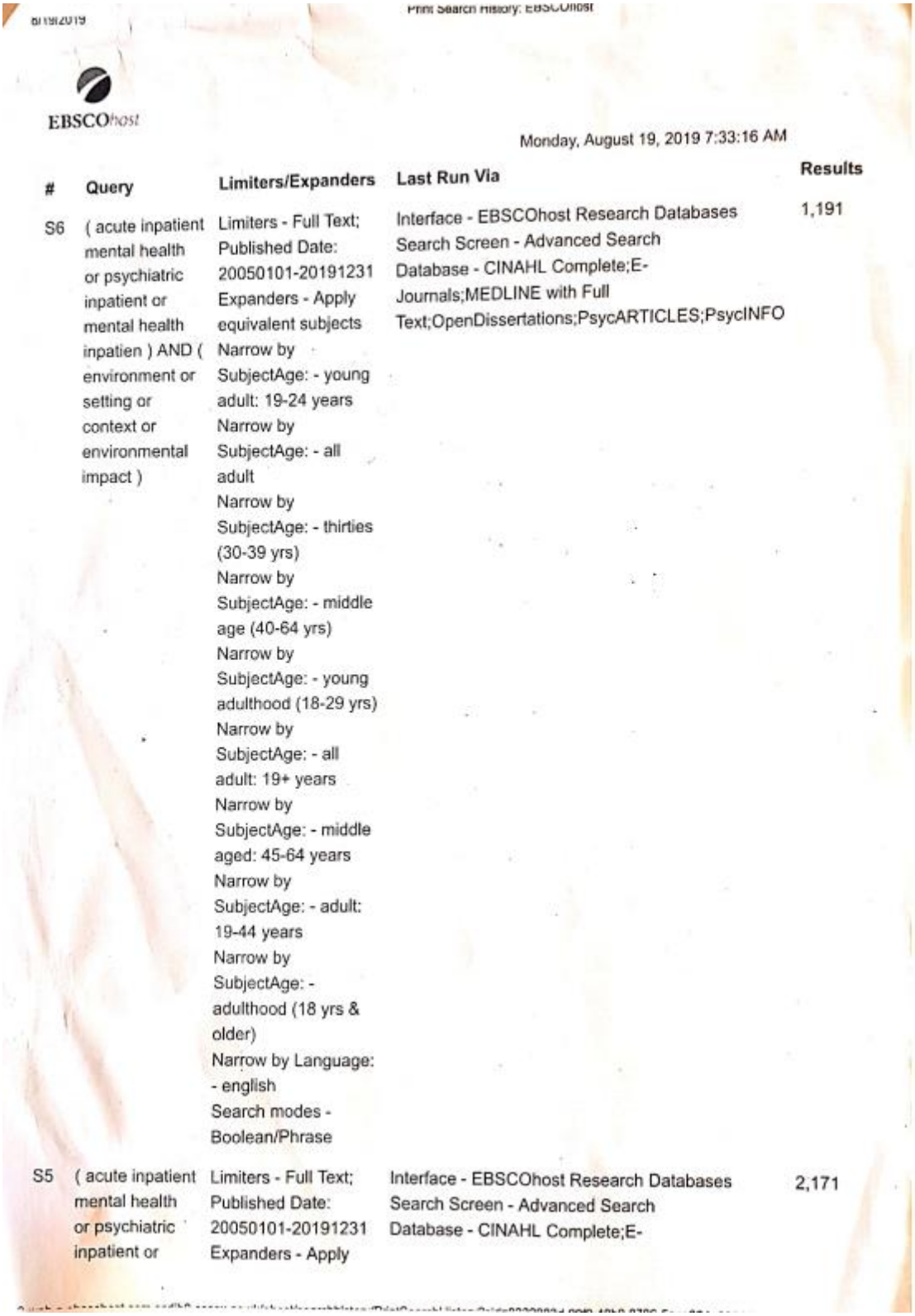
Name: Ellen Adomako

Signed ESA.

Date

I Ellen Adomako hereby confirm I will return a signed copy of this honorary contract within 5 days of receipt via scan and email within the electronic recruitment system.

Appendix C: Search history.



8/19/2019 Print Search History: EBSCOhost

EBSCOhost

Monday, August 19, 2019 7:33:16 AM

#	Query	Limiters/Expanders	Last Run Via	Results
S6	(acute inpatient mental health or psychiatric inpatient or mental health inpatien) AND (environment or setting or context or environmental impact)	Limiters - Full Text; Published Date: 20050101-20191231 Expanders - Apply equivalent subjects Narrow by SubjectAge: - young adult: 19-24 years Narrow by SubjectAge: - all adult Narrow by SubjectAge: - thirties (30-39 yrs) Narrow by SubjectAge: - middle age (40-64 yrs) Narrow by SubjectAge: - young adulthood (18-29 yrs) Narrow by SubjectAge: - all adult: 19+ years Narrow by SubjectAge: - middle aged: 45-64 years Narrow by SubjectAge: - adult: 19-44 years Narrow by SubjectAge: - adulthood (18 yrs & older) Narrow by Language: - english Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL Complete;E-Journals;MEDLINE with Full Text;OpenDissertations;PsycARTICLES;PsycINFO	1,191
S5	(acute inpatient mental health or psychiatric inpatient or	Limiters - Full Text; Published Date: 20050101-20191231 Expanders - Apply	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL Complete;E-	2,171

	mental health inpatien) AND (environment or setting or context or environmental impact)	equivalent subjects Narrow by Language: - english Search modes - Boolean/Phrase	Journals;MEDLINE with Full Text;OpenDissertations;PsycARTICLES;PsycINFO	
S4	(acute inpatient mental health or psychiatric inpatient or mental health inpatien) AND (environment or setting or context or environmental impact)	Limiters - Published Date: 20050101-20191231 Expanders - Apply equivalent subjects Narrow by Language: - english Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL Complete;E-Journals;MEDLINE with Full Text;OpenDissertations;PsycARTICLES;PsycINFO	3,331
S3	(acute inpatient mental health or psychiatric inpatient or mental health inpatien) AND (environment or setting or context or environmental impact)	Limiters - Published Date: 20050101-20191231 Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL Complete;E-Journals;MEDLINE with Full Text;OpenDissertations;PsycARTICLES;PsycINFO	4,462
S2	(acute inpatient mental health or psychiatric inpatient or mental health inpatien) AND (environment or setting or context or environmental impact)	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL Complete;E-Journals;MEDLINE with Full Text;OpenDissertations;PsycARTICLES;PsycINFO	7,063
S1	acute inpatient mental health or psychiatric inpatient or mental health inpatient	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL Complete;E-Journals;MEDLINE with Full Text;OpenDissertations;PsycARTICLES;PsycINFO	35,224

Appendix D: Summary table of the articles reviewed for the literature review.

No	Authors, year & Country	Themes	Keywords	Title	Aim/ purpose	Design and critical appraisal tool	Data collection/ measures	Participants	Findings	Strength and Limitations	Comments
1	Shattel et al. USA 2008	Safety and security Engagement in therapeutic activities	Acute care psychiatry Mental health nursing Therapeutic milieu	How patients and nurses experience the acute care psychiatric environment	To understand elements of the inpatient unit that nurses could focus their energy on to better the env't.	Phenomenological study CASP Qualitative Appraisal	Interviews In hospital On-campus office	Patients – 10, 6 women (non-psychotic) Nurses	Experience of environment was parallel for staff and patients 1.Both felt confined in a prison-like world Pt yearned for outside and took solace in windows and views Moment of connection with others occurred mainly **within groups** rather than between groups 2.experience of time differed, stood still for patients (bored),		Patients were paid $10 Not enough staff to go out with patients Nurses recounted other activities that patients could engage in but are not provided on the ward, although no references was made to occupational therapy Staff caught out in double bind

									moved quickly for nurses (busy)		Organisational constraint.
2	Gilburt et al, 2008 UK	Safety and security Engagement in therapeutic activities Social aspect of the acute unit	No key word	The importance of relationships in mental health care: A qualitative study of SU experiences of psychiatric hospital admissions in the UK	Explore the experiences of admission to acute psychiatric hospitals from SU perspective	Emancipatory, participatory approach CASP Qualitative appraisal	Interviews	19 service users	When SU shared their experience of the hospital, they did so largely within the context of the people that they had encountered. Treatment, freedom and environment defined the role of hospital and its physical aspect		Paid participants Relationship was core to SU exp. Lack of freedom linked to being in prison
3	Michelle Cleary et al, 2009 Australia	Satisfaction: old to a new facility	Mental health Models of care Psychiatric inpatient-staff satisfaction	A comparison of patient and staff satisfaction with services after relocating to a new purpose-built mental facility	To assess patients care delivery and to ascertain patients satisfaction levels and staff attitudes regarding their expectations, views and workplace satisfaction with the new premises	Interview and email questionnaire Survey McMaster Quantitative Critical review form (cross sectional)	Face to face survey for SU Email to staff The inpatient evaluation of services questionnaire	100 SU 16-64 yrs (Dr, nurses, AHP)	New ward env't was rated high by both Staf n SU AHP were least satisfied with staffing levels and team work compared to nurses and Drs 2/3 satisfied with time to spend with pt and family		Mandatory smoke free env't smoking Satisfaction was studied with little focus on engagement in therapeutic activities although asked participants quality of

									Dissatisfied with staffing level, dedicated staff facilities		groups/activities by OT.
4	Jones et al England 2010	Safety and security	Psychiatric wards Patient experience Risk mgt Hospital d/c	Psychiatric wards: places of safety?	Experiences of SU on acute inpatient psyc wards in England regarding feeling of safety and security while in hospital	Qualitative CASP Qualitative appraisal	Semi-structured f-to – f interviews	60 inpatients	Majority of SU reported feeling unsafe, bullied, intimidated Witnessing other SU bring in alcohol and drugs Other safety concern on theft and racism SU did **valued stability and security** when they were in crisis on the wards		Concept of permeability and use of drugs and alcohol ?? impact on access to outdoor facilities.
5	Kemp et al 2011	Satisfaction related to programmes or interventions implementation	Adult mental health ward Practice development	How to turn innovation into everyday practice	Implementation of star ward and productive ward programme on 9 acute wards to evaluate impact	Feature Service improvement report Survey McMaster Quantitative Critical review form (before and after)	Intervention of X2 programme Questionnaires the questionnaires were distributed twice, once before the project was implemented and again, seven	9 acute wards	SU felt were offered more info when arrived, were more involved in decision about their treatment and more occupied in useful and relevant activities More respected and satisfied with care that they received.		PW initiative can lead to nursing staff having more time to engage with service users. Star wards initiative To discuss in relation to Wykes ICT, that intervention

							months later, 71 staff, 84 service users 42 carers completed the questionnaires on both occasions		Project led to reduced length of stay and use of agency staff Staff contact hrs with SU from 21% to 60 %		of staff training improved SU perception.
6	Nolan and Bradley UK, West Midlands 2011	Safety and security	d/c preparation experiences of amhc perception of acute care admissions service users exp. Foll. d/c	Disengaging from acute inpatient psychiatric care: a description of SU experiences and views	To ascertain how individuals experiences disengagement from services with a view to determining what improvements could be made to render to render inpatient care more effective.	Service improvement project. CASP qualitative appraisal	Semi-structured interviews using questionnaires Interviewed in two phases (prior d/c and 2-4 wks by phone post d/c)	44 SU for 1st phase 18 follow up interview	32 SU satisfied with acute care in terms of provision of respite, reducing fear and uncertainties and opportunity to have their mental health reviewed Most snr nurses were perceived as preoccupied with administrative duties with little time for involvement in therapeutic activities.		Post discharge More emphasis needed to be places on the **transitioning from ward** to home and on helping cope with everyday economic and social reality **Temporal illusory sense of wellbeing**
7	Sheehan et al England 2013	The design features	Overall design Fitness for purpose Ensuring everyday safety	Evaluating the build environment in inpatient psychiatric wards	Investigated relationship between staff satisfaction with the built environment of the ward and	Quantitative McMaster Quantitative Critical review form Cross sectional	Format of the NHS staff Survey	1540 staff responded 98 inpatient wards	Satisfaction with built env't was associated with ensuite and non corridor design No difference btn nurses and other groups in		Defined acute care Identified limitations on published literature in acute care as at 2013

					objective design features of the environment. Develop an objective measure of the built environment				satisfaction with overall design Features that appeared to reflect **more modern design** Principles were associated with positive views of the env't. Personal bathroom improves SU dignity, privacy and dignity		as…. Refer to sheet **Recommendation that future research** can include measure of the built environment features.
8	Shepley et al USA (61%) Australia Canada UK 2017	The design features	Behavioural health Mental health Psychiatric facility design Tool survey	Mental and behavioural health settings: importance and effectiveness of environmental qualities and features as perceived by staff	4 fold aims To develop and test a tool for the evaluation of MBH facilities To evaluate the importance and effectiveness of specific env'tal qualities n features To generate design guidelines for MBH	Quantitative McMaster Quantitative Critical review form Cross sectional	Qualtric survey via online and email Through professional associations	Staff 134 59% nurses	Features rated more important: -well maintain env't, orderly and organised n physical access to outdoor -staff safety, noise control and daylight -pleasant gardens and landscape were highly ranked than pleasant street life Places for one to one converstn,		Defined mental and behavioural health Operational goals of MBH facilities differs so studies not focusing on this area cannot help us understand this area better. Creating appropriate environment for the variety of

									Indoor space for therapeutic activities (most imp't)		patients with different diagnoses is a challenge to designers.
9	Wood et al Northeast England, UK 2013	Satisfaction: old to a new facility Social aspect of the acute unit	Managed permeability Psychiatric hospital design In formal carers Therapeutic landscape phenomenology	Creating "therapeutic landscape" for mental health carers in inpatient settings: A dynamic perspective of permeability	Focused on the experiences of carers, F&f who provide "informal care" to the people with MHC	Part of a larger NIHR funded study Qualitative Social interactionist methodology CASP qualitative appraisal	Interviews Discussion groups Twice, before and after move.	9 carers Senior carer's support worker	Hospital environment facilitate or impede the carers journey along the pathway of caring within community and the hospital Issues of interest -closeness to home -locked doors, nurses as gate keepers reflected subordinate position of carers and SU in the hospital envt -good rlxnship btn staff n SU relieve carers distress and burden		Permeability Historically outside space for transitioning
10	Muir-Cochrane et al. Australia 2013	Safety and security Engagement in therapeutic activities	Absconding Inpatient Hospital psychiatric	The inpatient unit as both a safe and unsafe place: implications for absconding.	Why people abscond from psychiatric inpatient unit	Qualitative research CASP qualitative appraisal	Interviews Semi-structured interviews with open ended questions.	12 service users	Hospital perceived as both safe and unsafe place Absconding was related to		Prison-like Thermal discomfort Could go out for smoking.

									perceived unsafe place -individual factors - social factors, interaction with care providers and consumers - physical environment Symbolic environment characterised by lack of freedom, boredom and nothing to do.		
11	Curtis et al 2013 UK	Safety and security	Psychiatric hospital Mental health care Hospital design Risk governance Technical safety Surveillance Therapeutic landscape	Compassionate containment ? Balancing technical safety and therapy in the design of psychiatric wards.	To demonstrate empirically how institutional risk governance seeks to impose "technical safety" through security of physical env't … reality is by critical judgement by staff and pt.	Qualitative research CASP qualitative appraisal	Group discussions interviews	19 groups or individual meetings.			

12	Kennedy and Fortune 2014 Australia	Safety and security	Mental illness Women	Women experience of being in an acute psychiatric unit: an occupational perspective	To identify factors influencing the occupational engagement of women service users in acute inpatient mental health unit	Phenomenological study CASP qualitative appraisal	Semi-structured interviews	6 recruited, 1 dropout	The wards were exp. as a difficult env't. -feeling unsafe n out of their comfort zone -wanted greater division of living space to carry out various activities SU wanted staff to acknowledge them as important and provide practical assistant for them SU wanted more meaningful things to do.		Gap for future research … how environment impact the perception of safety and ability and inclination to participate in occupation. Women only lounge vrs women only time for activity.bn
13	Wykes et al 2018	How to turn innovation into everyday practice	Inpatient wards Mental health Patients perceptions Randomised trial Involuntary patients	Improving patients experience of mental health inpatient care. An RCT	To investigate pt perceptions of ward care following staff training and support for ward therapeutic activities and effect on involuntarily admitted patients To examine the impact of	Quantitative RCT Stepped wedge design CASP RCT Checklist	Staff training provided. Measures Views on inpatient care (VOICE) Service satisfaction scale - Res	16 wards In 3 waves of 8, 4 and 4. 1032 pts.	Increase in mean no of activities post intervention form 6.3 – 7.8, + attendance increased by 6.3 Involuntary pt perception of and satisfaction improved after staff training but no benefit to those admitted voluntarily.		Is not specifically on environment but patients perception of ward care after staff training Pt should have been on the ward for **7 days to participate** Measured **trust,**

					the programme on patients perception of the amount of care received especially those admitted involuntarily				Staff training improved the perception of the therapeutic environment in those less likely to want inpatient admission		**respect** and **therapeutic contact** **SSS-Res Physical env't** Modest cost of 10 pounds incurred in offering the training to staff. Acute wards
14	Bowers et al 2013 UK	Safety and security Engagement in therapeutic activities	Counter intuition Conflict Containment	Correlation between level of conflict and containment on acute psychiatric wards: The City – 128 study	To determine variables that were associated with high and low conflict and containment	Quantitative study McMaster Quantitative Critical review form Cross sectional	Secondary analysis of a primary data	136 acute wards	Unique feature of the HC and HC was the use of unqualified staff and temporal staff LC and LC of service in low social deprivatn and L level of formally detained pt Wards with large no of pt (n=23) had LC but HC and worse physical environment with more rule breaking.		Counter intuition Of finding Defined **conflict** and **containment** and **acute wards** *structure of ward and program clarity as on WAS could make ward have LC and LC. Philosophy of care adopted by setting

											*non amenable change like social deprivation of area the ward serve
15	Patton D Ireland 2012	Engagement in therapeutic activities	Qualitative data analytic framework	Strategic direction or operational confusion: level of SU involvement in Irish acute admission unit care	To explore level of involvement service users have in acute unit in Ireland.	Qualitative CASP qualitative appraisal	Semi-structured telephone interview	18 staff	Heroic nursing: involving SU in nursing process through offering them choices to either engage or not. Interaction with SU as people through developing trust with them and it did occurred slowly in the course of SU's admission. SU unwell and documentations required by policy impede SU staff interactions.		Study is part of a sequential mixed method design. Extent of illness acuity impact on extent of SU involvement *Nurses discussed interactions and not engaging the SU's in the interactions. Difficult context
16	Urbanoski et al 2013 Canada	Satisfaction: old to a new facility		Does the redesign of psychiatric inpatient unit change the treatment process and outcomes?	To investigate whether the ward atmosphere mediated the association between unit	Survey Questionnaires McMaster Quantitative Critical review form	Self administered questionnaire at admission and discharge	290 adults with mood and anxiety disorders	Participants on the newly redesign unit perceived a more positive atmosphere in terms of the X3 elements of the		X3 elements of the WAS Peer support, pt autonomy and practical skill dev't

					redesign and patients outcome (treatment satisfaction, changes in mh QoL and functioning	Cross sectional	Chart review		WAS and is associated with mh- related QoL and greater treatment satisfaction. Change in global function was independent of ward atmosphere.		Lack of research examining the mechanism through which the care setting may affect recovery. Study shed light on the complexity of the relnships linking treatment setting with outcome
17	Csipke et al 2013 UK	Engagement in therapeutic activities	Acute Inpatient Psychiatric Service users activities	Inpatient care 50 years after the process of deinstitutionalisation	Investigated the hypothesis that levels of acuity are associated with clinical functioning just as they were 5o years ago That activity and one to one contact continue to be closely correlated with service user's satisfaction	Quantitative McMaster Quantitative Critical review form Cross sectional	Cross sectional exploration	8 **single sex wards** over one month	Considerably, less time was spent in all forms of activity than in even the least active of the 3 hospitals studied 50 years ago which SU spent, hrs a day in activities. Symptoms severity did not impact the frequency pf participation in activities.		LOS 93 days Acute inpatient unit Service users on wards for 7 days Classification of activities Sensitivity analysis Reasons of low activities: staff shortage,

					with inpatient care						immediate crisis mgt and paper work and admin duties
18	O'Connor et al. Australia 2012	The design features Safety and security	Environment Space Healthcare Design Quality	The environment of inpatient healthcare delivery and its influence on the outcome of care.	To address issues arising in the literature regarding the env'tal design of inpatient healthcare setting and their impact on care	Discursive paper ? CASP systematic review checklist			In some setting with aging building, the available space may no longer be appropriate to the needs of the client group Suggested greater input into the design of healthcare spaces from those who use them. **5 factors** -Design of physical space -Family needs -Privacy consideration -Impact of technology -Patients safety		On **general environmental** factors in diverse inpatient care setting Some setting outgrown its initial purpose. **Crit.** Although comprehensive review on env't, no focus on SU engagement in therapeutic activities within the environment. Viewed SU as recipient of care and not active agent although made a call at the end that SU should be

											allow to contribute to the design.
19	Nicholls et al Australia 2015	Satisfaction: old to a new facility	Delivery of healthcare Hospital environment Mental health Psychiatric hospital	The value of purpose built mental health facilities: use of WAS to gauge the link between milieu and physical environment	To revisit notion of the environment in mental health setting including the influence of environment on the way in which care is delivered	Quantitative McMaster Quantitative Critical review form Cross sectional	Survey	92 staff 13 carers 100 SU	Significant difference between staff and SU responses in administration 1 and 2 Significant difference between participant type on the combined dependent variable -SU had higher mean score for staff control compared with staff Both staff and SU rated the new mental heath facility more favourable than the old mental health facility on order and organisation, program clarity and involvement.		Before and after relocation to a purpose built facility Negative description of the old facility Restriction on building limiting changes that can be made Defined WAS and used with carers. Research assistant assisted SU in completing WAS
20	Baker et al 2014	Satisfaction related to programmes or	Acute inpatient care	Acute inpatient care in the UK Part 1:	To summarise for clinicians the current	Literature review of policies			Cost effective factors that promote		Current views of acute mental

	UK	interventions implementation	Mental health nursing Recovery orientation	recovery – orientated wards	views on the status of acute inpatient mental health care in UK	CASP systematic review checklist			recovery include; -good risk mgt -Therapeutic relationship -meaningful activities -physical health -social inclusion Physical env't of acute mental health unit was identified as a barrier to care by both SU, health professional and carers Literature should shift from only **short coming** to report **positive** and **innovation**		health as at 2014 Organisational culture Identified current government policies for mental health Defined therapeutic engagement pg.20 Meaningful activities **Functions** of the wards are numerous
21	Pelto-Piri et al Sweden 2019	Safety and security	Psychiatry Inpatient Safety Violence Values Qualitative interviews Thematic content analysis	Feeling safe or unsafe in psychiatric inpatient care, a hospital based qualitative interview with inpatients in sweden	To enhance our understanding of feelings of being safe or unsafe in psychiatric inpatient care	Qualitative CASP qualitative appraisal	interviews	17 inpatients 5 women	-Predictable and supportive service are necessary for feeling safe -communication and taking responsibility enhance safety. SU indicated that **asking and waiting** was a big part of everyday life at ward pg.5.		Setting included more than acute unit included forensic + those with addiction Structure environment perceived mostly as positive

									Powerless and unpleasant encounters undermine safety Creating reliable treatment and care processes, a stimulating social climate in wards and better staff patient communication could enhance patients perception of feeling safe.		SU recruited through ward manager then research team informed of those who have agreed to participate
22	Blacker et al 2017 UK	Engagement in therapeutic activities	Organisational culture Psychoanalytic observation Thematic analysis Ward culture Social defence system	An indepth observational study of an acute psychiatric ward combining the psychodynamic observational method with thematic analysis to develop understanding of ward culture	To further understanding of complex healthcare culture in the NHS, with a focus on acute inpatient psychiatric ward	Qualitative CASP qualitative appraisal	Psychoanalytic Observational method Supervision group discussion	Six hrs long/ 1 hr a week 11 bed ward X3 group of participants -staff -SU -supervision group	Picture that emerged was of **fragile ward environment** in which staff appeared fearful of engagement with patients General sense of confusion regarding roles and decision making processes Nursing team felt burdened by responsibility, isolated and anxious about	**Criticism** Mixed opportunity to include ward staff in discussion. In addition to using clinical psychologist from outside the wards, ward staff could have well interpreted the observations	Unconscious life of an acute psychiatric ward Staff and ward env't had something flat and controlled about it. Repression atmosphere rather than "containment". Perhaps in the context of feared scrutiny and

									criticism from outside		criticism, more open and lively interaction felt too risky and needed to be avoided.

Appendix E: Questionnaire (staff version)

Title of research study: The impact of the environment on engagement in therapeutic activities of service users in an acute mental health unit.

Section A: Please tick the option that applies to you for each of the items below

You are: Male [ ] Female [ ] Age…… Grade:……..

Doctor [ ] Nurse [ ] Occupational Therapist [ ] Psychologist [ ]
Peer support workers [ ] Associate practitioner [ ] Art Therapist [ ]
Support worker [ ] Social Worker [ ] Pharmacist [ ]

Ward/Unit: Ward C [ ] Ward B [ ] Basement/therapies [ ] Ward A [ ]

Number of months worked at the Hospital ……

Section B - SOFTEN: How satisfy are you with some features of this place? Please tick your answer.

Items	Extremely dissatisfied 1	Very dissatisfied 2	Neutral 3	Very satisfied 4	Extremely satisfied 5
Ward layout and design					
Mixed sex accommodation					
Room privacy					
Security					
Order and organisation					
Damage resistant furniture					
Seating mix					
Colours of the environment					
Flooring of the environment					
Aesthetic and comfort					
Level of noise					
Access to daylight					
Views from bedroom					
Outdoor facilities					
Access to garden					
Location of nursing station					

Section C: Please circle your answer

	True	False
1. Service users put a lot of energy into what they do around here	T	F
2. Staff have very little time to encourage service users	T	F
3. Service users tend to hide their feelings from one another	T	F
4. The staff act on service users' suggestions	T	F
5. New treatment approaches are often tried on this ward	T	F
6. Service users hardly ever discuss their sex life	T	F
7. Service users often gripe	T	F
8. Service users' activities are carefully planned	T	F
9. The service users know when staff will be on the ward	T	F
10. The staff rarely punish service users by restricting them	T	F
11. This is a lively ward.	T	F
12. The staff know what the service users want	T	F
13. Service users say anything they want to the staff	T	F
14. Very few service users have responsibility here	T	F
15. There is very little emphasis on teaching service users solutions to practical problems	T	F
16. Service users tell each other about their personal problems	T	F
17. Service users often criticise or joke about the staff	T	F
18. This is well-organised ward	T	F
19. Staff do not explain what treatment is about to service users	T	F
20. Service users may interrupt when a staff is talking	T	F
21. The staff are proud of this ward.	T	F
22. Staff are interested in following up the service users once they leave the ward	T	F
23. It is hard to tell what the service users are feeling here	T	F
24. Service users are expected to take leadership here	T	F

25. Service users are strongly encouraged to plan for the future T F

26. Personal problems are openly talked about T F

27. Service users on this ward rarely argue T F

28. The staff make sure that the ward is always neat T F

29. If a service users' medicine is changed, a staff always explains why T F

30. Service users who break the rules are punished for it T F

31. There is very little group spirit on this ward T F

32. Staff have very little time to encourage service users T F

33. Service users are very careful about what they say when staff are around T F

34. Service users are encouraged to be independent T F

35. There is very little emphasis on what service users will be doing when they leave T F

36. Service users are expected to share their personal problems with each other T F

37. Staff sometimes argue openly with each other T F

38. The ward sometimes gets very messy T F

39. The service users clearly understand the ward rules T F

40. Service users who argue with other service users will get into trouble with the staff. T F

Section D

Do you think the environment has any effect on what service user's do on the ward? YES/NO If yes, can you say in what way?.....

……

……

Do you think the environment could be improved? YES/NO

If yes, can you say how?.....

……..

Appendix F: Service user questionnaire

Version 3

Title of research study: The impact of environment on engagement in therapeutic activities of service users in an acute mental health unit.

By completing this questionnaire, I consent to participate in this study.

Section A: Please tick the option that applies to you for each of the items below

You are: Male [ ] Female [ ] Other [ ] Age……

Ward: Ward C [ ] Ward B [ ] Ward A [ ]

Detention under MHA Yes / No Length of stay on the ward…….

Section B - SOFTEN: How satisfied are you with some features of this place?

Please tick

Items	Extremely dissatisfied 1	Dissatisfied 2	Neutral 3	Satisfied 4	Extremely satisfied 5
Access to daylight					
Access to garden					
Aesthetic and comfort					
Colours of the environment					
Damage resistant furniture					
Flooring of the environment					
Location of nursing station					
Level of noise					
Mixed sex accommodation					
Order and organisation					
Outdoor facilities					
Room privacy					
Seating mix					
Security					
Views from bedroom					
Ward layout and design					
Other, specify……					

Section C: Please circle your answer

	True	False
1. Service users put a lot of energy into what they do around here	T	F
2. Staff have very little time to encourage service users	T	F
3. Service users tend to hide their feelings from one another	T	F
4. The staff act on service users' suggestions	T	F
5. New treatment approaches are often tried on this ward	T	F
6. Service users hardly ever discuss their sex life	T	F
7. Service users often gripe	T	F
8. Service users' activities are carefully planned	T	F
9. The service users know when staff will be on the ward	T	F
10. The staff rarely punish service users by restricting them	T	F
11. This is a lively ward.	T	F
12. The staff know what the service users want	T	F
13. Service users say anything they want to the staff	T	F
14. Very few service users have responsibility here	T	F
15. There is very little emphasis on teaching service users solutions to practical problems	T	F
16. Service users tell each other about their personal problems	T	F
17. Service users often criticise or joke about the staff	T	F
18. This is well-organised ward	T	F
19. Staff do not explain what treatment is about to service users	T	F
20. Service users may interrupt when a staff is talking	T	F
21. The staff are proud of this ward.	T	F
22. Staff are interested in following up the service users once they leave the ward	T	F
23. It is hard to tell what the service users are feeling here	T	F
24. Service users are expected to take leadership here	T	F

25. Service users are strongly encouraged to plan for the future T F

26. Personal problems are openly talked about T F

27. Service users on this ward rarely argue T F

28. The staff make sure that the ward is always neat T F

29. If a service users' medicine is changed, a staff always explains why T F

30. Service users who break the rules are punished for it T F

31. There is very little group spirit on this ward T F

32. Staff have very little time to encourage service users T F

33. Service users are very careful about what they say when staff are around T F

34. Service users are encouraged to be independent T F

35. There is very little emphasis on what service users will be doing when they leave T F

36. Service users are expected to share their personal problems with each other T F

37. Staff sometimes argue openly with each other T F

38. The ward sometimes gets very messy T F

39. The service users clearly understand the ward rules T F

40. Service users who argue with other service users will get into trouble with the staff.T…F

Section D

Do you think the environment has any effect on what service user's do on the ward? YES/NO If yes, can you say in what way?.....

……

……

Do you think the environment could be improved? YES/NO

If yes, can you say how?.....

……..

……

University of Essex

Central and North West London NHS Foundation Trust

Section E: **SERVICE USERS' EXPERIENCE OF ACTIVITIES ON THE WARDS**

To your knowledge, do any of the following occur on the ward? *(If* **yes** *please tick the* ***value*** *you place on the activity*)

		Yes/ No	No Value	A little	Moderate amount	Quite a lot	A great deal
A	There is/are occupational therapy staff allocated to this ward						
B	Staff meet mainly with their allocated service users for 1 to 1 time						
C	Staff meet with any service user for 1 to 1 time						
D	Organised groups are run *(please note which)* _____ _____						
E	Games and activities are organised *(please note which)* _____ _____						
F	Service users can take leave (escorted or unescorted) from the ward						
G	Staff and service users watch TV and /or sit together						
H	Meals are eaten together by staff and service users						
I	Informal chats happen between staff and service users						
J	Time with staff can be spent off the ward (e.g. walks or in the rooftop garden)						
K	Service users' family/friends are allowed on the ward						
L	Service users can meet with their community workers on the ward						
M	Ward rounds take place						
N	The office/nursing station is closed/locked						
O	Any other (please state_____						

Appendix G : Participant Information Sheet (Service user version)

Title of research study:	**The impact of the environment on engagement in therapeutic activities of service users in an acute mental health unit**
Principal Investigator:	**Ellen Serwaa Adomako**

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. The researcher will go through the information sheet with you and answer any questions you may have. Please talk to others about the study if you wish.

Section one:

What is the purpose of the study?

This study is being undertaken as part of a doctoral programme at University of Essex and that the researcher is a PhD student, and also a registered occupational therapist. The study intends looking at the impact of the hospital environment on service users' engagement in therapeutic activities.
Engaging in therapeutic activities while on admission is an important part to mental health service users' recovery. However, some service users admitted to the acute wards have reported having few activities and therefore not feeling engaged in daily activity on the wards. In part, this has been attributed to the dynamics within the environment of the acute mental health hospitals. This study aims to explore the environment of the acute mental health unit from staff and service users' perspective, and to elicit those factors that participant think either promotes or inhibits their engagement in therapeutic activities. We intend to achieve this through participants completing questionnaires in a survey in module one and formation of a Participation Action Research (PAR) group of clinical staff to engage in a cycle of action and reflection.

Why are we approaching you?

We are asking for your help as you are currently a service user of the Acute unit Hospital in London. We are interested in your experience of being an inpatient in this hospital, and would be grateful if you could complete a questionnaire for us, which asks about various aspects of this.

What will happen to you if you decide to take part?

If you decide to take part we will ask you to complete a questionnaire about your experience of being on the ward. This forms part of module one of the study. You can complete the questionnaire either on your own or with assistance from the researcher or the service user co-facilitator. You may need a couple of sessions in order to complete it or to take a break occasionally, when completing the questionnaire. If you would prefer to

complete the questionnaire by yourself you can return it to the researcher by using the addressed envelope provided for this purpose, and hand it to

the researcher when she visits the ward, or to staff to give to her. The envelope should be sealed so that staff cannot read what you have written.

The questionnaire contains some details about you, which are your gender, age and whether you are or were detained under the mental health act during admission. This information will help us to determine whether there are any differences in how certain groups of service users experience being in hospital. You will be assigned a participant number which will allow us to record your participation and response without your name being associated with the data. This information will be kept safely for the duration of the research by the researcher and will be handed over to the academic supervisor to be stored securely in the University of Essex on completion of the research.

Confidentiality:

The questionnaire is confidential and we will allocate you a study number in order to preserve your anonymity in case anyone comes across your questionnaire by mistake. The list linking your name to your number will be accessible only to the researcher and will be securely stored and password protected on an office computer in the University of Essex. The study reports will be written in such a way that no-one can be identified by their responses. In order to protect both you and others we would however be obliged to inform ward staff if in the unlikely event of you disclosing any information of intent to harm yourself or others.

Section two:

Your decision about whether to take part

While we would be very grateful for your help with the research, your decision about whether to take part is entirely up to you. Your treatment will not be affected in any way, either positively or negatively, by this decision. If at any point, of having been involved in the study, you wish to withdraw from it, you are free to do so without having to give any explanation. Any data already gathered from you for the questionnaire will not be used for the study.

Benefits of taking part:

You will be given an amount of £10.00 in lieu of time spent in completing the questionnaire in accordance with trust policy on service user involvement. Indirectly, you may have an influence on positive changes made to the ward based on your experience and participation in this study.

Possible risks to taking part:

We do not anticipate that there are risks involved in taking part in this study. However, if you are harmed by taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone's negligence, then you may have grounds for a legal action but you may have to pay for it. Regardless of this, if you wish to complain about any aspect of the way you

have been approached or treated during the course of this study, the normal National Health Service (NHS) complaints mechanisms may be available to you.

The results of the study:

We anticipate that the results will be published in academic journals. You are also welcome to attend any events that we host in the future to present the findings. If you would like us to contact you by post to give you details of these events, and also to provide you with a summary of the results, please tell the researcher who will make a note of this.

How the study is funded:
This study is not funded but has received a small budget from Central and North West London NHS Foundation Trust, Acute Services to cover for staff participation and catering in the Participatory Action Research group meetings.

Ethical approval:

All research in the NHS is scrutinised by an independent group called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the xxxx Research Ethics Committee.

What if there is a problem?

If you have a concern about any aspect of the study, you should speak to the researcher who will do her best to answer your questions (**Ellen Adomako at ea16632@essex.ac.uk / 07722930943) or the Supervisor, Professor Fiona Nolan at f.nolan@essex.ac.uk / 07557863875.**

Formal Complaints

If you wish to make a formal complaint or if you remain unhappy and wish to complain formally, you can do this by contacting the Research Governance and Planning Manager, Research Office, University of Essex, Wivenhoe Park, Colchester CO4 3SQ, by emailing: **sarahm@essex.ac.uk**

Independent Advice

If you would like independent advice about taking part in research please contact staff of the “The Advocacy Project” at the Acute unit Hospital.

What do I need to do now?

If you would like to take part, please complete the tear- of sheet below and hand it to a staff member who will then pass your details on to the researcher (Ellen Adomako). The researcher will then contact you to discuss the study further.
Alternatively if you have any further questions please contact Ellen Adomako

Tear here…….

I …….. (Participant name) would like to take part in the above study.

I give consent for my contact details to be passed on to the researcher and to be contacted by Ellen Adomako (researcher) to discuss participation in this study.

Signed:……..

Telephone/email: ……

Appendix H : Participant Information Sheet. Staff version (Questionnaire)

Title of research study:	**The impact of the environment on engagement in therapeutic activities of service users in an acute mental health unit**
Principal Investigator:	**Ellen Serwaa Adomako**

You are being asked to participate in a research study. Please read the following details and take time to consider before you decide to take part. Please feel free to discuss the study with friends and colleagues and take the opportunity to ask questions of the researcher before making your decision.

Description of the study

Engaging in therapeutic activities whilst in hospital is an important part of mental health service users' recovery. However, service users admitted to acute wards in the UK have reported having few activities to engage in on the wards, which can lead to feelings of boredom and have a negative impact on their treatment and care. In part, this lack of activities has been attributed to the dynamics within the environment of the acute mental health hospitals. This study, as part of the Principal investigator's PhD study, aims to explore the environment of the acute mental health unit from the perspectives of staff and service users. The environment in the context of this study include the physical, social and cultural environment. The study also aims to identify factors that participants' think either promotes or inhibits service users' engagement in therapeutic activities. A potential output from the study will be recommendations for changes to the environment which might lead to improvements in service users' engagement.

Why have I been invited?

You are been asked to participate in this research as you are currently a clinical staff at the Acute unit hospital. We are interested in your experiences of working with service users within this hospital environment and will be grateful if you could complete a questionnaire for us, which asks about various aspects of this.

How is the study organised?

The researcher will be visiting the wards, attend meetings and handover where she will present the study and answer any questions. She will also be happy to discuss the study at any time with you or your colleagues.

The researcher will leave a large box or envelope in the staff office on the ward where you can put your completed questionnaires, in the sealed envelope provided. You can also hand the questionnaire to the researcher if you see her when she visits the ward.

What will happen to you if you decide to take part?

If you are willing to take part in the study, we would be grateful if you could complete the enclosed questionnaire, which includes:

- Your perception of the ward environment, measured by the Ward Atmosphere Scale
- Your satisfaction with the design and features of the ward in which you work
- Questions about you (on your gender, profession, grade and length of time working on the ward).

You also have a choice to request for a softcopy of the questionnaire to be email to you if you like this option and provide your email to the research. Your email will also be used solely for the purpose of sending you the questionnaire.

How will confidentiality and anonymity be ensured?

All your questionnaire responses will be confidential, published reports will not allow the responses of any individual worker to be identified in any way, nor will any information about individual responses be fed back to colleagues or managers in your service. However in the unlikely event that you should disclose any information related to professional misconduct we will be ethically obliged to inform senior staff. All data will be kept on password-protected computers in the University of Essex and will be accessible only to the researcher and her supervisors. You will be allocated a study number which means your name will not be linked to your responses if anyone comes across your questionnaire by accident. The list linking your name and your study number will be accessible to the researcher and her supervisor only and will be securely stored in a password protected file separately from your responses. This information will be kept safely for the duration of the research by the researcher and will be handed over to the academic supervisor to be stored securely in the University of Essex on completion of the research.

Your decision about whether to take part

While we would be very grateful for your help with the research, your decision about whether to participate is entirely a personal one and will not affect your employment in any way. If you do not wish to participate in the study then all you have to do is not to return the questionnaire when it is given to you, or inform the researcher of your decision not to participate. Your consent to participate in the study will be implied by completing the questionnaire. If you decide to leave the study at any point, data already gathered from you for the questionnaire will not be used. The only benefit to you of participating, is the indirect one that we hope the completed research may in future influence positively the working environment that you or staff elsewhere experience.

If you would like a copy of the study results please let the researcher know and you will be sent this once it is available.

Possible risks to taking part:

We do not anticipate that there are risks involved in taking part in this study. However, if you are harmed by taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone's negligence, then you may have grounds for a legal action but you may have to pay for it. Regardless of this, if you wish to complain about any aspect of the way you have been approached or treated during the course of this study, the normal National Health Service complaints mechanisms may be available to you.

The results of the study:

We anticipate that the results will be published in academic journals. You are also welcome to attend any events that we host in the future to present the findings. If you would like us to contact you by post to give you details of these events, and also to provide you with a summary of the results, please tell the researcher who will make a note of this. Also, the results from this module will form part of reflections and discussions in module two of the study, which will be during participatory action research group meetings held with staff participants

How the study is funded:

This study is not funded but has received a small budget from Central and North West London NHS Foundation Trust, Acute Services to cover for staff participation and catering in the Participatory Action Research group meetings.

Ethical approval:

All research in the NHS is scrutinised by an independent group called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by xxxx Research Ethics Committee.

What if there is a problem?

If you have a concern about any aspect of the study, you should speak to the researcher who will do their best to answer your questions (**Ellen Adomako at** ea16632@essex.ac.uk**) or the Supervisor, Professor Fiona Nolan at f.nolan@essex.ac.uk.**

Formal Complaints

If you wish to make a formal complaint or if you remain unhappy and wish to complain formally, you can do this by contacting the Research Governance and Planning Manager, Research Office, University of Essex, Wivenhoe Park, Colchester CO4 3SQ, by emailing: sarahm@essex.ac.uk

Appendix I : Participant Information Sheet

Staff version (Participatory Action Research)

Title of research study:	**The impact of the environment on engagement in therapeutic activities of service users in an acute mental health unit**
Principal Investigator:	**Ellen Serwaa Adomako**

Why have I been invited?

You have already helped us by participating in the questionnaire survey component of this study, for which we are very grateful. We are approaching you now to ask if you will help us again by participating in an action research group, as described below. Please read the following details and take time to consider before you decide to take part.

Description of the study

This is module two of the research investigating impact of the environment on service users' engagement in therapeutic activities in an acute mental health unit. The environment as used in this research constitutes the physical, social and cultural environment as they relate to the hospital setting. This section of the study is a participatory action research. It involves constituting a research group of clinical staff to engage in a cycle of actions and reflections and come up with recommendations. It is expected the group will explore deeper and from multi-professional perspective the aims of the study. Participating in this section of this study, makes you have the responsibility of helping us generate the data for the research. As a participant, you will work collaboratively with the researcher and service user co-facilitator.

How is the study organised?

This component of the study consists of a research group comprised of between 6 and 10 staff members in total from across the 3 acute wards in the Acute unit Hospital. The group will meet five times over a period of eight months, for four (4) hours each time. The purpose of the group will be to engage in discussions and activities, to reflect about the environment on the wards and across the unit, and come up with recommendations for action relating to identified issues. The group will be co-facilitated by the doctoral student (Ellen Adomako) and a service user co-facilitator. Topics for discussion will focus on social issues which the participating staff members believe impact on the engagement of service users on the ward in therapeutic activities.

The meetings will be audio-recorded and transcribed verbatim by the researcher, following which they will be erased.

How will confidentiality and anonymity be ensured?

All personal identified information will be kept confidential and published reports will not allow the responses of any individual staff to be identified in any way, nor will any

information about individual responses be fed back to colleagues or managers in your service. However in the unlikely event that you should disclose any information related to professional misconduct we will be ethically obliged to inform senior staff. All data will be kept on password-protected computers in the University of Essex.

Your decision about whether to take part

While we would be very grateful for your help with the research, your decision about whether to participate is entirely personal, voluntary and will not affect your employment in any way. You will be asked to sign a consent form if you decide to take part of the study. You can change your mind and withdraw at any time without having to give reasons. You should be available to participate in this research over an eight months period. If you decide to leave the study at any point, data already gathered from you will be included in the study as it will have form part of the ongoing participatory action research. No additional data will be collected from you.

Participants will need to book themselves off work to participate in the study at their own time, either as a day-off or an annual leave. Staff will be given a token payment of £100.00 per each of the five sessions to cover their time and any travel expenses they may incur. There is also the indirect benefit that we hope the completed research may in future influence positively the working conditions that you or staff elsewhere experience.

If you would like a copy of the study results please let the researcher know and you will be sent this once it is available.

Possible risks to taking part:

We do not anticipate that there are risks involved in taking part in this study. However, some may be distressed in sharing stressful experiences of working with service users or colleagues at the unit during group meetings. If you are harmed by taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone's negligence, then you may have grounds for a legal action but you may have to pay for it. Regardless of this, if you wish to complain about any aspect of the way you have been approached or treated during the course of this study, the normal National Health Service complaints mechanisms may be available to you.

How the study is funded:

This study is not funded but has received a small budget from Central and North West London NHS Foundation Trust, Acute Services to cover for staff participation and catering in the Participatory Action Research group meetings.

Ethical approval:

All research in the NHS is scrutinised by an independent group called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by xxxx Research Ethics Committee.

What if there is a problem?

If you have a concern about any aspect of the study, you should speak to the researcher who will do her best to answer your questions (**Ellen Adomako at**

ea16632@essex.ac.uk**) or the Supervisor, Professor Fiona Nolan at f.nolan@essex.ac.uk.**

Formal Complaints

If you wish to make a formal complaint or if you remain unhappy and wish to complain formally, you can do this by contacting the Research Governance and Planning Manager, Research Office, University of Essex, Wivenhoe Park, Colchester CO4 3SQ, by emailing: sarahm@essex.ac.uk.

Appendix J: Participant Information Sheet. Staff version (Interviews)

Title of research study:	**The impact of the environment on engagement in therapeutic activities of service users in an acute mental health unit**
Principal Investigator:	**Ellen Serwaa Adomako**

Why have I been invited?
You are been asked to participate in this research, which is part of a PhD dissertation as you currently works at the Acute unit hospital and will be grateful if you could be interviewed to talk about the topic. Please read the following details and take time to consider before you decide to take part. Please feel free to discuss the study with friends and colleagues and take the opportunity to ask any questions you may have.

Description of the study

Engaging in therapeutic activities whilst in hospital is an important part of mental health service users' recovery. However, service users admitted to acute wards in the UK have reported having few activities to engage in on the wards, which can lead to inactivity and may have a negative impact on their treatment and care. In part, this lack of activities have been attributed to the dynamics within the environment of the acute mental health hospitals. This study, as part of the Principal investigator's PhD study, aims to explore the environment of the acute mental health unit from the perspectives of staff and service users. The environment in the context of this study include the physical, social and cultural environment. The study also aims to identify factors that participants' think either promotes or inhibits service users' engagement in therapeutic activities. A potential output from the study will be recommendations for changes to the environment which might lead to improvements in service users' engagement.

How is the study organised?

This study is in two parts; a survey and a participatory action research. These interviews form part of the data collection for the participatory action research. Only selected staff from the Acute unit hospital, who are deemed to be key informants but their views have not fully been explored in the survey or through the participatory action research group will be contacted. This one-off, semi-structure interview will be conducted either face to face or through telephone interviews by the researcher (Ellen Adomako). Topics for discussion will focus on issues staff members believe impact on the engagement of service users on the ward in therapeutic activities.

The interview will be audio-recorded and transcribed verbatim by the researcher, following which they will be erased.

What will happen to you if you decide to take part?

If you are willing to take part in the study, an appointment will be made with you for the researcher to either meet with you at the Acute unit Hospital or call you on the phone number that you can be reached on provided by you to complete the interview. A copy of the interview guide and a consent form will be given to you in advance. The consent form needs to be signed and returned to the researcher either in person or electronically and you will have a copy. With the telephone interview the researcher will obtain a confirmation of your consent verbally over the phone prior to commencing the interview and it is estimated to take between 20 to 40 minutes.

How will confidentiality and anonymity be ensured?

All your interview response will be confidential, published reports will not allow the responses of any individual staff to be identified in any way, nor will any information about individual responses be feedback to colleagues or managers in your service. However, in the unlikely event that you should disclose any information related to professional misconduct we will be ethically obliged to inform a senior staff. All data will be kept on password-protected computers in the University of Essex and will be accessible only to the researcher and her supervisors. This information will be kept safely for the duration of the research by the researcher and will be handed over to the academic supervisor to be stored securely in the University of Essex on completion of the research. The data collected in the interviews might be shared as appropriate and for publication of findings, using some of your fully anonymised quotes.

Your decision about whether to take part

While we would be very grateful for your help with the research, your decision about whether to participate is entirely a personal one and will not affect your employment in any way. The only benefit to you of participating, is the indirect one that we hope the completed research may in future influence positively the working environment that you or staff elsewhere experience. You can change your mind and withdraw at any time without having to give reasons. If you would like a copy of the study results please let the researcher know and you will be sent this once it is available.

Possible risks to taking part:

We do not anticipate that there are risks involved in you taking part in these interviews. However, the interviews may be stressful to others in sharing their experiences of working with service users or colleagues at the unit. If you are harmed by taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone's negligence, then you may have grounds for a legal action but you may have to pay for it. Regardless of this, if you wish to complain about any aspect of the way you have been approached or treated during the course of this study, the normal National Health Service complaints mechanisms may be available to you.

The results of the study:

We anticipate that the results will be published in academic journals. You are also welcome to attend any events that we host in the future to present the findings. If you would like us

to contact you by post to give you details of these events, and also to provide you with a summary of the results, please tell the researcher who will make a note of this.

How the study is funded:

This study is not funded but has received a small budget from Central and North West London NHS Foundation Trust, acute services to cover for staff participation and catering in the Participatory Action Research group meetings.

Ethical approval:

All research in the NHS is scrutinised by an independent group called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by xxxx Research Ethics Committee.

What if there is a problem?

If you have a concern about any aspect of the study, you should speak to the researcher who will do their best to answer your questions (**Ellen Adomako at** ea16632@essex.ac.uk**) or the Supervisor, Professor Fiona Nolan at f.nolan@essex.ac.uk.**

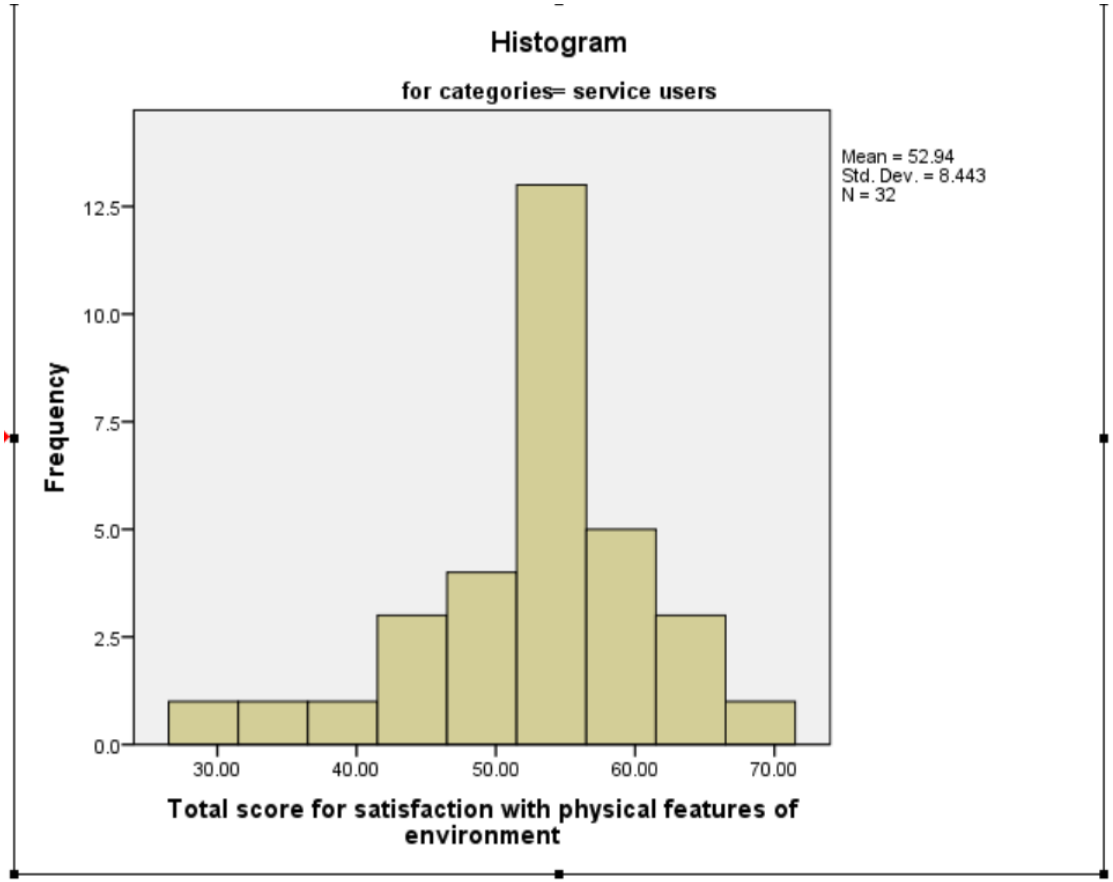
Formal Complaints

If you wish to make a formal complaint or if you remain unhappy and wish to complain formally, you can do this by contacting the Research Governance and Planning Manager, Research Office, University of Essex, Wivenhoe Park, Colchester CO4 3SQ, by emailing: sarahm@essex.ac.uk

Appendix K: SPSS Output on the test of normality and equal variance assumed

Total score for satisfaction with physical features of environment

Histograms



Group Statistics

	Staff verses service users	N	Mean	Std. Deviation	Std. Error Mean
Total score for satisfaction with physical features of environment	staff	40	48.1750	10.25292	1.62113
	service users	33	51.8182	10.50730	1.82909

Independent·Samples·Test¤

		Levene's·Test·for·Equality·of·Variances¤		t-test·for·Equality·of·Means¤			
¤		F¤	Sig.¤	t¤	df¤	Sig.·(2-tailed)¤	Mean·Difference¤
Total·score·for·satisfaction·with·physical·features·of·environment¤	Equal·variances·assumed¤	.289	.593¤	-1.494¤	71¤	.140¤	-3.64318¤
	Equal·variances·not·assumed¤	¤	¤	-1.491¤	67.729¤	.141¤	-3.64318¤

Appendix L Examples of SPSS Outputs of Survey data

Gender * Ward or unit * Staff verses service users Crosstabulation

			Wards or unit				
Staff verses service users			Ward C	Ward B	Ward A	Basement/therapies	Total
Staff	Gender	Males	7	7	-	4	**18**
		Females	6	5	2	9	**22**
	Total		13	12	2	13	**40**
Service users	Gender	Males	4	11	10	-	**25**
		Females	1	6	1	-	**8**
	Total		5	17	11	-	**33**
Total	Gender	Males	11	18	10	4	**43**
		Females	7	11	3	9	**30**
	Total		**18**	**29**	**13**	**13**	**73**

Satisfaction with physical features of the ward.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.874	.874	16

Ward Atmosphere Scale

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.703	.692	10

Tests of Normality for satisfaction with PFE

	Staff verses service users	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
		Statistic	df	Sig.	Statistic	df	Sig.
	staff	.076	40	.200*	.981	40	.722

Total score for satisfaction with physical features of environment	service users	.159	32	.038	.945	32	.105

*. This is a lower bound of the true significance.

a. Lilliefors Significance Correction

Satisfaction of ward staff and therapy staff: Significant difference

Group Statistics

	Ward staff vrs therapy staff	N	Mean	Std. Deviation	Std. Error Mean
Total score for satisfaction with physical features of environment	ward staff	23	50.9130	8.79521	1.83393
	therapy staff	17	44.4706	11.15862	2.70636

Independent Samples Test

		Levene's Test for Equality of Variances	t-test for Equality of Means						
								95% Confidence Interval of the Difference	
		Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
Total score for satisfaction with physical features of environment	Equal variances assumed	.179	2.043	38	.048	6.44246	3.15357	.05840	12.82652
	Equal variances not assumed		1.971	29.538	.058	6.44246	3.26920	-.23853	13.12344

Satisfaction of each ward and therapy unit: no significant difference exists among respondents

Test Statistics[a]

	Involvement	Support	Spontaneity	Autonomy	Practical Orientation	Personal problem orientation	Anger and aggression	Order and organization	Program clarity	Staff control
Mann-Whitney U	482.000	458.500	360.000	592.500	308.000	571.500	606.000	607.000	398.000	403.500
Wilcoxon W	1043.000	1019.500	921.000	1295.500	869.000	1132.500	1167.000	1168.000	959.000	1106.500
Z	-1.571	-1.831	-3.026	-.219	-3.666	-.471	-.055	-.043	-2.611	-2.519
Asymp. Sig. (2-tailed)	.116	.067	.002	.826	.000	.637	.956	.966	.009	.012

a. Grouping Variable: Staff verses service users

Test Statistics[a]

	Involvement	Support	Spontaneity	Autonomy	Practical Orientation	Personal problem orientation	Anger and aggression	Order and organization	Program clarity	Staff control
Mann-Whitney U	482.000	458.500	360.000	592.500	308.000	571.500	606.000	607.000	398.000	403.500
Wilcoxon W	1043.000	1019.500	921.000	1295.500	869.000	1132.500	1167.000	1168.000	959.000	1106.500
Z	-1.571	-1.831	-3.026	-.219	-3.666	-.471	-.055	-.043	-2.611	-2.519
Asymp. Sig. (2-tailed)	.116	.067	.002	.826	.000	.637	.956	.966	.009	.012

a. Grouping Variable: Staff verses service users

T tests

Group Statistics

	Staff verses service users	N	Mean	Std. Deviation	Std. Error Mean
Total score for satisfaction with physical features of environment	staff	40	48.1750	10.25292	1.62113
	service users	33	51.8182	10.50730	1.82909

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
Total score for satisfaction with physical features of environment	Equal variances assumed	.289	.593	-1.494	71	.140	-3.64318	2.43828	-8.50498	1.21861
	Equal variances not assumed			-1.491	67.729	.141	-3.64318	2.44410	-8.52066	1.23430

Group Statistics

	Gender	N	Mean	Std. Deviation	Std. Error Mean
Total score for satisfaction with physical features of environment	Male	43	52.2093	9.30836	1.41951
	female	30	46.4000	11.19914	2.04467

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
Total score for satisfaction with physical features of environment	Equal variances assumed	1.347	.250	2.412	71	.018	5.80930	2.40820	1.00748	10.61112
	Equal variances not assumed			2.334	54.888	.023	5.80930	2.48912	.82077	10.79783

Appendix M: Tear off slip

What do I need to do now?

If you would like to take part, please complete the tear- of sheet below and hand it to a staff member who will then pass your details on to the researcher (Ellen Adomako).

Tear here.....

I ..... (Participant name) would like to take part in the above study.
I give consent for my contact details to be passed on to the researcher and to be contacted by Ellen Adomako (researcher) to discuss participation in this study.

Signed:.....

Telephone/email: .....

University of Essex

Central and North West London NHS Foundation Trust

Appendix N: Informed Consent - Service user version

Title of research study:	**The impact of the environment on engagement in therapeutic activities of service users in an acute mental health unit**
Principal Investigator:	**Ellen Serwaa Adomako**

Please initial box

1. **I confirm that I** have read and understand the Information Sheet dated xx for the above study. I have had the opportunity to consider the information, ask questions and have had these questions answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw from the research at any time without giving any reason and without penalty. ☐
3. I understand that completing this questionnaire may not be suitable for service user's unwell and I can confirm that I feel well enough to complete this questionnaire. ☐
4. I understand that the identifiable data provided will be securely stored and accessible only to the members of the research team directly involved in the research, and that confidentiality will be maintained. ☐
5. I understand that data collected in this project might be shared as appropriate and for publication of findings, in which case data will remain completely anonymous. ☐
6. I consent to being contacted about the results of the study (optional). ☐
7. I understand that data collected during the study may be looked at by individuals from the University of Essex, from regulatory authorities or from the NHS Trust. Where it is relevant to my taking part in this research I give permission for these individuals to have access to my data. ☐

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

Participant Name	Date	Participant Signature
_____	_____	_____
Researcher Name	Date	Researcher Signature
_____	_____	_____

Appendix O: Informed Consent - Staff questionnaire version

Title of research study:	**The impact of the environment on engagement in therapeutic activities of service users in an acute mental health unit**
Principal Investigator:	**Ellen Serwaa Adomako**

Please initial box

1. I confirm that I have read and understand the Information Sheet dated xx for the above study. I have had the opportunity to consider the information, ask questions and have had these questions answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw from the research at any time without giving any reason and without penalty. ☐
3. I understand that the identifiable data provided will be securely stored and accessible only to the members of the research team directly involved in the project, and that confidentiality will be maintained. ☐
4. I understand that data collected in this project might be shared as appropriate and for publication of findings, in which case data will remain completely anonymous. ☐
5. I consent to being contacted about the results of the study (optional). ☐
6. I understand that data collected during the study may be looked at by individuals from the University of Essex, from regulatory authorities or from the NHS Trust. Where it is relevant to my taking part in this research I give permission for these individuals to have access to my data ☐
7. I agree to take part in the above study. ☐

Participant Name	Date	Participant Signature
_____	_____	_____
Researcher Name	**Date**	**Researcher Signature**
_____	_____	_____

Appendix Q: Informed Consent - Staff participatory action research version

Title of research study: **The impact of the environment on engagement in therapeutic activities of service users in an acute mental health unit**

Principal Investigator: **Ellen Serwaa Adomako**

Please initial box

1 I confirm that I have read and understand the Information Sheet dated xx for the above study. I have had the opportunity to consider the information, ask questions and have had these questions answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw from the research at any time without giving any reason and without penalty and all information collected prior to my withdrawal can be used, but no additional data will be collected. ☐

3. I understand that participating in this study comes with additional commitment outside my usual work routine and that I am ready for this responsibility. ☐

4. I understand that the identifiable data provided will be securely stored and accessible only to the members of the research team directly involved in the research, and that confidentiality will be maintained. ☐

5. I understand that data collected in this project might be shared as appropriate and for publication of findings, in which case data will remain completely anonymous. ☐

6. I understand that my fully anonymised words may be quoted in publications, reports, and other research outputs ☐

7. I consent to being contacted about the results of the study (optional) ☐

8. I understand that data collected during the study may be looked at by individuals from the University of Essex, from regulatory authorities or from the NHS Trust. Where it is relevant to my taking part in this research, I give permission for these individuals to have access to my data. ☐

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

Participant Name	Date	Participant Signature
_____	_____	_____

Researcher Name	Date	Researcher Signature
_____	_____	_____

Appendix R: Informed Consent - Staff interviews

Version 1

Title of research study:	**The impact of the environment on engagement in therapeutic activities of service users in an acute mental health unit**
Principal Investigator:	**Ellen Serwaa Adomako**

Please initial box

1. I confirm that I have read and understand the Information Sheet dated xx for the above study. I have had the opportunity to consider the information, ask questions and have had these questions answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw from the research at any time without giving any reason and without penalty and all information collected prior to my withdrawal can be used, but no additional data will be collected.
3. I understand that there will be audio-recording of the interviews which will be transcribed verbatim and use for data analysis.
4. I understand that the identifiable data provided will be securely stored and accessible only to the members of the research team directly involved in the research, and that confidentiality will be maintained.
5. I understand that data collected in this project might be shared as appropriate and for publication of findings, in which case data will remain completely anonymous.
6. I understand that my fully anonymised words may be quoted in publications, reports, and other research outputs
7. I consent to being contacted about the results of the study (optional)
8. I understand that data collected during the study may be looked at by individuals from the University of Essex, from regulatory authorities or from the NHS Trust. Where it is relevant to my taking part in this research, I give permission for these individuals to have access to my data.
9. I agree to take part in the above study.

Participant Name	Date	Participant Signature
_____	_____	_____
Researcher Name	Date	Researcher Signature
_____	_____	_____

Appendix S: RECRUITMENT OF A SERVICE PEER RESEARCHER

Study title: The impact of the environment on engagement in therapeutic activities of service users in an acute mental health unit

Introduction

This study is a PhD thesis aims at exploring the environment of the acute mental health unit from staff and service users' perspective. The study proposes to elicit factors within the environment that participants think either promote or inhibit engagement in therapeutic activities and to make recommendations on what can be done in this regard. It is a Participatory Action Research (PAR) research that will be in two modules. Module one of the study will involve a survey where questionnaires will be given to clinical staff and service users to gather their views on the environment. Module two is the formation of the PAR group with a maximum of ten clinical staff for the study.

Job description

You will be engage in the role of the service user-co facilitator to help with the data collection in the survey and in the participatory action research (PAR) group meetings. For the survey, you will assist mental health service users to complete questionnaires on the wards. The PAR group will meet five times over a period of eight months, for four (4) hours each time. You are be facilitating the group session with a PhD student who is the lead investigator. Your key roles during the PAR group meetings will include helping to take field notes and about the group dynamics. You will also be managing the recording equipment.

Person specification

A mental health service user with some experience of conducting research. Should have good communication skills and good interpersonal relationship. The person should be able to work in a team and be flexible with the time. Successful applicant will be required to obtain an honorary contract with the Central and North – West London NHS Trust.

Payment

To be discussed during interview

Disclosure and Barring Service Check

This post is subject to the Rehabilitation of Offenders Act (Exceptions Order) 1975 and as such it will be necessary for a submission for Disclosure to be made to the Disclosure and Barring Service (formerly known as CRB) to check for any previous criminal convictions.

The role service user co-facilitator in this research will be:

1. To assist service users to complete questionnaires on the ward. Paid hours allocated is 10 hours in all from March to June 2018.
    - Once a service user on the ward agree to be contacted to complete a questionnaire and specifically request that he/she be supported by a service user, then a meeting can be arranged.

2. As a co-facilitator on the PAR group meetings. Paid hours allocated is 20 hours from May to Dec 2018.
    - First meeting in May for four hours
    - Second meeting in June for four hours
    - Third meeting in August for four hours
    - Fourth meeting in October for four hours
    - Final meeting in December for four hours

(11)

Notes by [redacted] for PAR group on 13/7/18

Staff and environment is about the atmosphere where people work and the culture and ethos. Also the space in which you work and how people interact.

The culture of the environment can influence how people interact. Some people feel institutionalised

The environment is a living and community space with the staff.

On a practical level, the [redacted] is not a purpose built hospital so there are challenges. The basement is an airless box, [redacted] runs music therapy in an airless box room.

The locked door in the basement is a problem for [redacted] has had to close the 2020 group because of the locked door.

Every one has to book rooms.

(12)

[redacted]s rushed photography.

The management can override the room bookings. There are only limited rooms to book. It is a hospital not a prison. We are all trying to work for the recovery of service users.

MDT courses and working together as a team is important.

The gym is dark with no air con. It has been flooded and it took a while for it to be cleaned.

[redacted] said:

"We wanted to do a lunch group but we cannot because of the cooker. It is not connected".

The staff feel as though they cannot mend anything because of the contracts of organisations that work in the hospital.

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CERTIFICATE OF ATTENDANCE

This certificate is awarded to

NAME

In recognition of attendance of a half-day workshop on: **Introduction to Participatory Action Research Methodology** as part of your participation in the Oulton project (The impact of the environment on engagement in therapeutic activities of service users in an acute adult mental health unit) at the Gordon Hospital.

FACILITATORS

University of Essex

DR SIMONE COETZEE (LECTURER)

Name | Signature | Date

MS ELLEN S. ADOMAKO (PHD STUDENT)

Name | Signature | Date

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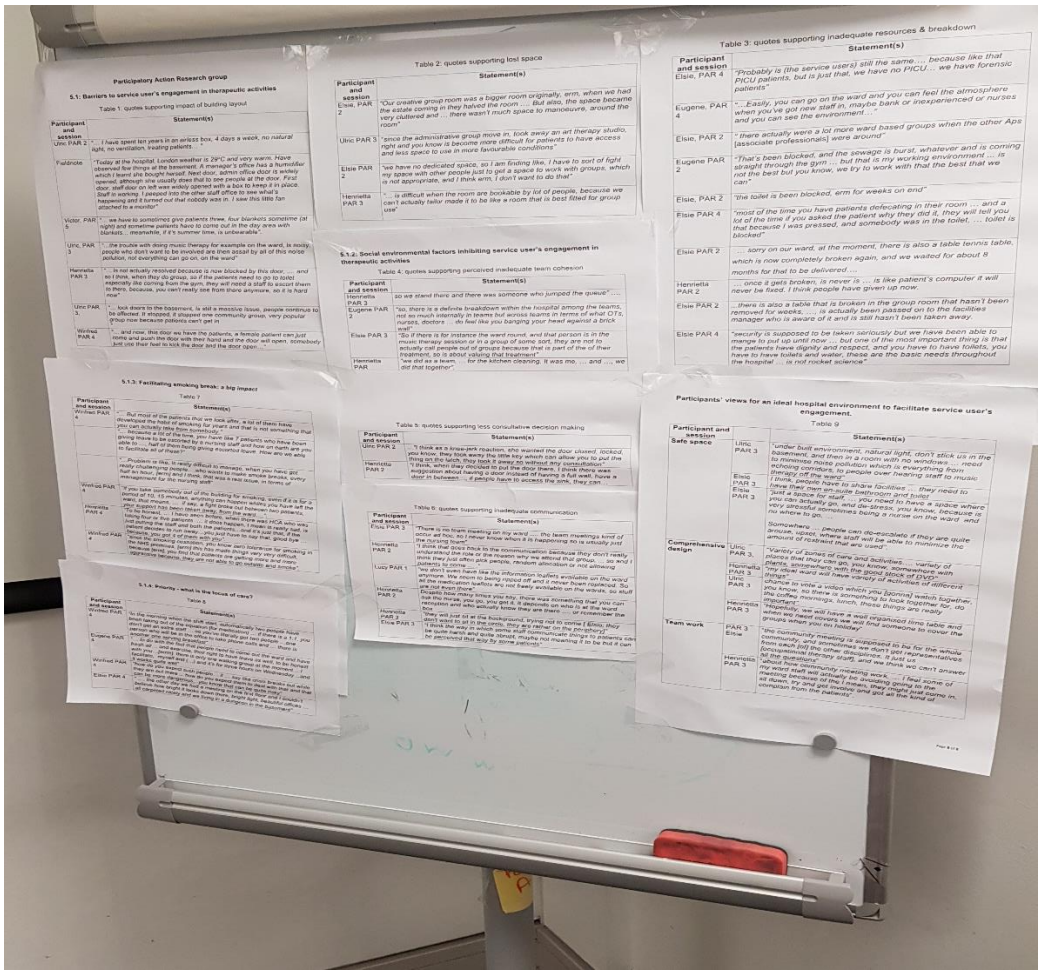
Appendix U: data for the PAR group analysis

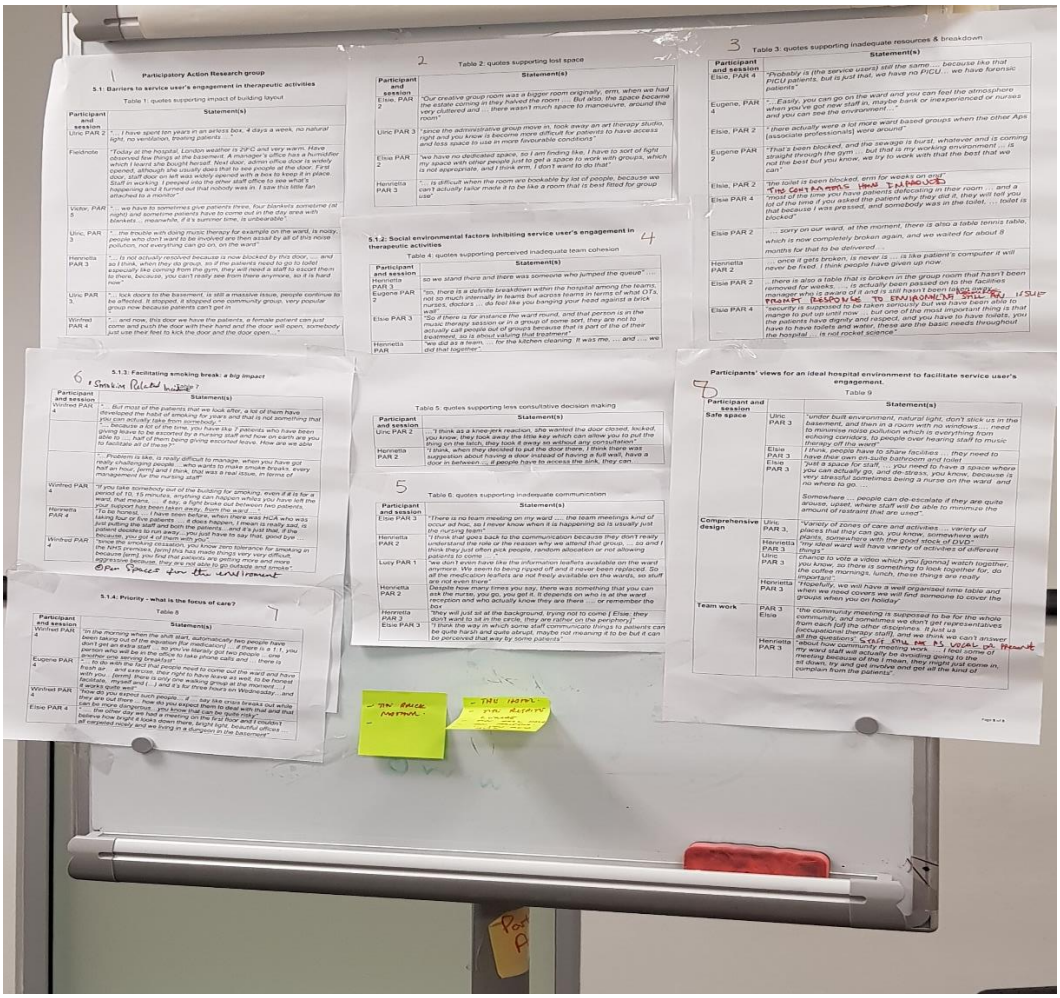
First PAR group analysis where emerging themes were ranked.

Second PAR group analysis

Before the group analysis



After the analysis



Appendix V : Interview guide

Title of research study:	**The impact of the environment on engagement in therapeutic activities of service users in an acute mental health unit**
Principal Investigator:	**Ellen Serwaa Adomako**

1. Can you tell me about service users engaging in therapeutic activities at this hospital.
2. What are your views of this hospital environment in terms of its use as a mental health facility?
3. What are some of the information shared with service users regarding their stay on the ward on the first day of admission?
4. How is leave to attend therapy sessions for service users processed ?
5. How does equipment use by service users get repaired when they breakdown?
6. What is the relationship between the ward and the therapy staff at this hospital?
7. What do you think of the security features of this hospital?
    - Does it in any way affect service users engaging in therapeutic activities?
8. Any other comments?

PAR 2 Notes.

CODES.

Definition of an environment.

Service users' perspective suggested by ICB

Factors that impacts on how people engage in activities. / sessions on the ward.

Challenges of the environment.
~~Environment not a purpose built.~~

Negative feeling about the environment where staff work.

Impact of the environment on staff. health & wellbeing

Discrepancies in staff opinion about physical space. (Management staff vrs Clinical staff).

Lost of therapy space / NO PICU

Incident of physical assault in the env't.

Knee jerk reaction to decision making (Less consultation) to decision making.

writing. Leave status (Locked door) limiting access to therapy groups at basement for both in/out patients

writing Impact of environmental factors on service users.

bordered Staff being territorial of physical spaces.

workings Management not sticking to the rule esp. when it comes to room booking

Inadequate knowledge of some staff on other staff's role across teams. - team cohesion and working together on similar su goals

Comparison of facilities at the Gordon to those in other places.

Felt not providing current evidence based interventic to service users due to limited equipments - difficult

Stage three coding

Using the codes to answer research question. Research question I was modified to include "inhibits".

Looks like;

A.

views on how environment promotes or inhibits engagement in T.A.

① Design of hospital.
- space inappropriate for some patient groups.
- sessions can be run.
- elements of weather.
- Access to groups off ward.
- Disabled access

② Lost of physical space leading to staff being territorial of space.
- storage space cuse
picture of kitchen with Bros

③ Inadequate resources facilities
constant facilities breakdowns & delay repair.
- small gym.

④ Few staff strength.
- to run groups with carer
- community clinical have to looking for space (Ref Lit on staff role in acute mhu.
- Post support staff welfare (reflective prop)

⑤ Knee jerk approach to decision making (less consultation)

Title of this section should be:

Factors limiting provision of therapeutic activities for service user's engagement in the acute mental health unit.

(B)

views on relationships that exist within the Unit

① Socialization of service users on the wards & with F & F.

② Perceived inadequate team cohesion within the environment.
- prioritizing freedom (from group to W/R)
- disconnection

③ Perception of management non-compliance.

④ incidents of physical assault on staff.

⑤ Perception of service user's not been heard.

⑥ Attendance of ward community meetings limited to OT & sometimes Nurses.

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Bigger NHS agenda not supported with resources to be implemented in environment.
(Priority Physical health.

Sense of urgency at getting emergencies things fixed.
Like flooding / gas leak.

No sense of accountability and bureaucracy

reclassification of staff role (virtual service) impact on space allocated for staff use.

Medication use on ward.

Benefit of service user's engagement on mood/behav

Others as comments.

- Space in which activities occur
- Staff as part of environment
- Working definition of the environment
- Institutional environment, service users feeling institutionalized
- Working and living environment

11/01/2019

- 5. making face at Admin support.
- Asked group members to have a look at codes if prioritized.
- Have x 2 nurses

Others.

- tension between OT and art therapy team at the basement on ownership of therapy space
- Description of music therapy group
- Challenges with getting support from admin staff to man groups at basement.
- Lost of therapy room during evaluation of groups.
- Appropriateness of room/physical space for particular activity
- Recommendation on how staff can understand each others role.
- Description of gym activities
- When therapist can use other skills they have. to help in clinical area
- Donations from service user's family to the hospital
- Looks like other old facilities are less well maintained.

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Summary of PAR 2 analysis as at 25th/01/19

After engaging with PAR meeting 2, themes identified are;

Design of the hospital.

- Lost of therapy space leading to staff being tem tired.
- Constant facilities breakdown and delay repair (inadequate resources)
- Kneel jerk reaction to decision making (less consultation)
- Few staff strength
- Perceived inadequate team cohesion within the environment. (power play)
- Incidents of physical assault
- Perception of management non compliance to room booking
- Perception of service user's not been heard
- Impact on service users and staff health
- Definition of the environment
- Factors that impact on how people engage in activities/sessions on the wards
- Challenges of the environment
- Negative emotions about the environment where staff work
- Discrepancies in staff opinion about physical space (management verses clinical staff)
- Overly medication of service users
- Comparison of facilities at the [redacted] to those in other places
- Inadequate resources to implement bigger/current NHS agenda in setting
- Sense of accountability and bureaucracy

PAR 3 notes 30/01/19.

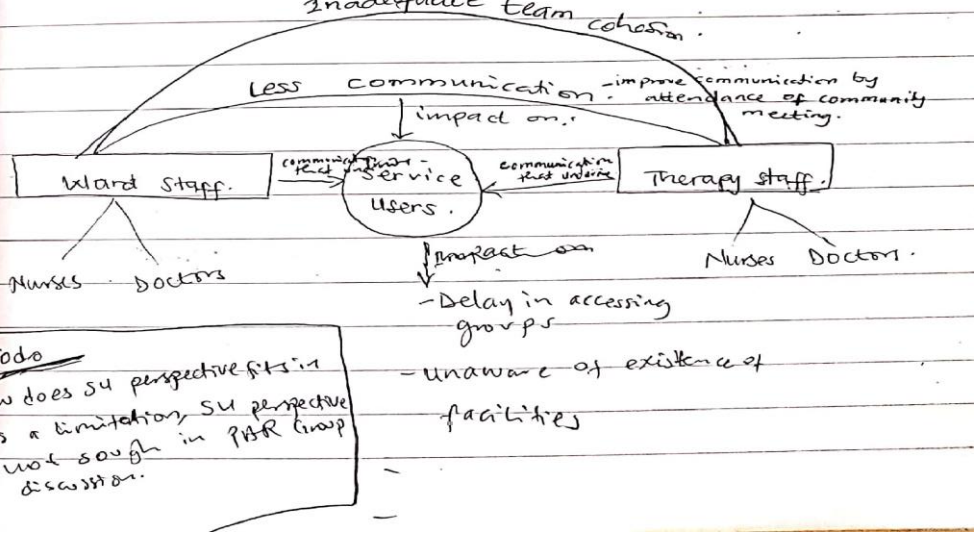
→ Participants started talking about some actions taken -

- more aware of environment.
- started to facilitate fresh air breaks to roof top garden.

⇒ Disabled access to the wards: wheel chair & those with crutches.

Communication, team cohesion and power dynamics within the env't

To refine later: 31/01/19.



Todo

how does SU perspective fit in

as a limitation, SU perspective not sought in PAR Group discussion.

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19/4/19.

Analysis of PHR 425.

Inhibits
- physical factors — Yellow
  - impact of building layout
  - Lost space
  - Inadequate resource & breakdown — brown (preferential treatment for staff)
    - ~ mgt concept of priority (toilets vrs cameras)
    - ~ few staff
- policy lapse .... black & white.

Social factors
- Inadequate communication — Seagreen +8 (feedback on repair reporting)
- Poor work attitude of some staff. → light blue (consultant lawyers get issues nurses go through)
- Less team cohesion — Green (misplace priority by staff & mgt.)
- Less consultative decision making. — light army green
- Sen Incidence of staff suspension — Army green

Ideal environment

Promotes
- Safe space. — ~~Safe space~~ blue
- comprehensive design — red
- team work. (encouraging nursing staff taking part in working group)
- conducive atmosphere. — beige +3
- Privacy, dignity & safety. (nursing staff allocation) — light green. +12

Priority .... Light green

of environment

Cultural / Symbolic environment
- service users smoking ✓
- smoking space allocated ✓
- staff facilitating smoking ✓
- CCTV ⇒ a new thing being introduced into space.
- Most service users are unwell when brought in & most of them detained
- Change in student involvement
- that bank staff tend not to contribute enough when they are on shift.
- Male staff usually lead out in restraining of su, this recently has led to more male staff being suspended on charges related to patient restrain.
- Have good job satisfaction if there is good staff su ration as was in PICU
- Fresh air break use to describe smoking breaks at the un appeared cultural change not well coped with by staff

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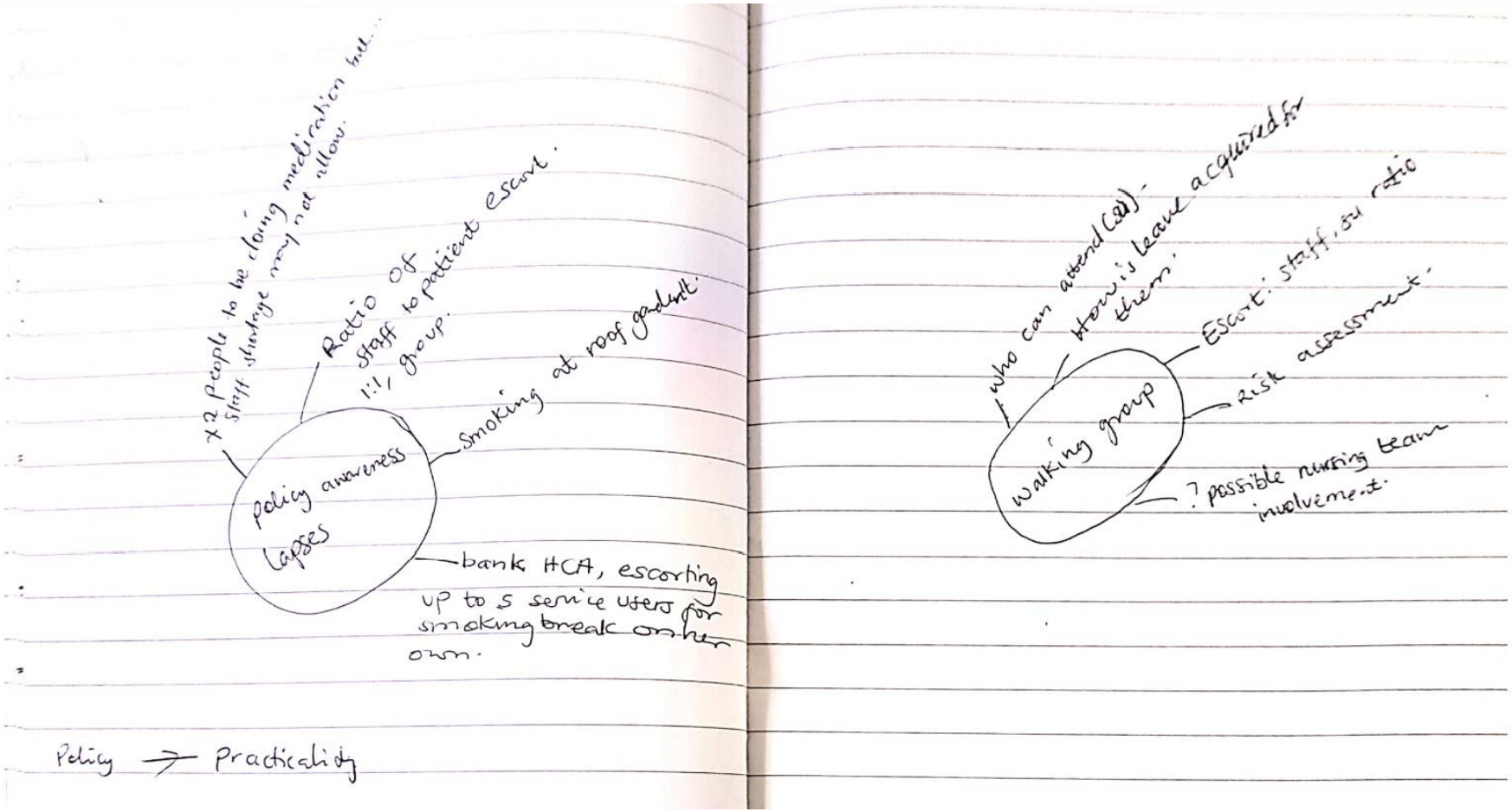

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Appendix X: Study protocol version 3 with REC ammendment

Study title: The impact of the environment on engagement in therapeutic activities of service users in an acute mental health unit

Background to the study

This research originated after two successful collaborative studies between an occupational therapy faculty at a university and the occupational therapy team at an acute mental health unit. Those studies looked at service users' perspective on the occupational therapy services they were receiving and how it contributed to their recovery. The studies found that service users' participation in occupational therapy provided them with something meaningful to do, relieved from a "tiny sort of world" (W. Bryant et al., 2016, p. 609) of the ward and illness and that recovery on the acute ward to them was not all about medication and monitoring (Wendy Bryant et al., 2015; W. Bryant et al., 2016). A recommendation arose that future research should look at how the environment influences service user's engagement in similar settings. A different acute mental health unit within the same NHS Trust agreed to collaborate with the university faculty to take this idea forward and constituted an advisory group to oversee the study. This idea was converted into a PhD funded position at the University of Essex, hence this proposal. This study has been developed in collaboration with faculties and a student from University of Essex (UoE), Colchester and staff from Central and North West London NHS Foundation Trust (CNWL) specifically, Acute unit – Vauxhall. The flowchart, Appendix XI depicts the stakeholders involved.

For the outline of this proposal, the acute mental health care is introduced with factors influencing service users' participation. The environment is looked at from the concept of therapeutic landscape and studies that have been done in mental health in this regard. The aims and research questions for this study are identified leading to the research methods and data collection process with the measures to be used. The study participants, service users' involvement, recruitment processes and ethical considerations are discussed. Potential benefits and risks of the study to participants and myself are explored. Finally, the analysis and dissemination of the findings are touched on.

Introduction

The care of service users' experiencing psychiatric emergencies (Crisp, Smith, & Nicholson, 2016) continue to occur in dedicated acute inpatients wards despite emphasis on community care within the National Health Services (NHS); and the setting up of services like crisis resolution and home treatment (CRHT) to support them in their homes. The acute mental health care services continue to be relevant service within the overall framework for mental health care in the United Kingdom (UK). Its' unique characteristics of having service users mostly unwell at the point of admission, providing short stay on the wards and emphasis on managing service users' risks and violence using medication, sometimes lead to little opportunity for service users to engage in therapeutic activities that also contributes to their recovery (Bowers, 2005; W. Bryant et al., 2016; Gilburt, Rose, & Slade, 2008; Ikiugu, Nissen, Bellar, Maassen, & Van Peursem, 2017; Mullen, 2009; Sims, 2014).

The Care Quality Commission (CQC) survey in 2009 reported that, thirty-five to fifty- four percent (34% - 54%) of people admitted on the acute mental health wards complained that, there were few activities to engage in on the ward during their stay. Service users engaging in less activity while on admission may be due to the severity of their illness and needing more support to engage in activity (Bowers, 2005; Medalia, Dorn, & Watras-Gans, 2000). Csipke et al. (2014) however, found that service users' ability to engage in activities was not related to the severity of their illness. This finding emerged from a study that looked at the state of care in the acute mental health wards fifty years after deinstitutionalization. The dynamics of the environment of the acute mental health care have also been cited as contributing to the limited engagement of service users in activities (Curtis et al., 2013). From an occupational therapy perspective, a profession concerned with what people do and how it contributes to their health, a transactional relationship has been established between the person, the environment and occupation (Kielhofner, 2008; Law, 2002). Thus, an effect on one of these elements influences the other two.

Literature review

The environment of the acute mental health units are of concern to service providers and new hospitals have been built to replace some old facilities (Curtis, Gesler, Fabian, Francis, & Priebe, 2007; Curtis et al., 2013). Staff working in acute mental health facilities spend lot of time within that environment and for most, especially in older facilities, the environment was designed and built many years before they started working in them. This, not withstanding, they have to provide care and support to promote recovery of their service users irrespective of limitations and challenges. Purpose-built new facilities may also come with their own challenges as to how they impact on service provision. Despite the focus on the physical infrastructure used for provision of mental health services, others have studied the environment from the concept of therapeutic landscape. Williams (1999 p. 2) defined therapeutic landscape as; "those changing places, settings, situations, locales, and milieus that encompass the physical, psychological and social environment associated with treatment or healing". From this perspective, the environment is explored holistically as identified by Gesler (1992) as the natural and built, symbolic and social environment that contributes to a healing sense of place.

From the literature, researchers have explored the relevance of the environment in mental health care. Most of them are qualitative studies with small number of participants (Cohn et al., 2010; Gahnström-Strandqvist, Josephsson, & Tham, 2004; Harrison, Angarola, Forsyth, & Irvine, 2016; Rebeiro, 2001). Others have looked at the inpatient psychiatric unit to identify elements that make it therapeutic landscape; an environment believed to promote healing and recovery. These studies have explored the concept of therapeutic landscape in terms of its components. Studies reporting on the physical environment components of the therapeutic landscape constitute elements of technical safety (Curtis et al., 2013) and what needs to be included in the design (Muir-Cochrane, Oster, Grotto, Gerace, & Jones, 2013; Sheehan et al., 2013; Shepley et al., 2017). For the aspect of social environment, Fortune and Fitzgerald (2009) identified staff relationship on the acute psychiatry unit as major elements that facilitate participation on the ward. In this Australian ethnographic study, the challenges of interdisciplinary collaborations were investigated through interviews and observation of occupational therapists and nurses. Interdisciplinary respect was identified as the key elements to collaboration.

So far, a gap identified in the review is that no study has been conducted in mental health that specifically looked at the link between the environment of the acute inpatient

unit, service user's participation from an occupational therapy perspective and the concept of therapeutic landscape. To explore these issues of the environment of acute mental healthcare holistically, this study will investigate from staff and service users perspective, how the environment of the acute unit support or hinders participation of service users. All these will be explored through the lens of viewing the acute mental health unit as a therapeutic landscape, a setting that promotes healing and comprises of a physical, social and symbolic environment. The following research aims and questions have been set for this study.

Aims of the study

- To explore the environment of the acute mental health unit from staff and service user perspective.
- To explore staff and service user perspective on how the ward environment affects mental health service user engagement in therapeutic activities.
- To examine the potentials of the acute mental health environment in contributing to the health and wellbeing of service users.

Research questions

- What are service user and staff views on the acute mental health care environment in terms of how it promotes engagement in therapeutic activities?
- What are service user and staff views on the relationships that exist within the acute mental health unit?
- What are service user and staff views on the environment of the acute mental health care unit in terms of how it promotes recovery and healing?
- What are service user and staff views on the acute mental health care environment in terms of how it promotes safety, privacy and dignity?

Design and Methodology

This study will be in two components in order to give opportunity to include most of the targeted population as possible and to address the aims set. Participatory Action Research (PAR) will be conducted using mixed method approach of data collection including surveys, field notes, photo-elicitation and formation of a research group to be involve in a cycle of action and reflection (Kemmis & McTaggart, 2008; Kindon, 2010; Wilding & Galvin, 2015). This is to help improve trustworthiness of the study through triangulation (Bryman, 2008).

Module one (1) of the study will involve a survey where questionnaires (Appendix I and Appendix II) will be given to staff and service users to gather their views on the environment; this is to address the first aim on exploring service users and staff views on the environment of the acute mental health unit. Matthew and Barron (2015) used survey as a method of data collection in their participatory action research on help-seeking behaviours of self-defined ritual abuse. In the study, the questionnaire included items on participant's information with closed and open ended questions. This method is convenient in reaching out to larger participants (Tacchi et al., 2008).

Module two (2) is the formation of the Participatory Action Research (PAR) group for the study. The PAR is used with the aim of production of knowledge and to take action directly useful to a group of people through research (Reason, 2004).The PAR group of clinical staff from the hospital will collaboratively work with me and a service user co-facilitator to identify an overall social issue or problem of the environment that impacts on service user's engagement in therapeutic activities. The members of this PAR group will be seen as co-researchers and that the research will be done *with* them and not *on* them (Kemmis & McTaggart, 2008).

Study site

Data for the study will be collected in one site in central London, specifically the Acute unit, which is part of Central and North West (CNWL) NHS Foundation Trust. The site is an adult acute mental health inpatient facility with three mixed gender wards namely Ward A, Ward B and Ward C on separate floors of a six level storey building. The hospital has fifty-five (55) beds with an average of eighteen (18) beds on each ward. There is a basement where therapy services are provided for service users and a roof garden on the floor six where some group sessions are held. There is also another facility of NHS Trust closed by with meeting rooms where meetings for the PAR group will be held.

Inclusion criteria for recruitment

For the module one;

- All clinical staff working at the Acute unit will have the opportunity to participate.
- Service users with capacity to consent will have the opportunity to participate
- The service users should have been on admission for at least seven days to be settled on the ward and to have had some experiences of the environment.
- Service user's with the ability to read or understand the English language when explained to them.

The inclusion criteria for selecting staff to join the PAR group for the module two are that; they should:

- be clinical staff, registered or non-registered including doctors, mental health nurses, occupational therapists, psychologists, associate practitioners, art therapists, peer support workers (ex-service users) and support workers with active responsibility for delivering care and treatment to service users at the hospital,
- either facilitate, support or provide therapeutic activities and group sessions to service users,
- have worked at the acute unit for a minimum of three months. This is because - the study focus is on those personnel who have had experience working at the hospital and understands how the hospital operates.

Exclusion criteria for recruitment:

Module one of the study:

- Service users unable to give consent.
- Service users who cannot read or understand verbal explanation in English
- Non-clinical staff e.g. administrative staff

Module two of the study:

- Non-clinical staff e.g. administrative staff
- Agency or bank staff
- Students – including nurses, doctors, occupational therapists, psychologists.
- Social workers and pharmacists will not be recruited for this part of the study as they do not directly provide activities for service users' engagement.

Study participants and sampling

Participants for module one of this studies include all clinical staff and service users with the capacity to give consent. Information gathered from the research site, in the course of putting together the study protocol indicated that, on average, thirty service users, who had been on admission for seven days or more are discharged from the hospital each month. This study does not seek to recruit adequate powered number based on the information provided by the research site due to budget constraint. However, a maximum of twenty-five service users from the three wards will be sampled to ascertain their views through completion of the study questionnaire.

A total of forty-five (45) clinical staff, twelve from each of the three wards (12 X 3=36) and nine (9) from the therapies department are expected to complete the survey. This is based on total clinical staff of sixty personnel. A study by Sweeney et al. (2014) recorded a total of 72% response rate from the eligible inpatient ward group. This study proposes to obtain similar response rate or even better for the participants, over the period of data collection.

Module two of this study will recruit a total of between six and ten clinical staff working on any of the three wards and the therapy unit to constitute the participatory action research (PAR) group. Of these clinical staff, the criteria to be used for those who can participate in this study are those who facilitate, support or directly provide therapeutic 'activities' and group sessions for service users. They can be registered or non-registered and will come from the following potential groups: doctors, mental health nurses, occupational therapists, psychologists, associate practitioners, art therapists, peer support workers (ex-service users) and support workers.

Purposive sampling techniques (Boswell & Cannon, 2014) will be used to constitute the members of the PAR group taking into consideration profession, grade, gender, age and ethnicity to get a representative sample of the clinical staff.

Service users' involvement

Service users' involvement in research in mental health has been found to be effective especially in studies that the lived experiences of people are explored (Makdisi et al., 2013). In this research, service users were consulted in the design of instrument to be used for data collection. Their involvement in this research had been and will also include;

- One of them in the core advisory group that oversees the study.
- Having a service user co-facilitator, with experience in conducting research to be recruited to assist with the data collection and analysis. This service user will be recruited through “The Advocacy Project” attached to the hospital. The Advocacy Project is a service user involvement group for those currently on admission and those discharged to be involved in services.
- Service users recruited as participants to complete the questionnaires to gather their views on what they think of the environment where they are receiving care.

Measures (Scales)

Instruments to be used to assist with data collection in the questionnaire are;

- A modified version of the Ward Atmosphere scale by Moss 1974 (Manual, 1974) the shortened version with 40 items will be used. This is a standardized tool that measures participants’ perception of the ward environment in ten areas of; involvement, support, spontaneity, autonomy, practical orientation, personal problem orientation, anger and aggression, order and organisation, program clarity and staff control. The modifications made included; changing ‘program’ in some cases to ‘ward’ to be fit for the United Kingdom context, using ‘service users’ instead of ‘patients’ and using staff instead of nurses or doctors. Each item is followed by true or false. The scores range from zero to one and items listed as true is scored one point if marked ‘true’ and items listed as false is scored one point if marked as ‘false’ by the participant. There is a subscale score for each of the ten items.
- Satisfaction with the design and features of the hospital will be assessed using a check list of items developed by the research team for this study, and led by the author, based on the work of three previous studies (O'Connor et al., 2012; Sheehan et al., 2013; Shepley et al., 2017), that looked at elements to be included in the design of psychiatric facilities. The sixteen (16) items representing features of the physical environment of the hospital will be rated on a five point scale of one (1) representing extremely dissatisfied to five (5) being extremely satisfied.
- We will include two open ended questions on whether participant thinks the environment has any impact on what service users do on the ward and how the environment can be improved.

Recruitment and informed consent

The study will be presented at staff meetings in the Acute unit to explain what the study is about, who can participate, what participation involves, any potential risks and benefits. Proposed meetings include: ward planning meetings attended by staff and service users, ward business meetings and ward handover attended by staff, therapies review meetings attended by occupational therapists, psychologists and art therapist, meetings of specific professions (including medical staff only, OT staff only, nursing staff only etc.) and senior staff meetings.

For module one, the survey component where questionnaires will be given to clinical staff and service users, participant information sheets (PIS) (Appendix IV) and questionnaires (Appendix II) will be given to staff after the study has been presented to them. Extra copies of these will be left in an envelope on the wards for those who may not be present. Consent to participating in the study will be implied by the staff returning the completed questionnaires. For service users, ward staff will assess for those with capacity to give consent and meet the inclusion criteria. Service users will be given the PIS (Appendix III) in the first instance by ward staff. If they would like me to contact them about the study, they will be encouraged to complete the tear-off slip at the bottom and leave it in a box that I will provide on the ward. I will then meet the service user on the ward to assess their capacity to give consent to participate in the study. Service users capacity will be continuously assessed throughout their participation in the study. They will be informed if they would like assistance or support in completing the questionnaire; this can be provided by a researcher on the study with experience of using mental health services. If they require this support I will liaise with the service user researcher to arrange a convenient time for them to meet. Service users who wish to complete the questionnaire on their own will be allowed to do so.

For module two, the participatory action research component, where clinical staff will come together to engage in a cycle of action and reflection to come up with recommendations, staff interested in participating can contact me directly on the ward, by phone or by email. I will encourage staff to contact me within two weeks of presentation to them to express interest to participate. A maximum number of 10 and a minimum of 6 staff will be recruited for the group. They will be asked to attend each of the 5 PAR meetings so that the group membership is stable. If more than 10 staff express interest, I will endeavour to purposively select staff who are representative of the wider clinical staff team in terms of grade, ethnicity, gender and profession, where possible (Wilding & Galvin, 2015). Selection of staff with similar characteristics will be made by ‘drawing

names from a hat' so that the process is transparent and fair. I will meet individually with those staff who volunteered to participate but were not finally selected for membership of the group. This is to give them an opportunity to discuss any feelings which may arise from this process.

On the other hand, if too few staff volunteer to participate in the study, I will liaise with the ward managers and team leads' to ask them to suggest staff that I can approach individually to ask if they will like to participate.

Timescale: Broad timetable for the stages of the research

The data collection period will span approximately ten months from March 2018. The key events have been presented in the table below;

Months **Events**	Mar	Apr	May	Ju	Jul	Aug	Sep	Oct	Nov	Dec
Presentations at meetings										
Recruitment of staff and service users to module 1										
Given out of questionnaires and collection										
Recruitment of staff to form PAR group										
Workshop for PAR group										
PAR group meetings				Cycle 1		Cycle 2		Cycle 3		Analysis of result 4
Analysis of results from Module 1										
Dissemination of the findings						Interim finding				Final results

What happens after participants are selected in module two?

I will create a group emailing list including staff participants, myself the service user co-facilitator. I will communicate information such as documentation and planning for meetings through email.

The first meeting of the staff participants will be scheduled for three hours within a month after recruitment. They will be asked to attend the groups in their own time, and will be reimbursed their transport cost and a nominal thank-you token. Release from clinical duties for groups of NHS staff to participate in research for a duration of this length is

currently not feasible, without considerable recompense to the employing organisation to ensure the safety and treatment standards of service users are maintained at acceptable levels. The study team, who have considerable experience in conducting large scale research with staff and service users in acute mental health services in England, have carefully taken this into account.

This will be an orientation meeting for the research group, to discuss the aims and objectives of the research and what is expected of them as participants. A training on Participatory Action Research (PAR) will be provided to help them be familiar with it and also to help them effectively participate in the study. This session is proposed to be delivered by Dr Simone Coetzee, a lecturer at the University of Essex, with experience in conducting participatory action research. Participants will be given certificate of attendance, which the research team will suggest can be used to enhance their professional portfolio as evidence of Continuous Professional Development (CPD). The research group will agree on the next meeting date possibly within a month to begin the process of data collection.

How long will participants be expected to be in the study

- Completion of the questionnaire is expected to take between ten to fifteen minutes for staff and thirty to forty-five minutes for service users.
- The staff PAR group participants will be requested to be available to participate in the research over an eight months period.
- There will be five meetings of the PAR group over the eight months period, one orientation meeting and four meetings for the data collection and analysis. Meetings for the data collection will be held once in every two month.
- A maximum of four hours and minimum of two and half hours is the proposed time for staff to be present for each cycle of the PAR group meeting.
- Staff will be asked to commit between thirty minutes to one hour of their own time in advance to reflect and put together a case study or scenario related to the environment where they work, that they intend to share with the PAR group.
- Staff participants may be asked by the researcher to do twenty (20) minute presentations at ward or team meetings to share recommendations from the research and plan with the team how it can be implemented.

Data collection and analysis

For module one, I will be recruiting staff by attending their scheduled meetings to discuss the study with them, provide them with information sheet and hand out questionnaires for completion. Participants will be given the option to complete the questionnaire and hand it back to me or agree on a time that I can come back for it.

With service users, they will be given the questionnaire after completing the tear-off slip to be contacted by the researcher to participate in the study. They will have the option of completing the questionnaire on their own or be supported by a service user researcher to complete the questionnaires. They can also request support from any other person of their choice, such as other staff member, friend or family member.

For module two of the study, after forming the research group and completing of the induction, a date will be set for the first meeting. At this meeting to be facilitated by myself and a service user co-facilitator;

- The concept and meaning of the environment will be explored. A word cloud will be used to generate key terms used. This will be repeated at the start of each cycle to monitor changes in participants' understanding of the environment.
- Findings emerging from the data from the questionnaires will be further explored by the PAR group at the first cycle meetings.
- The aims of the study will be explained and together, the group will be asked to collaboratively identify factors within the environment that facilitates or inhibits service users' engagement in therapeutic activities.
- Group members will be asked to prioritize these inhibiting factors and select the top three that they will like to work on to effect change.
- The group actions and reflections will continue to arrive at possible recommendations.
- The group members will be asked to come along with pictures of physical spaces of the hospital they will like to reflect on during the second cycle

These discussions will be audio-recorded using a voice recorder as well as field note taken by me.

The second and third meetings will follow similar patterns depending on problems identification and recommendation of actions to be taken. Other data to be gathered will include written reflections and field notes gathered by me. I will critically reflect on the various stages of the study as part of the data collection to ensure data generated aims towards answering the research questions and aims of the study (Swantz, 2008).

Clinical staff participants will be involved in simple survey responses (for example counting how many locked doors are passed through in a day's work or the number of other professionals involved in sessions with service users). Photographs of spaces where people work and other artefacts /documents related to staff working environment at the acute unit will also be used to facilitate the discussions of the PAR group. The decision to bring in such items will be dependent on the staff participants and they are to ensure that, these items have no service user identifiable information.
These processes for data collection have been outlined for the purposes of approval by a NHS research ethics committee to commence the study. However, as the study progressed, and in line with participatory action research method, the studies focus may change. When such instances occur, additional approval from the ethics committee will be sought to continue with the study. The fifth and final meeting of the PAR group will be pulling all the data together and having a look at the findings emerging from it to complete the cycle of data collection.

Data Analysis

The quantitative data generated from the survey will be analysed using Statistical Package for the Social Sciences (SPSS). For the qualitative data, the audio-recorded information from the discussions will be transcribed verbatim. Then thematic analysis (Bryman, 2008) will be conducted by me in collaboration with the staff participants in the PAR group to identify key themes emerging from the study. There will be further analysis by me using the software Nvivo version 11 to consolidate the findings. The final analysis of the data will be to engage in a process of constant comparative analysis to generate a theory from the research (Neuman, 2006).

Potential risks and burdens for research participants and how this will be minimized

The risks associated with participating in Module one for staff completing the questionnaire is very low. Should any issues arise for them which they wish to discuss with me, they will be encouraged to do so, and if they require further support they will be encouraged to speak with their line manager or occupational health.

Although not likely, there is a risk that service users may become distressed when completing their questionnaire. Should this happen, they will be encouraged to speak with their allocated nurse on the ward or another clinician with whom they have a therapeutic relationship. If I feel that they require immediate support I will alert clinical

staff to provide assistance. Service users will be assured that their care will not be affected in any way if they do not participate, or if they withdraw from the study at any point. However, if they are harmed due to someone's negligence, then they may have grounds for a legal action but they may have to pay for it. Regardless of this, if they wish to complain about any aspect of the way they had been approached or treated during the course of this study, they can first complain to my academic supervisor. If they are not fully satisfied, they can request for the contact of my sponsor from the University of Essex to escalate their concerns. The normal National Health Service (NHS) complaints mechanisms may also be available to them.

Staff will also be assured that their decisions to participate in the study will not affect their employment. There is also a small risk that staff can become distressed during the PAR groups. They will again be encouraged to seek support from their peers, manager or occupational health. The group participants can also provide support to each other in these situations. As the facilitator, I am also an experienced mental health professional and may offer support when the need arise.

These issues will be addressed by making participants aware at the beginning of the studies that such things are bound to happen. It will be stressed that their participation in the study is voluntary and that if at any point they feel burdened or distressed, they can withdraw from the study. Those who may need additional support following the group session will be advised to use existing facilities within the trust like having supervision and/or contacting occupational health department for support.

Potential benefit of the research to the participants

Service users will be reimbursed an amount of £10.00 in lieu of time spent in completing the questionnaire However, there will be no payment for staff completing the questionnaire. Staff participating in the PAR will be given a token payment of £50.00 per each of the five 4 hour sessions for their time and transport, as this participation will be undertaken in their own time, not during their working hours. Indirectly, we hope the completed research may in future have a positive influence service provision. The study will also offer staff the opportunity for their voices to be heard and the process of participating may facilitate reflection and a changed perspective on their work environment. There is an indirect potential benefit from the completed research which may in future positively influence the working environment that they or staff elsewhere experience.

Potential risk for the researcher

The research setting is an adult acute mental health unit that have service users very unwell, at risk to themselves and to others. I will be giving out and collecting questionnaires on the wards and at the therapy units. I may come across incidence of violence, aggression and psychological distress from service users. The service user researchers may also be exposed to similar situations. This has been addressed by going through the Central and North West London induction for all staff prior to working on the wards, which include a section on how to safely breakaway. The service user researcher will be required to undertake this mandatory induction when recruited.

The service researchers and I will be supervised and supported by the ward staff on each visit for data collection. We will also go through a safety induction on each visit for data collection to be aware of any risk and be familiar with how to raise alarm on the unit. Sessions to complete questionnaires with service users will be conducted in safe spaces within the unit and other staff will be made aware of our where-about on the unit all the time.

It is also anticipated that, a service user, who may not meet the inclusion criteria to participate in the study may express interest to be involve in the study to get the £10.00 or there may be more service users on the wards willing to participate once the targeted number of twenty-five service users has been reached. When these occur, it will be clearly explained to them why they cannot participate in the study.

Ethical consideration

This study will seek ethical clearance from the University of Essex Research Ethics Committee and approval from Health Research Authority of the National Health Services, UK. The participants will be provided with information sheet about the study for both modules and a consent form for module two to sign once they agree to participate in the study. They will be assured of confidentiality of any information provided and that their participation is voluntary and can withdraw from the study at any time. The staff participants will also be advised to adhere to the trust policy to protect the safety and dignity of service users during the group discussions.

Data storage

The personal data for service users will comprise gender, age, ethnicity and whether detained under the Mental Health Act. For staff, personal data will comprise gender, age, ethnicity, profession, grade and duration of employment. Access to these data will be

restricted to my two academic supervisors and me. Personal data (list linking names of participants to study numbers) will be stored for the duration of the study only and will be kept in a locked filing cabinet or in a passworded file on one of the University of Essex computer accessible only by me. Personal data will not at any point be kept on laptops. Non-essential data will be removed from laptops as soon as it is transferred to an office computer. Audio recorded data and other confidential information gathered from staffs and service user including completed questionnaire will be kept securely by me at the University of Essex during the period of research and handed over to my academic supervisor upon completion of the project. All information gathered will be treated in accordance with United Kingdom Data protection Act 1998.

Dissemination of the findings

Findings from this study will be shared with members of staff at the Acute unit through presentations and at management meetings at the Central and North West London NHS Trust. The PAR group collaboratively will design a leaflet to communicate the findings from this research. It is proposed that, the study will also be presented at conferences and eventually be published in peer reviewed journals.

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Appendix Y : Seminar and Conference presentations

Date	Conference	Title of Presentation	Mode
8/6/2017	Conference in London south bank university on "Promoting Mental Health Policy: Working in hard to reach & under-served communities".	Staff views on the impact of the environment on service user's engagement in their treatment within the acute mental health unit	Poster
13/06/2017	University of Essex School of Health and Human Sciences annual student – staff research conference 2017	Staff views on the impact of the environment on service user's engagement in their treatment within the acute mental health unit	Poster
26/06/2018	University of Essex. School of Health and Social Care annual student – staff research conference 2018	The impact of the environment on engagement in therapeutic activities of service users in an acute mental health unit	Poster
13/09/2018	Mental Health nursing conference, Manchester	The impact of the environment on service users' engagement in therapeutic activities in an inner London acute mental health unit	Poster
26/02/2019	Service user's research forum – UCL Division of Psychiatry	Staff and service user's perception of health facilities impact on service user's engagement in therapeutic activities	Oral
30/04/2019	To the senior management team at the acute unit	Initial findings of survey	Oral
14/05/2019	To the occupational therapy team at the acute unit	Initial findings of survey	Oral
24/06/2019	Presentation to the Divisional Board at the head quarters	Staff and service user's perception of health facilities impact on service user's engagement in therapeutic activities	Oral
18/06/2019	Royal College of Occupational Therapists annual conference at Birmingham	Staff and service user's perception of health facilities impact on service user's engagement in therapeutic activities	Oral
27/01/2020	Teaching session with University of Essex MSc year two Cohort	Smoking as a ?resistance occupation	Seminar
16/06/2020	University of Essex. School of Health and Social Care annual student – staff research conference 2020	The impact of the environment on service user's engagement in therapeutic activities in an adult acute mental health unit	Oral

24/10/2020	Society for the study of occupation - USA	The impact of the environment on service user's engagement in therapeutic activities in an adult acute inpatient mental health unit	Virtual pre-corded poster
23/10/2020	Occupational Therapy Association of Ghana Annual Scientific Conference.	The impact of the hospital environment on service user's engagement in therapeutic activities	Oral

University of Essex

1 February 2018

To whom it may concern

The Impact of the Environment on Engagement in Therapeutic Activities of Service Users in an Acute Mental Health Unit

I am pleased to confirm that the University of Essex will act as Sponsor under the Department of Health Research Governance Framework for Health and Social Care for the following research project undertaken by one of our postgraduate students:

Chief Investigator:	Ms Ellen Serwaa Adomako
Department:	School of Health and Social Care
Project Title:	The Impact of the Environment on Engagement in Therapeutic Activities of Service Users in an Acute Mental Health Unit
Academic Supervisors:	Professor Fiona Nolan, School of Health and Social Care, University of Essex, Dr Simone Coetzee, School of Health and Social Care, University of Essex
Work Place Supervisors:	Ms Suzie Willis, Central and North West London NHS Foundation Trust, Mrs Kiran McRobert, Central and North West London NHS Foundation Trust

The University will provide indemnity against negligent harm caused as a direct result of our employees' and students' actions.

Yours faithfully

Sarah Manning-Press
Research Governance and Planning Manager

cc Professor Fiona Nolan, School of Health and Social Care
Dr Simone Coetzee, School of Health and Social Care

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Appendix

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TO WHOM IT MAY CONCERN

15th July 2017

Dear Sir/Madam

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We confirm that the above Institution is a Member of U.M. Association Limited, and that the following cover is currently in place:-

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Yours faithfully

Susan Wilkinson
For U.M. Association Limited

U.M. Association Limited
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TO WHOM IT MAY CONCERN

15th July 2017

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Yours faithfully

Susan Wilkinson
For U M Association Limited

Study title: The impact of the environment on engagement in therapeutic activities of service users in an acute mental health unit

questionnaire No	Date Questionnaire completed	Service users name	Supported by ... to complete the questionnaire	Date SU Payment received (£10.00)	Service user Signature	Paid by

University of Essex

SCHOOL OF HEALTH AND SOCIAL CARE

Participant Payments

I .....have taken part in a research study conducted

by.....for which I claim the sum of £10.

Appendix AD timelines for the data collection for both module of the study

Table 3.5: timelines for the data collection for both modules of the study

Months **Events**	**May** **2018**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan** **2019**	**Sep**
Presentations at meetings										
Recruitment of staff and service users to Module One										
Distribution and collection of questionnaires										
Recruitment of staff to form PAR group										
Workshop for PAR group										
PAR group meetings for data collection										
Final meeting with PAR group for member checking										

Appendix AF New smoking policy of the acute unit

Excerpt from draft NCSCT guideline, pub March 2018: Smoking cessation and smoke free policies: Good practice for mental health services

Storage of tobacco: The storage of tobacco and smoking paraphernalia has become a source of contention since Mental Health Trusts started to go completely smokefree. Trusts may need to review and revise their existing policies on the management of personal belongings and what property is considered appropriate during an in-patient stay and what is considered contraband.

Trusts will already have in place polices on managing the possession and storage of alcohol and other contraband items. These policies can be adapted to include tobacco, matches and lighters. This needs to be clearly and widely communicated to every service user in receipt of community and in-patient services, preferably in advance of an inpatient admission.

The storage of tobacco is a clinical issue. If a smoker keeps tobacco on their person, in a bedroom, in a locked but accessible clinical area or with staff then it can be a cue to smoke and may cause them to experience additional strong urges for a cigarette. Facilitation of smoking takes up valuable clinical time and undermines attempts by service users who are taking the opportunity to quit smoking during an inpatient admission, and those who are trying hard to co-operate with the policy.

Therapeutic response to breaches of a smokefree policy: It is likely that some service users (and staff) will find it difficult to adhere to a smokefree policy and smoke in areas where it is not allowed. Initially, when smokefree polices are implemented, staff may see an increase of smoking in wards, as smokers struggle to adjust to the physical, psychological and environmental changes. When this occurs, it is helpful if staff respond in a supportive and consistent manner. The goal is to ensure safety, maximise engagement and create an environment that is conducive to recovery.

Staff who continue to smoke seriously undermine the enforcement of smokefree policies and they could potentially trigger cravings to smoke in service users because they smell of the cigarettes that they have smoked. It is important to support staff who smoke to make a quit attempt and/or manage temporary abstinence whilst at work.

If a service user is observed smoking on the ward, staff should ensure the area is safe. If there is an imminent risk then support should be enlisted. Where there is no immediate risk the staff should discuss the breach with colleagues and agree the most appropriate time and place to meet with the service user to review the care plan. People who are struggling to co-operate with the smoke-free policy should have their care plan reviewed, particularly the dose and frequency of NRT, the service user's adherence with NRT and their access to behavioural support.

[An example of a smokefree policy can be found here: http://www.slam.nhs.uk/media/24437/smoke_free_policy.pdf]

One of the main barriers to the implementation of smokefree policies is staff concerns that violence, absconding and fires will increase. Although understandable, the majority of research from the UK and other countries suggest that these untoward effects do not occur. A mental health trust in South London found there was a 47% decrease in physical assaults in the 12 months after they went smoke-free compared to the 32 months before hand; absconding and fires also reduced (Robson et al, 2017).

Therapeutic management of leave: NICE Guidelines for smoking in acute, maternity and mental health settings recommend there should be no staff facilitated smoking or smoking breaks (Nice 2013). This poses unique challenges for service users who are detained under the Mental Health Act and for clinicians who have to deliver care in the least restrictive environment. Since many Mental Health Trusts have gone completely smokefree there is anecdotal evidence that service users are escorted (or unescorted) to smoke outside the hospital boundaries several times a day.

According to the Mental Health Act 1983 Code of Practice, the Responsible Clinician needs to consider a number of things when granting Section 17 leave, regardless how short the period is, including:

the interests of the service user

the benefits and any risks to the service user's health and safety

the benefits to facilitating recovery

what support the service user needs during their period of leave

an assessment of risk

Whilst leave conditions should be personal to each individual service user, the use of Section 17 leave to smoke does not facilitate recovery, rather it impairs recovery. Cancelling leave as a punishment for breaching smokefree policies is also poor practice. Instead, leave should be planned with the service user in advance and a leave care plan developed. The preparation of leave should include a plan of when and how to use NRT or e-cigarettes and how to avoid and deal with smoking cues.

Changing the smoking culture: Smoking is often perceived to fill time in the absence of alternative activities for people on mental health wards, and for those living in the community. It often becomes a major part of a service user's daily routine, providing structure and a means of breaking up the day. It is often viewed as a shared experience, providing opportunities to make friends, interact and connect with others. Service users may be afraid of losing this perceived benefit despite the negative impact of smoking and they may see it as one of the few things they can control in their lives. With good mental health care, there should be alternative and healthier solutions offered to people to gain a sense of control in their lives.

Staff and service users need to work together to develop new ward routines (and community routines) to replace smoking and develop distraction techniques that help to avoid or manage cravings to smoke. The therapeutic management of boredom requires creativity and imagination, facilitating smoking requires neither. Smokefree policies, including treatment for tobacco dependence, has the potential to transform the culture of mental health organisations, where poor physical health of service users is prevented rather than expected.

Appendix AG: THREE KEY THEMES

Service user's engagement in therapeutic activities was limited by the building not purposefully built and designed as an acute inpatient mental health unit

Historical use of the acute unit building (5) Dissatisfaction-access to garden, outdoor facility and noise (4)	Impact of the physical layout of the building (5) Access to daylight, ventilation and thermal comfort Hemmed in (4)	Impact of the physical layout of the building (5) equipment Staff vision for an ideal working space (5)

Service users access to spaces that enabled them to engage in therapeutic activities was compromised with the use of formal systems as locked doors and booking systems

Impact of the physical layout of the building (5) Impact of the security features of the acute unit Staff control (4) perceived as high	Use and availability of space (5) lost space "Hemmed in": less freedom (4)	Use and availability of space (5) Designing spaces for specific use Staff vision for an ideal working space (5) no locked door no booking

Staff assigned profession specific roles and responsibilities impacting the extent non therapy staff can engage service users in therapeutic activities

Staff ability to influence the environment (5)	Interpersonal relationships at the acute unit (6) staffing levels	Interpersonal relationships at the acute unit (6) Decision making and communication (teamwork)

Context of therapeutic activities (6) Staff assigned roles **Interpersonal relationships at the acute unit (6)** [smoking facilitation & choice to smoke] **Service user personal factors (6**	Context of therapeutic activities (6) Therapeutic activities: essential or nice to have	Context of therapeutic activities (4) Ward staff verses therapy staff on WAS

Three key themes	**Subthemes**	**Quotes & participants**
Service user's engagement in therapeutic activities was limited by the **building <u>not purposefully built</u> <u>and designed</u> as an acute inpatient mental health unit**	Historical use of the acute unit building (5) Impact of the physical layout of the building (5)	*"We just continually having problem with the fabric of the building, … although people try and keep maintaining the building, but there is often a lot of issues <u>coming up with it, and they seem to be increasing" (Louisa, Team lead).</u>* *"I have spent ten years in an airless box, four days a week, no natural light, no ventilation, treating patients"* (Ulric, Therapy staff 2, PAR 2, L. 69, p. 4). *"The basement is really bad, dark, dingy, someday I am just there, I feel lethargic, withdrawn, there is no light that comes from outside"* (Eugene, Therapy staff 1 *"We have to sometimes give patients three, four blankets [at night]. And sometimes, patients have to come out in the day area with blankets, we can't stop them, … meanwhile if it's summertime is unbearable"* (Winfred, Nurse 2 PAR 5, L. 453, p.15).

	Impact of the physical layout of the building (5) equipment Dissatisfaction-access to garden, outdoor facility and noise (4) Hemmed in (4)	*"That's been blocked, and the sewerage is burst, and is coming straight through the gym, but that is my working environment, is not the best but you know, we try to work with that the best that we can"* (Eugene, Therapy staff 1, PAR 2, L. 234 p. 11). "*The toilet is blocked for weeks on end"* (Elsie, Occupational therapist 1, PAR 2, L. 532 p. 24). "*But having said that, the type of and methods of exercise and fitness change quite a lot and there are so many methods. Exercising, ways to engage people and I don't think we have kept up with that, I do think we are quite years behind in that respect"* (Eugene, Therapy staff 1, PAR 2, L. 202 p. 9). "*So, only one cooker is not enough for a group, you need to have at least two. … they are kind of limited in the number of people they can invite to that group now"* (Elsie, Occupational therapist 1, PAR 2, L. 284 p.13). H_3: The therapy staff were less satisfied with the physical features of the acute unit environment compared with the ward staff due to their location at the basement-confirmed *"service user often finds the environment to be claustrophobic and lack of open space" (SU 73).* *"because of the lack of easily accessible but secure outside garden area, patients do feel hemmed in. … Given the restrictions of limited space of the building's original design, I believe we have used the space to best effect (S11, Associate practitioner).*

	Staff vision for an ideal working space (5)	*"Those designated places that people go to, so whenever somebody was upset, angry or frustrated about whatever for whatever reason, … a place where they could go and sit and find comfort and relaxation"* (Victor, Nurse 1, PAR 4, L. 34 p. 2). *Somewhere … people can de-escalate if they are quite aroused, upset, where staff will be able to minimise the amount of restraint that are used"*. (Elsie, Occupational therapist 1, PAR 3, L. 215 p. 12). *Variety of zones of care and activities…. variety of places that they can go, you know, somewhere with plants, somewhere with a good stock of DVD"* (Ulric, Therapy staff 2, PAR 3, L. 180 p. 10)
Service users access to spaces that enabled them to engage in therapeutic activities was **compromised** with the use of **formal systems as locked doors and booking systems**	Impact of the physical layout of the building (5) Impact of the security features of the acute unit Use and availability of space (5) lost space	*Obviously, security has become a huge issue at the hospital after recent event, we feel the security is probably something that can be stepped up in many ways and reviewed* (Dr John, Consultant) *"lock doors to the basement, is still a massive issue, people continue to be affected. It stopped one community group, [a] very popular group now because patients can't get in"* (Ulric, Therapy staff 2, PAR 3, L. 63 p. 4) *"We used to do a trip to the roof garden, for people who didn't have leave, just for fresh air. We do not do that anymore, … I know like C really wanted to go and get fresh air but there's no one to take you"* (Josephine, HCA, PAR 1, L. 86 p. 5). *"The trouble with doing music therapy for example on the ward, is noise. People who don't want to be involved are then assailed by all of this noise pollution, not everything can go on, on the ward" (Ulric, Therapy staff 2, PAR 3, L. 170, p. 9)* *"Our creative group room was a bigger room originally, when we had the estate [personnel] coming in, they halved the room …. But also, the space became very*

		cluttered and … there was not much space to manoeuvre, around the room (Elsie, Occupational therapist 1, PAR 2, L. p. 24). *"Activities that take place on the ward itself for instance are often [crowded]. You do get a sense, there is not enough space, … , it takes up the whole of the available space of the ward sometimes"* (Dr John, Consultant). *"Well, there isn't much space to be doing a lot of therapeutic activities. We are all cramped in, squashed in especially now… On the ward, there is only one room to do activities, and down here in the basement there is one room but that is also a bookable space* (Louisa, Team lead).
	Use and availability of space (5) Designing spaces for specific use	*"… is difficult when the room are bookable by lot of people, because we can't actually tailor-make it to be like a room that is best fitted for group use*" (Henrietta, Occupational therapist 2, PAR 3, L. 306 p.16).
	Staff control (4) perceived as high	Related to locked doors and service user's inability to leave ward
	"Hemmed in": less freedom (4)	*"service user often finds the environment to be claustrophobic and lack of open space" (SU 73).* *"because of the lack of easily accessible but secure outside garden area, patients do feel hemmed in. … Given the restrictions of limited space of the building's original design, I believe we have used the space to best effect (S11, Associate practitioner).*
	Staff vision for an ideal working space (5) no locked door no booking	*"Those designated places that people go to, so whenever somebody was upset, angry or frustrated about whatever for whatever reason, … a place where they could go and sit and find comfort and relaxation"* (Victor, Nurse 1, PAR 4, L. 34 p. 2).

Staff **assigned profession specific roles and responsibilities** impacting the extent non therapy staff can engage service users in therapeutic activities	Staff ability to influence the environment (5)	*" The other day we had a meeting on the first floor and I couldn't believe how bright it looks down there, bright light, beautiful offices, all carpeted nicely and we living in a dungeon in the basement"* (Elsie, Occupational therapist 1, PAR 4, L. 1061, pp. 54-55). *"Although as I said, I wouldn't promote smoking because is a health hazard and is also a bad habit. Yet, people do it and it is a culture and habit that people develop for years and years and is very difficult for them to stop" (Victor, Nurse 1, PAR 4, L. 32 p. 2).* *"We used to do a trip to the roof garden, for people who didn't have leave, just for fresh air. We do not do that anymore, … I know like C really wanted to go and get fresh air but there's no one to take you"* (Josephine, HCA, PAR 1, L. 86 p. 5).
	Interpersonal relationships at the acute unit (6) staffing levels	*"If a patient comes to me, and says to me I want to go for smoke break now and I tell them, look at the moment I cannot facilitate it, I haven't got staff to facilitate it, … patients will lash out, because for them that is the only way they can get their voice heard … and then when they lash out, the alarm will be activated and this will have to be managed somehow (Victor, Nurse 1, PAR 4, L. 918 p. 47).* *"In the morning when the shift starts, automatically two people have been taken out of the equation [for medication], if there is a one-to-one, you don't get an extra staff, so you've literally got two people, one person who will be in the office to take phone calls and there is another one serving breakfast" (Victor, Nurse 1, PAR 4, L. 952 p. 49).* *"If on that particular day…provisions could be made for an extra staff to be booked purely for that purpose… all these things could go a long way in benefiting the patients but again because of funding, you know there is not even enough staff on the ward" (Victor, Nurse 1, PAR 4, L. 703, 718 pp. 36- 37).*

	Interpersonal relationships at the acute unit (6) Decision making and communication (teamwork)	*"At the moment I rarely see admin staff on the ward, so is the nursing staff sitting in the reception sorting out cigarette and answering calls opening doors for visitor" (Henrietta, OT 2, PAR 5, L. 714 p. 23).* *"Hopefully, we will have a well organised timetable and when we need covers, we will find someone to cover the groups when you are on holiday" (Henrietta, Occupational therapist 2, PAR 3, L. 147 p.8).* *"Because they [ward staff] do not really understand the role or the reason why we attend that group, ... I think they just often pick people, random allocation or not allowing patients to come" (Henrietta, Occupational therapist 2, PAR 2, L. 464 p. 21).* *"They [management] should have considered (the environment) before they impose these laws on a unit like this" (Dr John, Consultant).* *"I've close contact with occupational therapists and some of the other therapy department" … "[they] also contributes to the assessment process, because is not like I see the patients every single minute that I'm here, I values the feedback I get from the therapists in the groups" (Dr John, Consultant).* *"I think for Ward B, we've been working perfectly fine and I can attest that because we've got a dedicated occupational therapist. I will go down to basement floor and ask the OTs to come and base themselves on the ward". (Peter, Ward manager)* *"So, there is a definite breakdown [of teamwork] within the hospital among the teams, not so much internally in teams but across teams in terms of what OTs, nurses, doctors do. Feel like you are banging your head against a brick wall" (Eugene, Therapy staff 1, PAR 2, L. 178 p.8).* *"I think as a knee-jerk reaction, she wanted the door closed, locked, they took away the little key which can allow you to put the thing on the latch, they took it away without any consultation" (Ulric, Therapy staff 2, PAR 2, L. 86 p. 4).*

		"When they [management] decided to put the door there, I think there was suggestion about having a door instead of having a full wall, have a door in between…, if people want to have access to the sink, they can (Henrietta, Occupational therapist 2, PAR 2, L. 566, p. 25). *"I believe that, ok, like most of the time the main decision making lies in the hands of the consultants … but we are supposed to be working as a team, as a multidisciplinary team and because of that everybody's view is important" (Victor, Nurse 1, PAR 4, L. 891 p. 46).* *"There is no team meeting on my ward, the team meetings kind of occur ad hoc, so I never know when it is happening, is usually just the nursing team" (Elsie, Occupational therapist 1, PAR 3, L. 261–263 p. 14).* *"So yes if you check your emails, the newsletter is there, good things coming up. The division, whatever they are planning as an organisation, if you don't check your email you wouldn't know, until you wait for two weeks at staff meeting" (Peter, Ward Manager).*
	Context of therapeutic activities (6) Staff assigned roles	*"We are expected to provide some variety of therapeutic activities to engage them [service users] alongside their medication and the other treatment" (Louisa, Team lead).* *"The activities on the wards were all provided by the occupational therapists and the associate practitioner" (Louisa, Team lead).* *"We do really important assessments for [service users], how people are going to function in the community" (Ulric, Therapy staff 2, PAR 5, L. 72 p. 3).* *"I often encourage people in ward rounds to engage in activities. And especially, people who are admitted informally (Dr John, Consultant).*

		"In the morning when the shift starts, automatically two people have been taken out of the equation [for medication], if there is a one-to-one, you don't get an extra staff, so you've literally got two people, one person who will be in the office to take phone calls and there is another one serving breakfast" (Victor, Nurse 1, PAR 4, L. 952 p. 49). *"To be honest with you, there is only one walking group at the moment. I facilitate; myself and (…) and it's for three hours on Wednesday, and it works quite well" (Eugene, Therapy staff 1, PAR 4, L. 650 p. 38).* *"If on that particular day…provisions could be made for an extra staff to be booked purely for that purpose… all these things could go a long way in benefiting the patients but again because of funding, you know there is not even enough staff on the ward" (Victor, Nurse 1, PAR 4, L. 703, 718 pp. 36- 37).* *"I mean things got better, when nurses even come upstairs and run around to get leave cleared from consultants, I mean they do what they can" (Eugene, Therapy staff 1, PAR 4, L. 844 p.43).* *"Sometimes is like, we have to wait for the doctors to fill the leave form or do the gym form for patients to access groups." (Eugene, Therapy staff 1, PAR 2, L. 446, p. 20).* *"Yes, I mean I do have to give the final say, if someone can go on the walk" (Dr John Consultant).* *"Like I said, if you give me a hammer and a tool, I will probably go around and fix half of the problem, is that easy, then the bureaucracy will set in that, you can't do that, you not [allowed], health and safety" (Eugene, Therapy staff 1, PAR 2, L. 324 p. 15).*

		Despite how many times you say, there was something that you can ask the nurse, you go, you get it. It depends on who is at the ward reception and who know they are there …. or remember the box (Henrietta, Occupational therapist 2, PAR 2, L. 496 p. 22).
	Context of therapeutic activities (6) [Therapeutic activities: essential or nice to have]	*"Remember, is not just medication only. Is the key thing for people's recovery… Is spirituality, activities that will help them, activities of their own choice, that will occupy their day." (Peter, Ward manager).* *"Eugene did mention, they are trying to introduce protected time engagement with patient but that will never work, they will never work, and I am pessimistic" (Victor, Nurse 1, PAR 4, L. 219 p.11).* *"So, if there is for instance the ward round, and that person is in the music therapy session or in a group of some sort, they are not to actually call people out of groups because that is part of the of their treatment, so is about valuing that treatment (Elsie, Occupational therapist 1, PAR 3, L. 268-270 p. 14).* *Obviously, we do not take kindly to drugs and alcohol, but for smoking, I cannot say to someone not to smoke, it causes problem for us (Dr John, Consultant).*
	Context of therapeutic activities (4) Ward staff verses therapy staff on WAS	*the ward staff had slightly higher mean scores for most of the subscales compared to the mean scores for the therapy staff*
	Interpersonal relationships at the acute unit (6) [	*"Since the smoking cessation, you know zero tolerance for smoking in the NHS premises, this has made things very very difficult. Because you find that patients are getting more and more aggressive. Because they are not able to go outside and smoke"* (Victor, Nurse 1, PAR 4, L. 36 p. 2).

	smoking facilitation & choice to smoke] Service user personal factors (6)	*"It has been a huge thorn in our side. Since they stopped people going out for smoking. Because it does create frustration for a detained patient that you will often see an escalation in aggression and violence behaviour"* Dr John *"If you take somebody out of the building for smoking, even if it is for a period of 10 - 15 minutes, anything can happen while you have left the ward, that means, if say, a fight broke out between two patients, your support has been taken away, from the ward"* (Victor, Nurse 1, PAR 4, L. 40 p. 2)

Appendix AI NHS REC ethics approval

NHS
Health Research Authority

London - Camden & Kings Cross Research Ethics Committee
NHSBT Newcastle Blood Donor Centre
Holland Drive
Newcastle upon Tyne
NE2 4NQ

Telephone: 0207 104 8086

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

27 April 2018

Ms Ellen Serwaa Adomako

PhD Student

University of Essex

School of Health and Social Care

Colchester

CO4 3SQ

Dear Ms Adomako

Study title:	**The impact of the environment on engagement in therapeutic activities of service users in an acute mental health unit.**
REC reference:	**18/LO/0331**
IRAS project ID:	**234832**

Thank you for your letter of 15th April 2018, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered in correspondence by a Sub-Committee of the REC. A list of the Sub-Committee members is attached.

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 opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact hra.studyregistration@nhs.net outlining the reasons for your request.

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, subject to the conditions specified below.

Conditions of the favourable opinion

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

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

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for NHS permission for research is available in the Integrated Research Application System, www.hra.nhs.uk 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 management permissions from host organisations

Registration of Clinical Trials

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

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

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

If a sponsor wishes to 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 the HRA. 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

NHS sites

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

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [University of Essex indemnity letter]	one	15 July 2017
IRAS Application Form [IRAS_Form_05022018]		05 February 2018
Letter from funder [Letter from funder]	one	12 February 2018
Letter from sponsor [Sponsorship letter from University of Essex]	one	01 February 2018
Non-validated questionnaire [Questionnaire service user's version]	two	05 April 2018
Non-validated questionnaire [Questionnaire, version for staff]	two	05 April 2018
Other [University of Essex Public Liability letter]	one	15 July 2017
Other [Response to the REC]	one	15 April 2018
Participant consent form [Consent form for staff questionnaire]	one	18 January 2018
Participant consent form [consent form for service user's questionnaire]	two	05 April 2018

Participant consent form [Consent form for staff participatory action research]	two	05 April 2018
Participant information sheet (PIS) [Participant Information sheet for service users]	two	05 April 2018
Participant information sheet (PIS) [Participant information sheet for staff questionnaire]	two	05 April 2018
Participant information sheet (PIS) [Participant information sheet for staff action research]	two	05 April 2018
Participant information sheet (PIS) [PIS short service user version]	one	05 April 2018
Research protocol or project proposal [Study Protocol]	two	05 April 2018
Summary CV for Chief Investigator (CI) [CV for Chief Investigator Ellen Adomako]	one	02 November 2017
Summary CV for student	one	02 November 2017
Summary CV for supervisor (student research) [Academic Supervisor's CV]	one	15 December 2017
Summary CV for supervisor (student research) [Second academic supervisor's CV]	one	03 November 2017

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.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received

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/

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

18/LO/0331	**Please quote this number on all correspondence**

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

Yours sincerely

pp

Mrs Rosie Glazebrook Chair

Email:nrescommittee.london-camdenandkingscross@nhs.net

Enclosures: *List of names and professions of members who were present at the meeting and those who submitted written comments*

"After ethical review – guidance for researchers"

Copy to: *Ms Sarah Manning-Press*
Ms Lynis Lewis, Noclor Research Support

London - Camden & Kings Cross Research Ethics Committee

Attendance at Sub-Committee of the REC meeting in correspondence

Committee Members:

Name	*Profession*	*Present*	*Notes*

Ms Heidi Chandler	Deputy Research Delivery Manager	Yes	
Mrs Rosie Glazebrook (Chair)	Consumer Marketing	Yes	

Also in attendance:

Name	*Position (or reason for attending)*
Miss Christie Ord	REC Manager

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Ms Ellen Serwaa Adomako
PhD Student
University of Essex
School of Health and Social Care
Colchester
CO4 3SQ

Email: hra.approval@nhs.net
Research-permissions@wales.nhs.uk

27 April 2018

Dear Ms Adomako

HRA and Health and Care

Study title: **The impact of the environment on engagement in therapeutic activities of service users in an acute mental health unit.**
IRAS project ID: **234832**
REC reference: **18/LO/0331**
Sponsor **University of Essex**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

How should I continue to work with participating NHS organisations in England and Wales? You should now provide a copy of this letter to all participating NHS organisations in England and Wales*, as well as any documentation that has been updated as a result of the assessment.

Following the arranging of capacity and capability, participating NHS organisations should **formally confirm** their capacity and capability to undertake the study. How this will be confirmed is detailed in the "*summary of assessment*" section towards the end of this letter.

You should provide, if you have not already done so, detailed instructions to each organisation as to how you will notify them that research activities may commence at site following their confirmation of capacity and capability (e.g. provision by you of a 'green light' email, formal notification following a site initiation visit, activities may commence immediately following confirmation by participating organisation, etc.).

It is important that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details of the research management function for each organisation can be accessed here.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within the devolved administrations of Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) has been sent to the coordinating centre of each participating nation. You should work with the relevant national coordinating functions to ensure any nation specific checks are complete, and with each site so that they are able to give management permission for the study to begin.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?

HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your nonNHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including: Registration of research

- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

I am a participating NHS organisation in England or Wales. What should I do once I receive this letter?

You should work with the applicant and sponsor to complete any outstanding arrangements so you are able to confirm capacity and capability in line with the information provided in this letter.

The sponsor contact for this application is as follows:

Name: Ms Sarah Manning

Tel: 01206873561

Email: sarahm@essex.ac.uk

Who should I contact for further information?

Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **234832**. Please quote this on all correspondence.

Yours sincerely

Miss Lauren Allen
Senior Assessor

Email: hra.approval@nhs.net

Copy to: *Ms Sarah Manning-Press*
Ms Lynis Lewis, Noclor Research Support

Appendix AJ: Health Research Authority approval

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [University of Essex indemnity letter]	one	15 July 2017
HRA Schedule of Events	1.1	09 February 2018
HRA Statement of Activities	1.0	06 February 2018
IRAS Application Form [IRAS_Form_05022018]		05 February 2018
Letter from funder [Letter from funder]	one	12 February 2018
Letter from sponsor [Sponsorship letter from University of Essex]	one	01 February 2018
Non-validated questionnaire [Questionnaire service user's version]	one	18 January 2018
Non-validated questionnaire [Questionnaire, version for staff]	one	18 January 2018
Non-validated questionnaire [Questionnaire service user's version]	two	05 April 2018
Non-validated questionnaire [Questionnaire, version for staff]	two	05 April 2018
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Summary CV for student	one	02 November 2017
Summary CV for supervisor (student research) [Academic Supervisor's CV]	one	15 December 2017
Summary CV for supervisor (student research) [Second academic supervisor's CV]	one	03 November 2017

Summary of assessment

The following information provides assurance to you, the sponsor and the NHS in England and Wales that the study, as assessed for HRA and HCRW Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England and Wales to assist in assessing, arranging and confirming capacity and capability.

HRA assessment criteria

Section	HRA Assessment Criteria	Compliant with Standards?	Comments
1.1	IRAS application completed correctly	Yes	No comments
2.1	Participant information/consent documents and consent process	Yes	There are separate information sheets and consent forms for Module 1 service users and staff and Module 2 staff.
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	The Statement of Activities and Schedule of Events will act as the agreement between the sponsor and site.
4.2	Insurance/indemnity arrangements assessed	Yes	Where applicable, independent contractors (e.g. General Practitioners) should ensure that the professional indemnity provided by their medical defence organisation covers the activities expected of them for this research study
4.3	Financial arrangements assessed	Yes	Funding has been secured from the site (Central and North West NHS Foundation Trust).
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	Arrangements for securely transferring data from the site to the University have been confirmed.
5.2	CTIMPS – Arrangements for compliance with the Clinical	Not Applicable	No comments

Section	HRA Assessment Criteria	Compliant with Standards?	Comments
	Trials Regulations assessed		
5.3	Compliance with any applicable laws or regulations	Yes	No comments
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Yes	No comments
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

Participating NHS Organisations in England and Wales

This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.
There is one participating site. The research team will attend staff meetings to recruit staff participants for modules 1 and 2. Ward staff at the site will be responsible for identifying potential service-user participants for module 1. Questionnaires will be completed at the site and returned to the research team. Staff taking part in module 2 will be expected to attend up to 5 group sessions which will take place at the site. The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England and Wales in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. Where applicable, the local LCRN contact should also be copied into this correspondence. If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England and Wales which are not provided in IRAS, the HRA or HCRW websites, the chief investigator, sponsor or principal investigator should notify the HRA immediately at hra.approval@nhs.net or HCRW at Research-permissions@wales.nhs.uk. We will work with these organisations to achieve a consistent approach to information provision.

Principal Investigator Suitability

This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and Wales, and the minimum expectations for education, training and experience that PIs should meet (where applicable).
A Local Collaborator should be identified to facilitate access arrangements for the external research team (where needed). GCP training is not a generic training expectation, in line with the HRA/HCRW/MHRA statement on training expectations.

HR Good Practice Resource Pack Expectations

This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken
Access arrangements will not be applicable for study activity conducted by members of the research team who have a contractual relationship with the site. Members of the research team who do not have a contractual relationship with the site will be expected to obtain a Letter of Access to conduct study activity which involves contact with patient participants or is conducted in patient care areas of the site. Disclosure and Barring Service and Occupational Health checks should be confirmed where a Letter of Access is in place.

Other Information to Aid Study Set-up

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales to aid study set-up.
The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix AK University of Essex ethics approval

MS ELLEN ADOMAKO

KEYNES TOWER

KEY / 0 / 5 / 7

UNIVERSITY OF ESSEX

WIVENHOE PARK

COLCHESTER

ESSEX

CO3 4SQ

Dear Ellen,

Re: Ethical Approval Application (Ref 17036)

Further to your application for ethical approval, please find enclosed a copy of your application which has now been approved by the School Ethics Representative on behalf of the Faculty Ethics Committee.

Yours sincerely,

Lisa McKee

Ethics Administrator

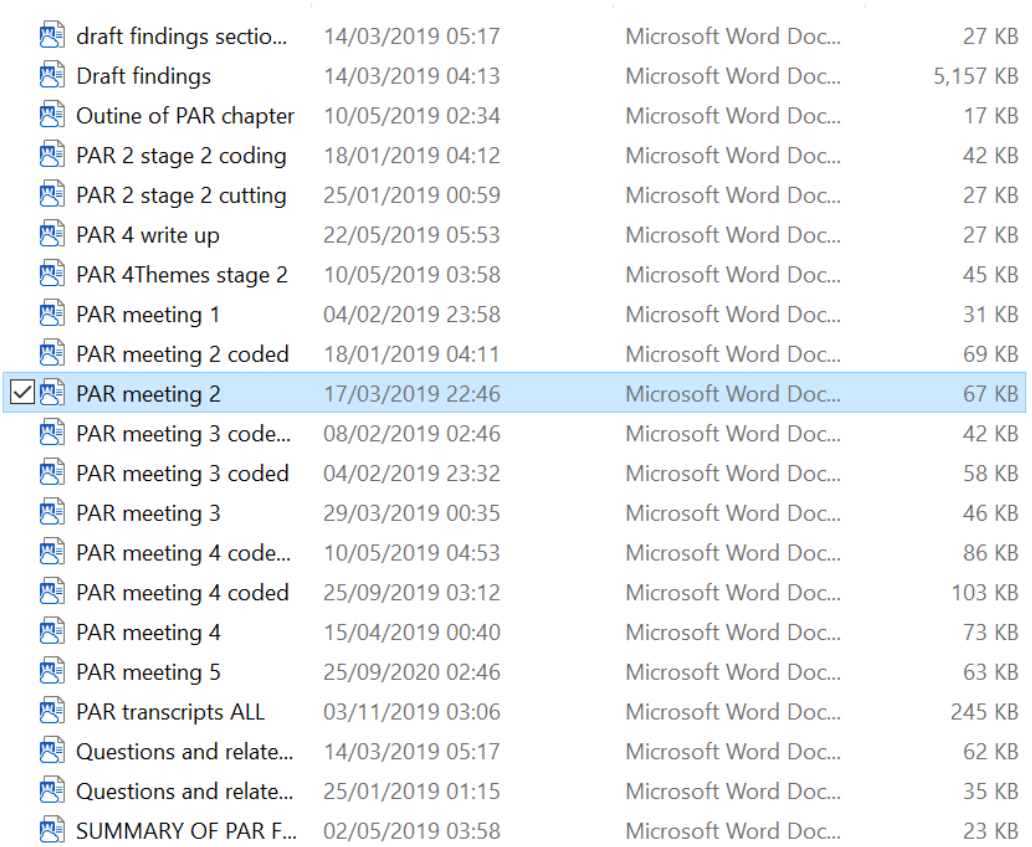
School of Health and Social Care

cc. Research Governance and Planning Manager, REO

Supervisor

Appendix AN: Snapshot of the thematic data analysis

1.1: Extract of documents saved to organise the analysis step by step



draft findings sectio...	14/03/2019 05:17	Microsoft Word Doc...	27 KB
Draft findings	14/03/2019 04:13	Microsoft Word Doc...	5,157 KB
Outine of PAR chapter	10/05/2019 02:34	Microsoft Word Doc...	17 KB
PAR 2 stage 2 coding	18/01/2019 04:12	Microsoft Word Doc...	42 KB
PAR 2 stage 2 cutting	25/01/2019 00:59	Microsoft Word Doc...	27 KB
PAR 4 write up	22/05/2019 05:53	Microsoft Word Doc...	27 KB
PAR 4Themes stage 2	10/05/2019 03:58	Microsoft Word Doc...	45 KB
PAR meeting 1	04/02/2019 23:58	Microsoft Word Doc...	31 KB
PAR meeting 2 coded	18/01/2019 04:11	Microsoft Word Doc...	69 KB
PAR meeting 2	17/03/2019 22:46	Microsoft Word Doc...	67 KB
PAR meeting 3 code...	08/02/2019 02:46	Microsoft Word Doc...	42 KB
PAR meeting 3 coded	04/02/2019 23:32	Microsoft Word Doc...	58 KB
PAR meeting 3	29/03/2019 00:35	Microsoft Word Doc...	46 KB
PAR meeting 4 code...	10/05/2019 04:53	Microsoft Word Doc...	86 KB
PAR meeting 4 coded	25/09/2019 03:12	Microsoft Word Doc...	103 KB
PAR meeting 4	15/04/2019 00:40	Microsoft Word Doc...	73 KB
PAR meeting 5	25/09/2020 02:46	Microsoft Word Doc...	63 KB
PAR transcripts ALL	03/11/2019 03:06	Microsoft Word Doc...	245 KB
Questions and relate...	14/03/2019 05:17	Microsoft Word Doc...	62 KB
Questions and relate...	25/01/2019 01:15	Microsoft Word Doc...	35 KB
SUMMARY OF PAR F...	02/05/2019 03:58	Microsoft Word Doc...	23 KB

1.2: phases of thematic analysis - Braun and Clarke (2016)

1.2.1: Familiarising yourself with your data: Etract from PAR 2

A if you want to do a one to one for instance, it might be difficult to get them off the ward, but is all conversely to that, you also got people who are also so chaotic to be in a group situation, who perhaps won't really benefit from coming to that group at that point, and it will be quiet too distructive when people do bring them down so, is about making a judgement, isn't it sometimes about what is the best for that person.

B And I think that goes back to the communication because they don't really understand the role or the reason er why we attend that groups, and ...so and I think they just often pick people random allocation or not allowing patients to come to the things that the judgement is difference between us and how ward staff ..

A yea, because it can be specific [Phone vibrating..] sorry just ignore that, erm focus if you like really, might be that we just talking about drugs and alcohol or something and the bring in someone who doesn't have a drug and alcohol problem or any difficulty with drug and alcohol, is not really relevant for them so why bring them to those sort of thing.

8.20 **F** And also, something just occured to me, lets, you say if a service user is a bit not well, and a bit aggressive on the ward, er they, how do they communicate that? do they have to wait to when there is a session or when the therapy staff are available? SN to assess, ... to assess an activity

A The thing is, is difficult, because we are short of because we got less staff now in the therapy's team. I think is impacted on how many sessions we actually do that are ward based, because, I think, there actually were a lot more ward based groups when the other APs were around.. [**B** yea we use to have APs on the wards, there were two ...eh] .. so there were C, and a couple of other APs infact, three additional APs before P even started, and erm that had an impact on how many groups now run on the wards, so we have to run because we are fewer staff, we run them across, the three wards sometimes which means we have a space off the ward but I think actually, there need to be, a space where people can have on the ward. they do, we do run groups on th wards but they are not as frequent as groups run off the wards. so we have things like coffee morning, erm we have commun.. er thats not really a group.

1.2.2: Generating initial codes – line by line coding: Extract from PAR 2 analysis

1.2.2: Generating initial codes – line by line coding: Extract from PAR 2 analysis

B the interaction between the facilitator like when you run a group, you normally have two persons running the group, so how that two facilitator works or how is it work if the participant in the group are saying that probably is kind of that stuff of environment. and physical space is like the material like you just like even the table, the chair, everything you got in there, tea and coffee over there ... erh erh

A do we even provide those? how and how encouraging is it for people to come to that group, that is not offered sometimes as well.

B how accessible is the group? like erh, whether is easy for people to attend or ..., there problem now and I think is also like language barrier as well like ... my first language is not English so I think like sometime, erm, if people don't know to speak that language their ... and ... [**A** chipped in] and then again, there is culture as A was saying about things being very institutionalised as well. on the flip side of that, i think is erm, definitely represent working and living environment as well, working and living community as well so there is definitely a community feel to the Hospital reason being that, essentially a lot of the patients live in the borough so they will know people in the borough, they might be on the same ward as people they have met in the borough like they will have erm an identity within the hospital based on the community and with the nurses and some of the staff, patients, so i do feel that sometime is like a community kind of cohesion that goes on sometimes, that represent post WM borough as a whole.

A some of the staff are also institutionalised

F so we've explore space as in the environment, culture, staff, access to the environment, language barrier and community cohesion like the wider community as part of the environment.

Adomako, Ellen S
Definition of culture

Adomako, Ellen S
Discussion easily switched to factors that impact service users attendance of groups. (what is provided and language barrier.

Adomako, Ellen S
Working and living environment of the Gordon hospital
The meaning of the environment extends beyond the immediate hospital, including the borough as a whole.

Adomako, Ellen S January 07, 2019
Theme 1: What is the environment

The environment is defined as a space where activities occur including the people and facilities within it and the immersed culture.

F·so·we've·explore·space·as·in·the·environment,·culture,·staff,·access·to·the·environment,· language·barrier·and·community·cohesion·like·the·wider·community·as·part·of·the·environment.· any·other·thought?·¶

A·I·think·on·a·more·practical·level,·there·is·also·i·suppose,·is·not·a·purpose·built·hospital·and·that· is·the·difficulty·i·think·and·space·is·of·a·premium·at·the·moment·and·it·can·be·quiet·difficult·to· access,·so·i·think·that·is·kind·of·a·challenge.·so·the·challenges·of·the·environment·as·we·all·know,· because·of·the·shortages·of·funds·as·we·all·know,·things·dont·get·fixed·quickly,·tables·probably· broken·sometimes·in·rooms·and·you·know,·the·environment·is·not·cared·for·as·it·used·to·be.·So· things·like·the·kitchen·windows....·[B·chipped·in]...·yea...that·is·inappropriate·therapeutic·spaces...¶

B·yea,·I·got·that·picture·and·i·have,·i·think·we·have·box·stored·in·the·rehab·kitchen·and·yes¶

...·because·there·is·no·other·place·to·store·them.¶

[giggles....·C·chipped·in]¶

F·so·let·me,·the·environment·we·are·working·in·now,·this·hospital,·how·do·you·feel·about·it?..¶

D·[big·sigh]·smiles·from·others...··I·mean·err··I·mean·i·have·been·driven·half·mad,·i·am·not·joking,·· have·spent·ten·years·in·an·airless·box,·4·days·a·week,·no·natural·light,·no·ventillation,treating· patients·who·are·at·most·extreme·patients·coming·to·see·music·therapy·as·nothing·else,touching· them·kind·of·thing...·And·is·half·killed·me·i·think,·you·know,·and·this,·the·little·box·that·i·work·in·is· the·envy·of·my·colleagues·if·only·i·had·an·airless·box·like·you·Andy..is·so·much...·My·line· manager·came·in·when·she·first·came·...·i·had·been·working·there·a·few·years·before·and·she· came·in·and·she·went,·oh·what·a·lovely·room·and·the·first·time·i·have·met·this·woman·and·I·went,·

within·it·and·the·immersed·culture.·¶
¶
There·is·an·institutional·and·a·community·feel·to·the· environment.·¶

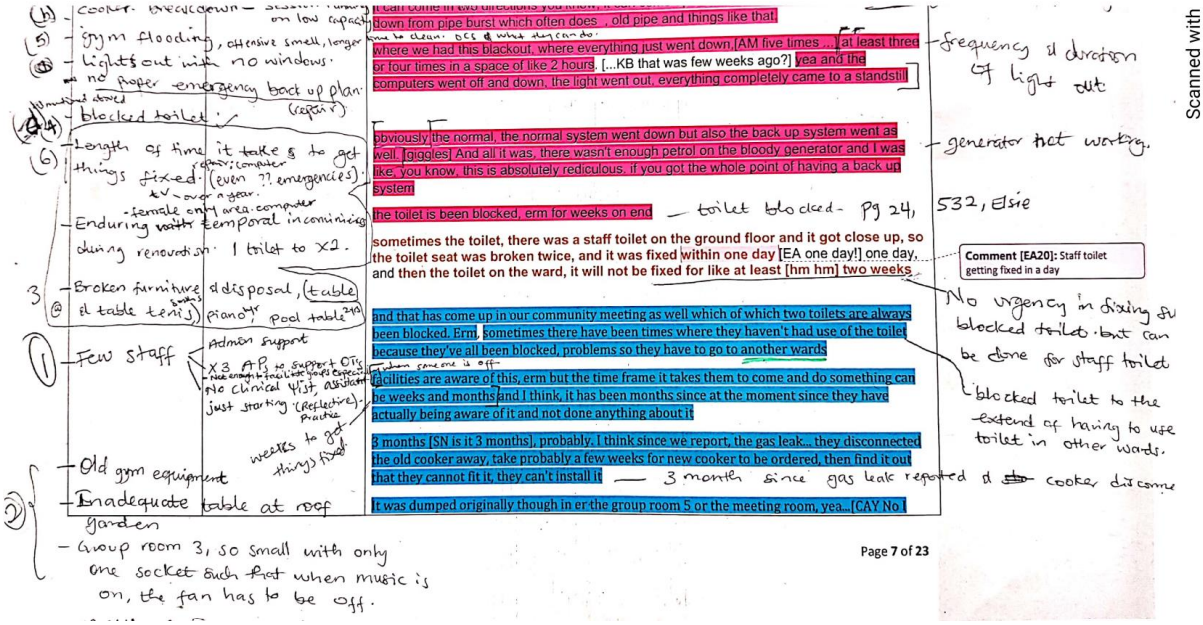
Adomako, Ellen S
Challenges·of·the·environment¶
--Limited·space¶
-Limited·funds¶
-Broken·facilities¶
-Delay·maintenance.¶
¶

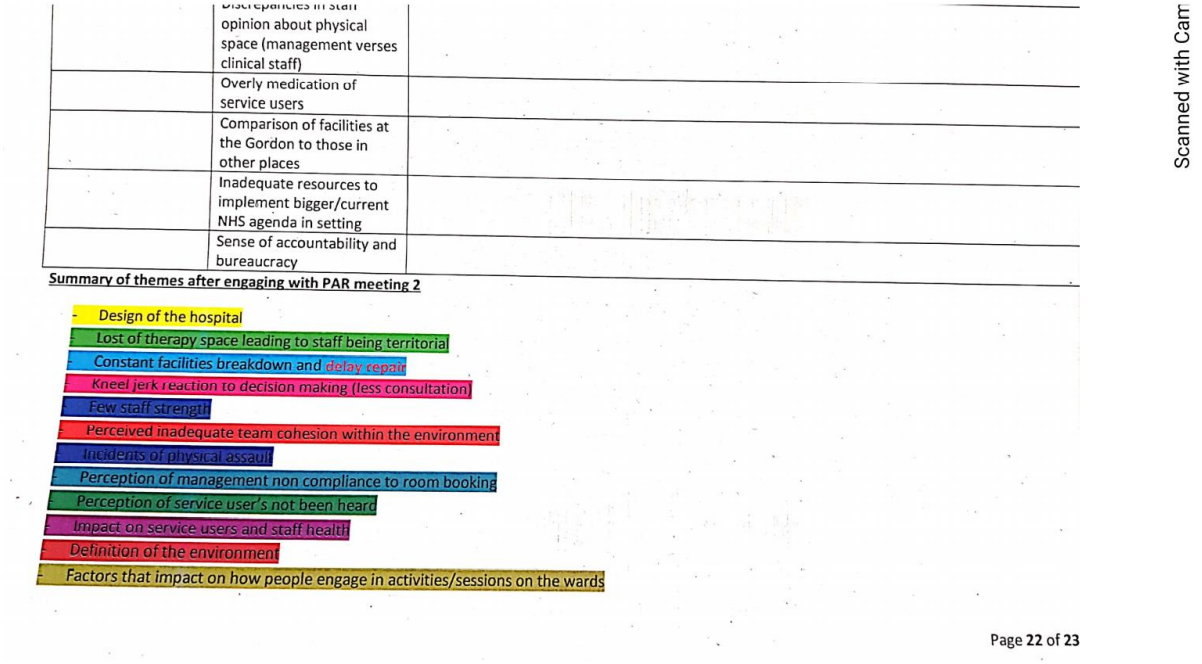
Adomako, Ellen S
Limited·physical·space.¶

Adomako, Ellen S
A·prompt·question·following·up·from·the·interview¶

1.2.3: Searching for themes

Definition of the environment	sometime is like a community kind of cohesion that goes on two sides of the environment, the practical and the working relationship so you got this situation, where people are being, sort of housed into this aggressive environment there was language, there was culture instead of staying on the ward which is quiet chaotic, and quiet manic	
Service user's perspective suggested by KB	quiet often the service users interpreted it that way when we do the questionnaire	
Factors that impact on how people engage in activities/sessions on the wards	, the culture of of the environment can impact on how people engage in activity do we even provide those? how and how encouraging is it for people to come to that group, that is not offered sometimes as well problem now and I think is also like language barrier as well like	





1.2.4: Reviewing themes

Evidence presented in Appendix W Extract from code book and Appendix U PAR group analysis data

1.2.5: Defining and naming themes

Evidence presented in Appendix W Extract from code book

2.6: Producing the report