A mixed-methods study exploring therapeutic relationships and their association with service user satisfaction in acute psychiatric wards and crisis residential alternatives

Angela Sweeney,1 Sarah Fahmy,1 Fiona Nolan,2,3 Nicola Morant,1 Zoe Fox,4 Brynmor Lloyd-Evans,1 David Osborn,1,2 Emma Burgess,1,2 Helen Gilburt,5 Rosemarie McCabe6 and Sonia Johnson1,2*

1Mental Health Sciences Unit, University College London, London, UK
2Camden and Islington NHS Foundation Trust, London, UK
3Centre for Outcomes Research and Effectiveness, University College London, London, UK
4Institute of Neurology, University College London, London, UK
5National Addiction Centre, Institute of Psychiatry, King’s College London, London, UK
6Unit of Social and Community Psychiatry, Queen Mary University of London, London, UK

*Corresponding author

Declared competing interests of authors: none

Published July 2014
DOI: 10.3310/hsdr02220

Scientific summary

Relationships and their association with service user satisfaction
Health Services and Delivery Research 2014; Vol. 2: No. 22
DOI: 10.3310/hsdr02220

NIHR Journals Library www.journalslibrary.nihr.ac.uk
Scientific summary

Background

In 2011/12, 30% of the government’s £5.5B adult mental health care budget was spent on acute services. Despite this investment, many service users are dissatisfied with the care they receive, finding acute wards frightening places of little therapeutic value.

Studies have repeatedly found that service users value the time they spend with staff. They appreciate feeling listened to and understood. However, disappointment with therapeutic alliances – that is, the affective bonds between service users and clinicians in which the service user feels valued and supported as an individual – in acute settings is a recurring theme.

Crisis houses are one alternative to acute wards. They are usually smaller than wards, more domestic in atmosphere, and based in residential areas. They serve similar populations to acute wards, although few admit people who are compulsorily detained.

The Alternatives Study (TAS) [Johnson S, Gilburt H, Lloyd-Evans B, Osborn DPJ, Boardman J, Leese M, et al. In-patient and residential alternatives to standard acute psychiatric wards in England. Br J Psychiatry 2009;194:456–63] indicated that service users prefer crisis houses to hospital. However, this was not explained by content of care, amount of staff–service user contact, or shown to be associated with differences in outcomes. Instead, qualitative research suggested staff and peer relationships, personal safety and lack of exposure to disturbed behaviour were important.

Factors that promote good relationships in acute settings are poorly understood and the reasons service users prefer crisis houses have not been assessed quantitatively.

Aims/objectives

This study had two main aims. First, we aimed to identify potential explanations for service users’ greater satisfaction with crisis houses. We focused on factors identified in the qualitative phases of TAS as important to service users: relationships with staff and peers, recovery and exposure to negative events. Qualitative methods were used to understand the factors that impede and facilitate therapeutic relationships in acute settings.

Methods

Quantitative component

Setting and sample
We collected data from four crisis houses in two London mental health trusts. Data were shared with a study on Protected Engagement Time (PET) (URL: http://public.ukcrn.org.uk/search/StudyDetail.aspx?StudyID=7802), which collected data from 16 acute wards in the same trusts enabling us to compare the
same measures across crisis houses and wards. Our sample size calculation indicated we needed to interview 108 crisis house participants. The inclusion criteria were:

- good level of English
- capacity to provide informed consent
- resident in the crisis house for 1 week (this was 5 days in one site with a short average stay).

Participants were eligible for inclusion regardless of diagnosis or Mental Health Act status (Department of Health. *Code of Practice, Mental Health Act 1983*. London: The Stationary Office; 2008). Comparison data were taken from the PET study, in which 247 participants from acute wards were interviewed, selected using similar criteria except that participants were resident in hospital for a minimum of 2 weeks.

**Recruitment**

Potential participants were approached by a member of staff. For those willing, a researcher explained the study fully and sought written consent. Data collection continued at each service until the target number of participants had been recruited.

**Measures**

1. Sociodemographic characteristics: sex, age, ethnicity, country of birth, admission date, diagnosis, history of admissions and current Mental Health Act status.
2. Satisfaction with services [Client Satisfaction Questionnaire (CSQ)].
3. Therapeutic relationships [Scale To Assess the Therapeutic Relationship0- Patient (STAR-P)].
4. Peer support [Interpersonal Relationship Inventory (IPRI)].
5. Recovery [Recovery Assessment Scale (RAS)].
6. Negative events experienced during admission (negative events schedule).

**Data management and analysis**

Data were recorded on forms by researchers and transferred into an SPSS version 19 database (Statistical Product and Service Solutions; SPSS Inc., Chicago, IL, USA). Three stages of analysis were undertaken:

i. descriptive data were generated for all variables
ii. mean scores for continuous measures were compared for The Alternatives Study 2 (TAS-2) and PET samples, using cluster-adjusted linear regression to adjust for participants’ characteristics and service use history
iii. a model was developed to explore the factors relating to service user satisfaction, including service type, service user characteristics and other outcome measures.

**Qualitative component**

**Sample**

Qualitative data were collected from crisis houses and from wards which were not offering PET. We sought to interview 32 service users and 16 staff. Purposive sampling was used to ensure a wide range of clinical, sociodemographic and service experience characteristics. For service users, this was informed by routine service data for the preceding year regarding service users’ sex, age, ethnicity, diagnosis and number of previous hospital admissions. For staff, we sought a wide variety of experiences and characteristics (e.g. sex, age, level of seniority and clinical experience). Similar inclusion criteria to the quantitative component were applied.

**Recruitment**

Service user participants were recruited via clinical staff. Staff participants were identified via senior staff or the service manager.
Measures

Semistructured interviews were conducted covering respondents’ views on the characteristics of good staff–service user relationships and factors promoting or hindering relationships. The majority of interviews were conducted by service user researchers.

Data management and analysis

Qualitative interviews were audio recorded, transcribed and transferred into NVivo 9 (QSR International, Warrington, UK) qualitative analysis software for analysis. The research team collaborated to create a coding frame which reflected both the original research questions and emergent inductive themes. A service user researcher led the analysis of service user data.

Results

Quantitative component

Sample numbers and response rates

We recruited 108 crisis house service users whereas the PET study recruited 247 acute ward participants. We achieved a good response rate, with 85% of crisis house service users and 72% of hospital service users agreeing to be interviewed.

Sample characteristics

As one of the crisis houses admitted only women, there were substantially more women in the crisis house arm of the study than on acute wards. There was a smaller percentage of people from black Caribbean, black African and Asian backgrounds in crisis houses. Diagnoses also varied between setting, with hospital participants more likely to be diagnosed with schizophrenia or schizoaffective disorder and crisis house residents more likely to be diagnosed with depression or personality disorder. Across both groups most participants had experienced previous hospital admissions. Two-thirds of the hospital group but only one crisis house service user (transferred on leave from hospital) were detained under the Mental Health Act.

Ratings of satisfaction, therapeutic relationship and other aspects of inpatient experience

Hospital service users had, on average, a satisfaction score just above neutral (mean CSQ score = 21). Crisis house service users were on average somewhere between ‘fairly satisfied’ and ‘very satisfied’ (mean CSQ score = 27.5). This large difference remained significant after adjustment for participants’ demographic, diagnostic and service use characteristics.

Similarly, adjusted data found significantly better therapeutic relationships and peer support in crisis houses compared with wards, but no difference in recovery. Therapeutic relationships and peer support, unlike recovery, were both strongly associated with satisfaction.

Exploratory analyses suggested negative events tended to occur more frequently on wards. The most frequent negative event in both settings was witnessing disturbed behaviour: 74% on wards and 34% in crisis houses. Multivariate analyses suggested that negative events relating to staff – such as service users being forced to take medication or being dismissed or ignored – were independently associated with satisfaction. With the inclusion of negative events in our model of satisfaction, as well as therapeutic relationships and peer support, there was no longer a significant association between service setting and satisfaction, suggesting that these variables may have considerable explanatory value in accounting for this association.

Qualitative component

Twenty-nine service users were recruited, 14 from crisis houses and 15 from acute wards. Our sample was reflective of the sex, age and ethnicity of service users from the previous year.
What do service users want from their relationships with staff?
Ideal relationship attributes showed a great deal of overlap between crisis house and hospital participants. Three major themes emerged:

1. Basic human qualities lie at the heart of therapeutic alliances. Service users in both environments valued relationships with staff who were caring, honest, empathic and approachable.
2. Service users wanted staff to talk to them more, listen to them more, and demonstrate therapeutic counselling skills in structured and unstructured interactions.
3. A focus on recovery and hope were also important, though less so than the above factors.

Understanding and professionalism were also important to service users.

The most prominent factors that impacted on the relationships between staff and service users were as follows.

**Freedom**
Crisis house service users valued their freedom whereas those from wards reported that their lack of freedom established a negative dynamic between themselves and staff.

**Autonomy**
Crisis house service users reported greater autonomy than those on wards. Some service users in crisis houses welcomed this autonomy, whereas a minority found it difficult to manage. Most acute ward service users resented their lack of autonomy.

**Atmosphere and environment**
Most crisis house service users described the atmosphere and environment positively, using words such as homely, relaxed and peaceful. On wards, opinion was divided on whether the atmosphere was positive or negative. The built environment of acute wards was described unfavourably, particularly the lack of green space and claustrophobic rooms, escalating tensions in relationships.

**Activities**
Shared engagement in activities was a key factor affecting relationships between staff and service users. Service users from both settings reported a lack of activities, with those on wards most affected by this.

**Staff visibility and availability**
Service users in both settings felt that staff were available if they had an immediate need for help. They understood the competing demands on staff, but at times felt disregarded if staff did not have time for them. Service users in crisis houses reported having more one-to-one time with staff. Staff who spent most of their time in the office were described less favourably than those who spent time in communal areas. Sharing meals was highlighted as being particularly beneficial for therapeutic relationships.

**Relationships with peers**
Positive peer relationships were reported by several service users. In wards, some service users reported exposure to disturbed behaviour or violence.

Participants' recommendations for improving therapeutic relationships
In both crisis houses and wards service users wanted to spend more time with staff and to have more therapeutic input, extra training for staff and greater investment in services.

On acute wards service users suggested training staff on the experience of mental distress and dealing with aggressive service users, a focus on rehabilitation, increased staff numbers, granting the right levels of freedom and a respect for confidentiality. In crisis houses, staff continuity, peer support and preparation for discharge were considered important.
Staff interviews
Themes arising from staff interviews largely overlapped with those from service user interviews. Staff views of what service users want from relationships mirrored what service users said they wanted: interpersonal skills such as listening, understanding, warmth, respect, trust and honesty. In addition, professionalism and finding a balance between setting boundaries and being warm were viewed as important.

Influences on therapeutic relationships
Staff in both settings highlighted the importance of spending time with service users. Ward staff described greater pressure to complete duties and paperwork and a more hectic atmosphere than in crisis houses. Staff described seeking a balance between promoting autonomy and maintaining safety.

Staff recommendations for improving relationships
Staff discussed reducing paperwork, increasing staffing levels and improving organisational contexts.

Conclusions
Main findings
This study confirms previous findings of greater satisfaction in crisis houses than acute wards and found considerably better therapeutic relationships between staff and service users in crisis houses. Therapeutic relationships, staff-related negative events and peer relationships were all significantly associated with satisfaction. With adjustment for these three factors, service setting and satisfaction were no longer significantly associated, suggesting that the three factors in themselves can account to a considerable degree for the difference in satisfaction between settings.

Demographic, diagnostic and service use characteristics were not associated with satisfaction, suggesting that the determinants of service user satisfaction lie in the service user’s environment rather than in service users themselves. The lack of association between perceived recovery and satisfaction mirrors findings in TAS where there was greater satisfaction but no greater clinical improvement in crisis houses.

Our qualitative results identified several potential determinants of good therapeutic relationships: the most important was the personal qualities of staff – kindness, warmth and empathy – as well as professionalism.

Influences on relationships
Freedom and autonomy had a significant impact on therapeutic relationships, especially on the ward where the lack of freedom impaired therapeutic relationships and could lead to service users attempting to convince staff that they were ready for greater freedoms, even where this meant concealing distress. This contrasts with the crisis house where freedoms were negotiated on a daily basis and participants felt safe and supported. Among hospital service users, those who were detained under the Mental Health Act did not appear to be less satisfied than those who were there voluntarily suggesting that restrictions of freedom also impact on voluntary service users. Negotiating the correct level of freedom is thus an important area for ward staff and one with inherent challenges.

Descriptions of a negative atmosphere on the wards echoed our quantitative findings where incidents of negative events were much more common. The trend towards managing less distressed service users in the community may have led to a concentration of the most distressed in hospital, leading to a vicious cycle where staff become overwhelmed and distance themselves from service users, leading to greater disturbance.

Staff and service users were agreed on the importance of shared activities. Eating together was a simple yet powerful way of promoting interaction.
Expectations of peer relationships were variable, with some service users hoping only for a quiet life, others for a sense of camaraderie. Mutual understanding appeared to be present to a greater extent in crisis houses – this was confirmed both qualitatively and quantitatively. However, crisis houses are under less pressure as they are able to screen referrals and usually accept only voluntary admissions.

**Future research priorities**

1. A grounded theory study to explore the nature and purpose of social interaction in residential crisis facilities.
2. In-depth qualitative research to explore the drivers behind a lack of compassion and humanity on acute wards.
3. Participatory research into strategies to improve therapeutic alliances between staff and service users with an explicit focus on training and support for staff, and changing workplaces cultures and contexts.
4. An in-depth exploration of whether or not therapeutic alliances differ between different crisis house models, including service user-led crisis houses.
5. Research with or by service users to further develop a model of the main determinants of service users’ experiences of and satisfaction with acute care.

**Funding**

The National Institute for Health Research Health Services and Delivery Research programme.
Criteria for inclusion in the *Health Services and Delivery Research* journal

Reports are published in *Health Services and Delivery Research* (HS&DR) if (1) they have resulted from work for the HS&DR programme or programmes which preceded the HS&DR programme, and (2) they are of a sufficiently high scientific quality as assessed by the reviewers and editors.

**HS&DR programme**

The Health Services and Delivery Research (HS&DR) programme, part of the National Institute for Health Research (NIHR), was established to fund a broad range of research. It combines the strengths and contributions of two previous NIHR research programmes: the Health Services Research (HSR) programme and the Service Delivery and Organisation (SDO) programme, which were merged in January 2012.

The HS&DR programme aims to produce rigorous and relevant evidence on the quality, access and organisation of health services including costs and outcomes, as well as research on implementation. The programme will enhance the strategic focus on research that matters to the NHS and is keen to support ambitious evaluative research to improve health services.

For more information about the HS&DR programme please visit the website: [www.netscc.ac.uk/hsdr/](http://www.netscc.ac.uk/hsdr/)

**This report**

The research reported in this issue of the journal was funded by the HS&DR programme or one of its proceeding programmes as project number 09/1001/51. The contractual start date was in April 2011. The final report began editorial review in January 2013 and was accepted for publication in July 2013. The authors have been wholly responsible for all data collection, analysis and interpretation, and for writing up their work. The HS&DR editors and production house have tried to ensure the accuracy of the authors' report and would like to thank the reviewers for their constructive comments on the final report document. However, they do not accept liability for damages or losses arising from material published in this report.

This report presents independent research funded by the National Institute for Health Research (NIHR). The views and opinions expressed by authors in this publication are those of the authors and do not necessarily reflect those of the NHS, the NIHR, NETSCC, the HS&DR programme or the Department of Health. If there are verbatim quotations included in this publication the views and opinions expressed by the interviewees are those of the interviewees and do not necessarily reflect those of the authors, those of the NHS, the NIHR, NETSCC, the HS&DR programme or the Department of Health.

© Queen's Printer and Controller of HMSO 2014. This work was produced by Sweeney et al. under the terms of a commissioning contract issued by the Secretary of State for Health. This issue may be freely reproduced for the purposes of private research and study and extracts (or indeed, the full report) may be included in professional journals provided that suitable acknowledgement is made and the reproduction is not associated with any form of advertising. Applications for commercial reproduction should be addressed to: NIHR Journals Library, National Institute for Health Research, Evaluation, Trials and Studies Coordinating Centre, Alpha House, University of Southampton Science Park, Southampton SO16 7NS, UK.

Published by the NIHR Journals Library ([www.journalslibrary.nihr.ac.uk](http://www.journalslibrary.nihr.ac.uk)), produced by Prepress Projects Ltd, Perth, Scotland ([www.prepress-projects.co.uk](http://www.prepress-projects.co.uk)).
Health Services and Delivery Research Editor-in-Chief

Professor Ray Fitzpatrick  Professor of Public Health and Primary Care, University of Oxford, UK

NIHR Journals Library Editor-in-Chief

Professor Tom Walley  Director, NIHR Evaluation, Trials and Studies and Director of the HTA Programme, UK

NIHR Journals Library Editors

Professor Ken Stein  Chair of HTA Editorial Board and Professor of Public Health, University of Exeter Medical School, UK

Professor Andree Le May  Chair of NIHR Journals Library Editorial Group (EME, HS&DR, PGfAR, PHR journals)

Dr Martin Ashton-Key  Consultant in Public Health Medicine/Consultant Advisor, NETSCC, UK

Professor Matthias Beck  Chair in Public Sector Management and Subject Leader (Management Group), Queen's University Management School, Queen's University Belfast, UK

Professor Aileen Clarke  Professor of Public Health and Health Services Research, Warwick Medical School, University of Warwick, UK

Dr Tessa Crilly  Director, Crystal Blue Consulting Ltd, UK

Dr Peter Davidson  Director of NETSCC, HTA, UK

Ms Tara Lamont  Scientific Advisor, NETSCC, UK

Professor Elaine McColl  Director, Newcastle Clinical Trials Unit, Institute of Health and Society, Newcastle University, UK

Professor William McGuire  Professor of Child Health, Hull York Medical School, University of York, UK

Professor Geoffrey Meads  Professor of Health Sciences Research, Faculty of Education, University of Winchester, UK

Professor Jane Norman  Professor of Maternal and Fetal Health, University of Edinburgh, UK

Professor John Powell  Consultant Clinical Adviser, National Institute for Health and Care Excellence (NICE), UK

Professor James Raftery  Professor of Health Technology Assessment, Wessex Institute, Faculty of Medicine, University of Southampton, UK

Dr Rob Riemsma  Reviews Manager, Kleijnen Systematic Reviews Ltd, UK

Professor Helen Roberts  Professor of Child Health Research, University College London, UK

Professor Helen Snooks  Professor of Health Services Research, Institute of Life Science, College of Medicine, Swansea University, UK

Please visit the website for a list of members of the NIHR Journals Library Board: www.journalslibrary.nihr.ac.uk/about/editors

Editorial contact: nihredit@southampton.ac.uk