RESEARCH PROTOCOL

TITLE:

Improving the Experience of Service Users in Inpatient Rehabilitation:

An exploration of the impact of motivational interviewing training on staff-patient interactions and patient experience in inpatient mental health rehabilitation settings.

LEAD INVESTIGATOR

Dr Mel Bunyan – Consultant Clinical Psychologist

Oxleas NHS Foundation Trust

ABSRACT AND SUMMARY

Motivational interviewing (MI) is a person-centred, directive counselling approach focusing on resolving ambivalence about behaviour change, based on partnership and honouring autonomy rather than expert - recipient roles. It is well researched with a strong evidence base primarily from alcohol studies but with successful application in many other areas. MI training and supervision approaches have been implemented and evaluated in many settings but not in inpatient rehabilitation.

The literature on inpatient rehabilitation (rehab) settings, despite their provision by almost all NHS Trusts, is very limited. Anecdotally, staff in inpatient rehab settings find it difficult to motivate service users to engage with the programme and change problem behaviours. MI may be a useful way to enhance communication and improve the experience of service users. MI fits well with current concerns about putting patients first in the NHS and with the recovery model.

This will be an exploratory study to evaluate the impact of a two day team training and on-going group supervision in MI for staff on interactions between staff and clients, immediately after training and after a three month period. The aim will be for staff to use MI 'spirit' (partnership, acceptance, compassion and evocation) in all their interactions with service users. This will be measured using a mixture of quantitative and qualitative approaches and service users will be supported to participate by research assistants, who have themselves been users of mental health services.

BACKGROUND AND RATIONALE

Mental health rehabilitation can be considered an under-researched area, even though almost all NHS Trusts offer inpatient rehab placements (Killaspy et al., 2005) and this relatively small client group, who present with complex needs, take up to 25% of the mental health budget (DH, 1999). Service users usually spend 18 months as inpatients on rehab units (Killaspy et al., 2012), having had on average a 13-year history of contact with mental health services and four previous inpatient admissions. Despite this, there has been very little research into the experience of patients in rehab settings and what approaches might improve their experiences.

The quality of staff-client relationships and therapeutic alliance between nurses and patients have been linked to outcomes for people with severe mental health problems generally (Tattan & Tarrier, 2000; Bentall et al., 2003; Taylor et al, 2009) and specifically in rehab settings (Chronister et al, 2008). Positive staff-patient relationships are not always easily achieved in mental health though; they may be affected by stigmatising attitudes (Read & Hare, 2001), difficulties with social situations experienced by service users (Pinkham & Penn, 2006), staff beliefs that their clients can control their problem behaviours (Berry et al., 2012) and nursing practices (e.g. Price & Wibberley, 2012). In inpatient rehab settings one of the main aims is to support people to gain skills and confidence to live more independently in the community (JCP-MH, 2012) and tensions in relationships may occur especially around motivating clients to participate in the programme of activities. More studies have addressed staff-client relationships in acute care, often finding that staff spend less time with clients than other staff (Sharac et al., 2010)), even though empathic relationships and time with staff are desired by patients (Rethink, 2010).

Recently, there has been a national outcry regarding poor care and lack of compassion in the NHS (DH, 2013). In response, a vision of nursing, characterised by the "6C's" (care, compassion, competence, communication, courage and commitment) has been set out by the Department of Health (2012). Similarly, local patient satisfaction surveys and serious incident reviews have criticised staff-patient relationships and the staff's communication skills in the inpatient rehab units. Training staff in listening skills has been suggested as one way to address this.

MI is a collaborative, person-centred form of guiding to elicit and strengthen motivation for change (Miller & Rollnick, 2009). The underlying "spirit" of MI is

described as collaborative, evocative and respectful of the recipient's autonomy (Miller & Rollnick, 2002). Using specific listening and reflective skills, the clinician validates the client's views, gently timing the eliciting and strengthening of 'change talk', to develop their commitment for positive behaviour change. Training inpatient rehab staff in MI was considered as it encompasses both listening skills but also wider skills to support motivation that could be helpful in a rehab environment.

Staff in many settings have been trained in MI (Barwick et al., 2012) and the elements and process of delivering successful training have been refined (e.g. Miller & Moyers, 2005). From research over a number of years, brief training alone has not been found to produce significant improvements in skills but adding supervision and coaching sessions has (Miller et al, 2004; Joyce and Showers, 2002). Training staff in MI was therefore seen as advantageous over training in listening skills alone, especially as it has been widely disseminated in varied settings and the training approaches themselves have been well-researched.

The principles of MI fit well with the new vision of nursing (NHS England, 2013), with its emphasis on therapeutic relationships as the basis of all care and on nurses using “specialist knowledge and skills to interact with services users in a therapeutic and purposeful manner to aid their recovery and quality of life”. MI also fits well with the recovery principles that have come to shape mental health care over the last few decades (Anthony, 1993), focusing on the person with mental health problem's individual journey towards developing a meaningful life.

The efficacy of MI has been well researched with over 200 trials, mainly in addictions, finding small to medium effect sizes (Miller & Rollnick 2012). The main body of work concerns alcohol; although a brief intervention, a review of 361 controlled studies of alcohol treatments ranked MI second (Miller & Wilbourne 2002). There is evidence that MI is effective in increasing engagement with treatment and reducing drinking (e.g. Brown & Miller 1993; Smedslund et al 2011). It has also been used with many other areas of behaviour change such as physical health improvements (Knight et al., 2006).

MI has been used specifically with people with severe mental health problems. Using MI to address adherence to medication regimes for people with severe mental health problems, however, led to mixed results (Kemp et al 1996 & 1998;O’Donnell et al 2003; Bryerly et al 2005). There is evidence that MI can improve attendance at alcohol treatment services (Bechdolf et al., 2012) and reduce drinking (Baker et al.,

2012) for people with psychosis. MI has been taught to families of young cannabis users (Smeerdijk et al., 2012) and successfully combined with CBT and family interventions (Barrowclough et al., 2001) to improve outcomes for people with psychosis.

MI "spirit" is underpinned by a set of beliefs that people themselves possess the expertise and wisdom to develop positively, in the context of the right support; Miller and Moyers (2005) argue that "this spirit is less a precondition than a result of practising MI" (p.5), thereby proposing that staff can develop a compassionate and respectful, as well as a skilful, approach through the practice of MI. As a study exploring whether MI training has a positive impact on the communication skills and practices in inpatient rehab staff teams has not been done before, it seemed important to evaluate the training planned within the Trust.

AIMS AND OBJECTIVES

This study aims to provide information for clinicians in the field on whether a brief MI training and supervision package could improve relationships and the experience of service users in inpatient rehab settings. If improvements are found, larger controlled studies to assess the efficacy, and further exploration of the impact of MI interventions on the uptake of the rehab programme and outcomes for service users, might be merited.

The objective is:

To evaluate the MI training and supervision being rolled out by the Trust in the inpatient rehab units by

- Assessing whether staff are able demonstrate MI “spirit” after the training package and at three month follow up compared to before, using a questionnaire measure of the recipient’s experience of interactions with staff and examples of narrative from diaries, clinical notes and shift handover sessions
- Assessing the impact of the MI training package immediately after and at three month follow up on service user’s overall experience of being on the unit using “patient experience” questionnaire measures

- Assessing changes in unit functioning immediately after the training package and at three month follow up compared to before through rates of PRN medication use, staff sickness and incidents.

EXPERIMENTAL DESIGN

The design is exploratory, because MI has not been evaluated in this type of setting before. A mixture of quantitative and qualitative measurement approaches will be used to allow participants opportunities to express their views in different ways. The study design is also "naturalistic", aiming to evaluate an approach that could be fairly easily replicated in other inpatient rehab settings. This is because, as clinicians ourselves, we are interested in exploring approaches that could be useful to other clinicians working in similar settings.

METHOD

Participants

Service users who are current inpatients in the Oxleas NHS Trust rehabilitation units (45 beds in all) will be invited to participate in the study. Only those people where there are concerns about their capacity to consent to participate in the study will be excluded.

Measures

The questionnaire measures are:

1. The Motivational Interviewing Measure of Staff Interaction (MIMSI) (Hohman & Matulich, 2010) – this is a 10 item measure for evaluating skill acquisition amongst staff learning MI through ratings made by the clients receiving MI
2. Views On Inpatient Care (VOICE) (Evans et al., 2012) – a 19 item measure of service users' perceptions of inpatient care
3. The General Milieu Index (GMI) (Rossberg & Friis, 2003) – 5 items assessing the person's overall experience of the care environment

Qualitative information will be gathered using samples from:

1. Diaries (staff and service users) (Alaszewski, 2006)
2. Clinical notes – taken from the Trust's electronic record system

3. Shift handover sessions – audio-recordings of staff handover sessions will be made
4. Focus groups

, Unit functioning will be evaluated further by comparing:

1. Staff sickness days
2. Incidents
3. Use of PRN medication

-over three four-week periods, before the training and supervision package, immediately after and at three month follow up.

Procedure

Service users on the three inpatient units will be informed about the study through clinical review and community meetings, given written information sheets and the chance to discuss the study with volunteer research assistants, recruited for the study, who have themselves had experience of using mental health services. After a two week gap, consent to participate will be sought formally.

Staff will attend focus group sessions to discuss the issues and areas of concern for them in interacting with clients. Information from these will be used to tailor the MI training package, designed and piloted previously by Trust MI trainers.

A pre-training two week evaluation period will take place in which service users are invited to complete the questionnaires, diaries and participate in a focus group session. Several handover sessions will be recorded.

The staff training and supervision period will then take place over approximately 10 weeks. All clinical and administrative staff in the three inpatient rehabilitation units will attend a two day team training in motivational interviewing approaches. Group supervision sessions will be offered to all staff to attend after the training for a period of 6 weeks.

Immediately after this, a second two week evaluation period will commence in which participants are invited to complete the questionnaires, write interaction diaries and attend a focus group. Staff will have the opportunity to complete diaries as well. Further handover sessions will be recorded.

After a gap of three months, the evaluation period will be repeated as above. Data will be obtained retrospectively from the Trust's electronic clinical record system.

Following data analysis, feedback sessions (group and individual) will be offered on the rehab units for staff and service users and written summaries made available.

Analysis

Statistical analysis will be carried out using SPSS.

- Questionnaire scores for the three time periods will be compared using analytical statistics (e.g. Friedman's test for related samples with repeated measures).
- Narrative from diary samples, focus groups, clinical notes and handovers will be analysed using thematic analysis (Braun & Clark, 2012).
- Counts of incidents (verbal abuse, property damage, physical assault, self-harm, and absconding), PRN medication use and staff sickness days will be compared for the two week evaluation periods at the three time points using analytical statistics (e.g.TO BE CONFIRMED)

ETHICAL CONSIDERATIONS

The study is not expected to raise complex ethical, organisational or legal issues, or touch on highly sensitive issues for participants, but a number of issues need to be taken into account:

1. Respecting the autonomy of potential service user participants:

This will be addressed by ensuring that it is clear that participants can choose to take part or not freely and that their decision will not affect their care/treatment or relationships within the unit in any way. Their participation in the study will be supported by research assistants who are not part of the clinical team. The research team will remain alert to information from carers or advocates about the service users' views on the project, via the unit clinical team

2. Sensitivity to any sense of coercion:

Service users in the rehab units are in an unequal relationship with staff and may feel dependent on them, especially those under section of the Mental Health Act; this will be addressed by people who have used services themselves and who are outside the clinical care team obtaining their consent, supporting them with the questionnaires and conducting the focus groups. It will be made clear in verbal and in written materials that participants have the right to withdraw their consent at any time without fear of impact on their care or treatment.

3. Issues concerning potential service user participant's capacity to consent:

This will be addressed through liaison with the clinical team (the multidisciplinary care team that oversees the person's placement, treatment etc in the unit); where it is considered that the person does not have capacity to consent, then they will not be asked to participate. The opportunity to commence or resume participation will be available, however, if the person recovers capacity.

4. Data management:

Participants' data will be pseudonomysed and kept confidential so that individuals' responses will not be identifiable.

5. The Possibility of a negative impact on a participant's mental state or level of distress:

Whilst the areas addressed by the research are unlikely to be sensitive for most people, there is still the possibility that the research might cause someone distress. The research team and the clinical team will remain alert to this possibility and to any concerns raised about or by the participants, their carers or advocates; if there were concerns that a participant were becoming distressed, then the clinical team will offer extra support to them.

BENEFITS OF THE STUDY

The findings from the study may help to inform clinicians working in inpatient rehab settings about an approach that may enhance communication and relationships between staff and service users. It will provide information regarding whether training staff in MI in inpatient rehab settings is of value and can make a difference to patient experience.

It is hoped that the experience of participating in a research study will be empowering for service users. Participants will be exposed to research approaches, as well as seeing others who have been service users themselves working on the project.

RESOURCES AND COSTS

The main costs of the study will be borne by Oxleas NHS Foundation Trust. An application has been made to the Psychosis and Complex Mental Health Faculty of the British Psychological Society to pay the service user research assistants (response due in May 2014).

Dr Mel Bunyan, Consultant Clinical Psychologist, Oxleas NHS Foundation Trust

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