Full Title: Interruptions to therapy sessions on acute psychiatric wards; how frequent are they, and who does the interrupting?

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Abstract

Aim

To find out how often therapy sessions conducted on acute psychiatric wards are interrupted and who by.

Methods

Interruptions or early endings to therapy sessions were recorded as part of a trial of a brief talking therapy for psychosis delivered on acute psychiatric wards.

Results

Only a minority of therapy sessions were interrupted (19/146; 13%) or ended early (5/146; 3%). Interruptions most commonly came from staff (15/19; 79%) rather from other patients on the ward (4/19; 21%).

Conclusions

These data show most inpatient therapy sessions can be completed as planned, and provide further support to the feasibility of delivering psychological therapies within these challenging clinical settings.

Keywords

Wards; Inpatients; Psychosis; Psychotherapy; Mental Health Services

Introduction

Across most models of therapies, consideration is given to creation of a private, comfortable space where therapist and client can meet to do their therapeutic work together. The creation of a *physically* 'safe' space can be thought of as facilitating the essential process of creating a *psychologically* 'safe' space. The door to a therapy room thereby serves a dual function; a physical barrier which provides privacy, and also a symbolic barrier which represents the threshold between the therapy space and the outside world (van Vuuren, 2017). Conducting therapy on an inpatient ward adds extra layers of complexity. For example, the main entrance to the ward is both a physical and symbolic barrier which can be experienced by service users as creating a 'safe haven' (Wood & Alsawy, 2016); or as an unwelcome restriction on freedom (CAAPC, 2015). However, whilst the entrance door to the ward may be locked and relatively inviolable, other doors within the ward may be more easily breached. For example, nurses make hourly observation checks by knocking on, or looking through bedroom windows as part of 'intentional rounding' (Moran et al., 2011). Perhaps as a result of this culture of checks and observations even within spaces which are usually kept private, therapy rooms are rarely seen as sacrosanct spaces. As far back as the 1960s, Yalom made explicit reference to this difficulty when discussing challenges to the successful running of therapy groups on acute inpatient wards.

> *"Meetings are scheduled irregularly and are often disrupted by members being yanked out for individual therapy or for a variety of other hospital appointments."*
>
> - *p.481, (Yalom, 1967)*

Although recent studies conducted on acute inpatient wards indicate that it is feasible to deliver brief therapies successfully in these challenging clinical environments e.g. (Reynolds, Desai, Zhou, Fornells-Ambrojo, & Garden, 2017; Sheaves et al., 2018; Wood, Byrne,

Enache, & Morrison, 2018), one of the on-going prejudices against the provision of inpatient therapies is that the chaotic and challenging environment may preclude the creation and maintenance of an appropriate therapy space (Kahn & White, 1989; Ng, Kumar, Ranclaud, & Robinson, 2001). However, empirical data on the frequency and nature of interruptions is lacking. A recent systematic review of inpatient therapies for psychosis (Jacobsen, Hodkinson, Peters, & Chadwick, 2018) did not incidentally find any reference or reporting of interruptions to therapy sessions in any of the 300 full-text articles reviewed. A broader search of inpatient literature making reference to interruptions to therapy sessions also did not return any relevant results. The purpose of this brief report is therefore to share some empirical data from a recent inpatient therapy trial for psychosis on how often interruptions to therapy sessions occurred, and who did the interrupting.

Method

Therapy sessions were conducted as part of the amBITION trial (Brief Talking Therapies on Wards; ISRCTN37625384). Ethical approval for the study was given by the London-Camberwell St Giles Research Ethics Committee (REC reference number: 15/LO/1338, 29th Sep 2015). Participants were eligible if they reported at least one positive psychotic symptom in the context of a schizophrenia-spectrum (F20-29) or a mood-disorder (F30-39) diagnosis, and were interested in having a brief talking therapy during their admission. Data from the National Health Service (NHS) Benchmarking Network (2018) shows that 63% of bed days are occupied by patients experiencing psychosis. Participants were offered a flexible number of sessions (range 1-5) over the course of their inpatient admission, in order to fit the typical treatment window for an acute admission of 30 days (NHS Benchmarking Network Report, 2018). The study was conducted across four acute inpatient wards in an inner-city psychiatric hospital. For the purposes of this paper, data was collapsed between

intervention and control arms of the trial. For full trial protocol see Jacobsen, Peters, and Chadwick (2016).

All therapy sessions took part in a private room on the ward (usually the visitors or activity room). For each therapy session, the trial therapist recorded whether the session was interrupted, or ended early. An interruption was defined as someone knocking and/or opening the door, or speaking directly to the participant (including through the closed door). Staff simply looking through the window of the door for observation checks was not counted as an interruption (nor was general background noise/shouting from the ward, unless directly addressing the participant or therapist). Interruptions were categorised as initiated by either staff or other patients on the ward. Ending the session early was defined as an unplanned termination to the session, such as the participant being called out of the therapy session for a clinical intervention/meeting (e.g. ward round, blood test) or because they had a personal visitor (friends or family). Planned or mutually negotiated endings between therapist and participant were not counted as early endings, as flexibility in the length of session, and adaptation to the needs of the participant (e.g. reduced concentration span) was built in to the therapy protocol.

Results

A total of 50 participants were recruited to the trial, receiving a total of 146 therapy sessions between them. Participants were 34 men (68%) and 16 women (32%), with an average age of 34 years old (range 18-65 years). Most participants were black (21; 42%), with 16 white (32%), 6 Asian (12%), 6 mixed heritage (12%) and 1 other ethnic background (2%). Participants attended on average 3 therapy sessions over the course of their admission (range 1-5). The maximum duration of each therapy session was 60 minutes, and the mean average was 41 minutes. As can be seen in Table 1, only a minority of sessions were interrupted

(19/146; 13%) or ended early (5/146; 3%). Interruptions most commonly came from staff (15/19; 79%) rather from other patients on the ward (4/19; 21%). Only a very small number of sessions ended early (5/146; 3%), which was due to a clinical meeting/intervention on 3 occasions, and a personal visitor on 2 occasions. Looking at the data per participant, the majority did not experience interruptions/early endings to any of their therapy sessions (29/50; 58%). In total, 17/50 participants (34%) experienced an interruption/early ending to 1 therapy session, and 4/50 participants (8%) experienced an interruption/early ending to 2 therapy sessions (no-one experienced interruptions to >2 sessions).

Table 1: Frequency of interruptions/early endings per therapy session

	Session 1	**Session 2**	**Session 3**	**Session 4**	**Session 5**	**TOTAL**
No interruptions/early endings	44	30	23	15	10	121
Interruptions	4	7	4	2	2	19
- **Staff**	3	7	3	1	1	15
- **Patient**	1	0	1	1	1	4
Ended Early	2	3	0	0	0	5
- **Clinical meeting/intervention**	1	2	0	0	0	3
- **Personal visitor**	1	1	0	0	0	2
TOTAL NO. OF SESSIONS	50	40	27	17	12	146

Discussion

Interruptions and early endings to therapy sessions were recorded as part of an inpatient therapy trial of a brief talking therapy for psychosis. The overall rate of interruptions and early endings was low, and the majority of therapy sessions were conducted uninterrupted and with a mutually agreed and planned ending. This is consistent with evidence that inpatient therapies can be delivered successfully on acute wards, and may show benefits in terms of reducing psychotic and affective symptoms, and reducing re-admission rates (Paterson et al., 2018).

A limitation of the data presented here is that the study was only conducted on wards within one psychiatric hospital, and it is possible there may be variability in different hospitals and across different parts of the country. These data were also collected as part of a clinical trial, rather than as part of routine clinical practice. Interruptions may possibly be less likely to occur during a clinical trial due to stricter adherence to procedures such as checking in with the nurse in charge of the shift prior to the start of the therapy session. The nurse co-ordinator can then play an important role in letting other staff on the ward know that a therapy session is taking place and should not be disturbed. However, it is also possible that interruptions may also be low in routine clinical practice if the therapy sessions are being delivered by a psychologist or therapist who is part of the ward team, and is in a better position to help educate the team about the importance of protecting the therapy space on the ward. Practical steps such as having a 'Do not Disturb' sign on the therapy door may also be helpful; this was not part of the protocol for the amBITION trial however.

It would be interesting to see data on interruptions to therapy sessions being reported more widely both in future inpatient trials, and also recorded as part of an audit of routine clinical practice. It would be valuable to know more about how therapy interruptions are viewed

from the service user point of view, and what factors may influence whether they are experienced as seriously disruptive or merely minor annoyances. This may be important for example, in influencing how service users engage in inpatient therapies, and whether it affects whether they choose to return for subsequent therapy sessions during their admission. Another important area for further work, would be a deeper investigation of staff experiences of interrupting inpatient therapy sessions, and how this relates to broader issues around power structures and staff-group dynamics in inpatient settings.

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