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Feasibility and Patient Experiences Of Method Of Levels Transdiagnostic Therapy In An Acute Mental Health Inpatient Setting

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RUNNING HEAD: METHOD OF LEVELS IN AN ACUTE INPATIENT SETTING

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Abstract

This study sought to investigate the feasibility and acceptability of a flexible psychotherapeutic approach - the Method of Levels (MOL) - in an acute mental health inpatient setting. A multi methods approach was used. The feasibility of implementation was investigated by examining the referral rate and the attendance patterns of participants. The acceptability of MOL was explored using a thematic analysis of participant interviews and by recording attendance patterns of participants. Inpatient staff consistently referred patients and the majority of eligible people accepted invitations for therapy. Thematic analysis of peoples' experiences of the therapy generated themes that described participants' experiences of MOL in contrast to routine NHS care, having spent meaningful time with the therapist, and having gained something from the session. The referral rate and uptake of MOL therapy indicates that the resource was appropriate for the setting and acceptable to most participants. Qualitative analyses indicated that participants were comfortable with the therapists' approach, felt understood, and there was a meaningful quality to their interaction. Participants also valued the opportunity to reflect and generate new perspectives of their difficulties. Further research is required to determine the effectiveness of the approach and its translational value beyond this pilot investigation.

Keywords: Method of Levels, psychotherapy, inpatient, qualitative research, thematic analysis

Introduction

Mental health in-patient services in England and Wales have been highly criticised for overcrowding, lack of therapeutic activities, high staff turnover and impoverished environments (Joint Commissioning Panel for Mental Health, 2013; Mind, 2013). Patients report a lack of emotional support from staff during their stay (Care Quality Commission, 2017). There have been calls for a wider range of positive ward activities and, particularly, psychological therapies to be made available to inpatients (British Psychological Society, 2015). Qualitative research on the perspectives from members of multidisciplinary teams, including mental health nurses, also indicates that psychological therapies are valued in key areas (Wood, Williams, Billings and Johnson, 2019). They were reported to be helpful in fostering patients' understanding of their difficulties and so ameliorating interpersonal difficulties with staff. These are likely to be important benefits given high levels of emotional exhaustion in mental health inpatient staff (Johnson et al. 2011).

Pressures on inpatient mental health services have been accompanied by efforts to shorten the length of hospital stays (Craig, 2016), which, in 2015, was an average of 32 days (NHS Benchmarking Network, 2015). In this context, therapists have reported they are unable to deliver a structured approach to therapy, often adapting by providing "stand alone" sessions, causing concerns over whether practice is evidence based (Small, Pistrang, Huddy and Williams, 2018). Similarly, Wood Williams, Billings and Johnson (2019) reported that therapists prioritise "immediate crises" to address risk and facilitate discharge, rather than thinking about the wider context of individuals' lives, ongoing factors precipitating an admission or, repeated stays in hospital. This focus on discharge planning often contradicts patients' preferences for

space and time to think broadly about their experiences and adjust to ward life (Small et al. 2018).

People using specialist hospital inpatient services present with multiple, co-occurring difficulties more frequently than in community mental health services (Rush & Koegl, 2008). Although disorder-specific therapeutic approaches have been found to be efficacious in one recent meta-analytic review of inpatient studies (Patterson et al. 2018a), it is unclear whether they address the totality of patients' difficulties in this setting. Recent work has evaluated the implementation of cross diagnostic psychological therapy in an inpatient setting (Paterson et al. 2018b). A striking aspect of this study was that only a quarter of patients who were eligible for therapy received individual sessions. Qualitative research suggests patients specifically value individual contact with a therapist as it allows for personalised "meaning making" during an episode of inpatient care (Small et al, 2018). One-to-one interactions with nursing staff are also valued by patients as they generate meaningful contacts, which are associated with a more positive experience of ward life (Csipke et al. 2014). It is possible that increasing access to psychological therapies could increase the likelihood of meaningful contacts with nursing staff. Indeed, research on psychological therapies in acute mental health settings indicates nurses are well placed to deliver these interventions (Jacobsen, Hodkinson, Peters and Townsend, 2018). Given resources, it may be appropriate for nursing therapists to take on a greater role in the delivery of psychological therapies. However, further research is needed on the best approach and what adaptions are necessary to address the challenges of the setting.

The foregoing discussion indicates a need for a psychotherapeutic approach that can focus on a variety of problems, potentially concurrently, that is not of fixed

duration, and has no pre-determined session content or phases of application (i.e. assessment, formulation to intervention). Method Of Levels (MOL) therapy has potential to address these requirements within an inpatient setting (MOL; Carey, 2008). MOL is an application of Perceptual Control Theory (PCT; Powers, 1973), which states that psychological distress results from an individual having reduced control over experiences important to them. The task of a therapist delivering MOL is to 1) help the patient talk about what is distressing them by asking questions to sustain the client's attention on the problem. The second step is 2) to notice and explore background thoughts about the problem being discussed. Background thoughts are usually detectable when the client experiences 'disruptions' – for example, moments when the client emphasises certain words, pauses, laughs, looks away, or otherwise indicates they are thinking about something else. In MOL, the therapist's task is to ensure the patient generates the focus of conversation, rather than the therapist being directive. Evaluations of MOL in primary care (Carey & Mullen, 2008, Carey, Carey, Mullan, Spratt & Spratt, 2009) and secondary care services (Carey, Tai and Stiles, 2013) report positive outcomes with effect sizes at least as positive as other interventions such as CBT. Qualitative evaluation of patients' experiences of MOL across different service contexts indicated that the approach is acceptable (Carey et al. 2009; Griffiths et al. 2019).

The current study aimed to establish whether it is possible to implement MOL therapy in an acute inpatient setting. The appropriateness of the therapy was assessed by recording the number of referrals made and the proportion of patients who accepted the invitation or were seen by a therapist. We examined whether the approach was acceptable to participants through both observing attendance patterns and also interviewing patients.

Method

Design and setting

Feasibility of implementation was assessed through descriptive analysis of patients' attendance patterns. Patients' experience of MOL was explored using a thematic analysis of qualitative interviews (Braun & Clarke, 2006). The study was conducted in two adult acute inpatient units (one female, one male) at a large psychiatric hospital in London. Each ward had dedicated input from a qualified psychologist (2.5 days per week) and a full time assistant psychologist who, together with the multi-disciplinary team, referred patients. Routine clinical therapy provision involved the psychologist offering individual therapy using predominantly cognitive behavioural principles. The assistant psychologist delivered a range of low intensity psychoeducational groups.

Service users were eligible to be referred for MOL sessions if they: 1) were resident on the ward; 2) were low risk to the therapist, as assessed by the clinical team; 3) did not have a learning disability. These criteria ensured patients seen by MOL therapists were broadly similar to those seen by the ward psychologists.

Participants

Service users were eligible to be interviewed if they had: 1) received at least one individual MOL therapy session; 2) sufficient grasp of English to provide consent and participate in an interview; 3) mental capacity to provide informed consent.

Thirty-eight people attended at least one MOL session. Of these, 33 were eligible for interview; 4 were excluded because of acute symptoms and 1 patient was

judged not have sufficient understanding of English to participate. The remaining 33 patients were invited to interview; five declined, resulting in 28 patients consenting to being approached by a researcher. Twelve were discharged before they could be seen for an interview and were lost to follow up. One later declined to interview after speaking to the researcher. Fifteen participants were interviewed with one declining to give consent to report their demographic information. All participants received a £15 shopping voucher as compensation for their time. Demographic and clinical details are presented in Table 1.

Insert Table 1 here

Ethical approval

Ethical approval was obtained from an NHS Research Ethics Committee (Ref: 15em/02/63 The East Midlands Research Ethics Committee).

Therapy

MOL therapy entails two steps: 1) help the patient focus on and verbally express what is distressing them and 2) notice and encourage exploration of thoughts the patient is having about the topic of conversation. Both steps involve the therapist asking questions about patients' thoughts and feelings with the purpose of helping them talk and think about their problems in ways they may not have previously considered. For example, if a patient talks about thoughts, the therapist asks a pertinent question about what's been said. In one example given in a MOL manual (Mansell, Carey and Tai, 2012) a client said "I've had to come here and see you and I'm struggling to get to work" and in response the therapist asked "Can you tell me a bit more about the struggle?" The questions are not standardised but aimed to be detailed and specific

follow-ups on the topics of conversation generated by the client. This means that therapists ask a wide variety of different questions according the content of the session and context.

Therapy was conducted by the first and last authors and supervision provided by the first and fourth authors. The last author had attended annual training events for the previous four years. He received supervision sessions with the fourth author, who is an established MOL practitioner and trainer who has published key texts on the therapy. The first author undertook three-days of training in MOL and received supervision from the last author. Supervision included discussions of therapy sessions guided by ratings from the MOL evaluation scale (Carey & Tai, 2012) and listening to audio recordings. The chaotic nature of the ward environment, combined with patient reluctance, meant only a minority of sessions could be audio recorded so no formal evaluation of therapy fidelity was attempted. Patients were invited to sessions whenever the therapist was present on the ward, on a weekly basis. If therapy in the community was not available on discharge and the client was willing to travel to the unit for this purpose, MOL sessions were offered on discharge.

Attendance patterns

The frequency and number of sessions attended was recorded to assess feasibility of implementation. The key feasibility indicator was the proportion of patients invited to therapy that could be seen at least once during their stay on the ward.

Semi-structured interview

A semi-structured interview schedule was developed for the study in line with the planned thematic analysis (Braun and Clarke, 2006). Questions in the interview

explored people's general experience of therapy; what was helpful and unhelpful about the approach; patients' perceptions of any changes therapy made to the way they thought and felt about their difficulties and the future. The first author, second author and last author conducted interviews. To reduce potential conflict of interest interviewers did not conduct interviews with the same patients they had seen for therapy. Discussion between interviewers was used to ensure interviews were conducted consistently, ensuring a similar focus to the interview, consistency in follow-up questions and prompts asked, and that participants were given an equal amount of space to talk. Interviews utilised open and non-directive questions as much as possible, with follow-up questions and prompts when necessary to gather more information or clarify meanings. Interviewers made efforts to explore contradictions or alternative experiences.

Interviews with participants were conducted within three weeks of having been invited to participate. Interviews lasted between 10 and 57 minutes; all were audio-recorded and transcribed verbatim by the second and last authors. To maintain consistency, transcription rules were generated for use by the two transcribers.

Data analysis

Braun and Clarke's (2006) method of thematic analysis was used to identify patterns across the data set. An essentialist stance was used insofar as the researcher accepted that what participants said reflected their actual experiences and ways of making sense of what they had experienced (Dyson & Brown, 2006). The six recommended phases of the Braun and Clarke's (2006) method of thematic analysis were employed. Firstly, all transcripts were read several times, enabling the researcher to familiarise herself with the data and note initial ideas. The second step entailed

coding features of the data relevant to the research question. Transcripts were systematically coded and data relevant to the generated codes were recorded. The third step entailed collating codes into subthemes and gathering all relevant data to each potential theme. The researcher combined steps four and five, reviewing subthemes, tentatively naming themes, and reviewing in relation to the coded extracts, and the entire data set. When the researcher completed step six - producing the written report - themes were further refined, including naming of themes and subthemes were generated. Selected extracts were used to reflect the themes generated and the overall story of the analysis. In order to ensure that themes were grounded in the data and not in the researcher's preconceptions and prior assumptions of the researcher, raw data were repeatedly revisited and subthemes revised if appropriate (Flick, 2006).

Reflexivity statement

The first author was, at the time, a trainee clinical psychologist. The second author was working as a psychological therapist in primary care and completing a Masters degree in psychology. The third author is a consultant clinical psychologist and professional lead for the inpatient and acute psychology service in which the study took place. The fourth author is a consultant clinical psychologist experienced in providing MOL in acute in-patient settings. She is a researcher, trainer, supervisor and practitioner of MOL. The last author is a clinical psychologist and researcher with a long-standing interest in MOL. All the authors had an interest in developing psychological therapies in multidisciplinary team settings and working collaboratively with nursing colleagues to improve care quality and safety.

Credibility checks

In accordance with good practice guidelines (Stiles, 1999) for enhancing credibility and validity, two participants were invited to review themes and subthemes generated throughout the data. Due to difficulties contacting patients following discharge, only a small number of people could be invited to review themes. One participant agreed and was provided with a table of domains, themes and subthemes, which were later explained and discussed via telephone. The participant commented that her views were fully captured in the subthemes and domains.

To mitigate individual researcher bias influencing the analysis, one interview was cross-coded by an independent researcher, as recommended by Flick (2006), Results of the thematic analysis were reviewed by the internal supervisor and another independent researcher and triangulated between the researcher, internal supervisor and independent researcher. Discrepancies were resolved until the final thematic structure was created.

Results

Referrals for therapy

A total of 75 people were referred for MOL sessions, with 38 (50%) accepting the first invitation to a session, 18 declined the invitation (25%), and 19 unable to be invited (25%). Reasons for not being invited to a session included: sleeping, being on leave, at other appointments, for safety reasons, language barriers, preparing for discharge, attending family visits, or at work. For patients offered an appointment (n = 56) the majority accepted this invitation (n = 38; 68%) indicating a demand for therapy in the most cases.

Attendance patterns

Duration of therapy ranged between one and four sessions with mean = 1.8 and median = 2 sessions. Nine participants attended a second session but six participants were discharged from hospital following their first appointment and could not be invited for a second session. One participant continued to attend MOL therapy sessions following discharge whilst waiting for an assessment with another service. All others (N=5) were either unwilling or unable to return to the hospital. Participant 10 declined to attend further sessions available to her while she was still on the ward.

Patients' experience

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

Insert Table 2 here

Domain 1: Respect and Human Connection.

Quotes from twelve participants perceived they were treated with consideration, without intimidation or judgment. They also reported a sense of respect from the therapist for what they wanted to say and how they felt.

Theme 1.1. Being treated as a person

This theme encompassed subthemes relating to qualities of interactions with the therapist. Seven participants spoke about the importance of feeling comfortable to

talk and not being rushed by the therapist.

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

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

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

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

"[Therapist] made me feel like my thoughts and feelings are just as important as the next person's, which a lot of mental health [professionals] don't." – (P12).

Qualities of professionalism such as being trustworthy, dependable, non-judgmental and kind were qualities participants appreciated.

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

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

Participants spoke about these qualities as something that was sometimes lacking in previous interactions with mental health professionals in inpatient settings,

but not as different to previous therapy experiences.

Positively, four participants spoke about feeling treated more like a person rather a number during their therapy session. P12 said that after the session they felt as though "*I'm not just a number, I'm actually a person with feelings"*. It does indicate that feeling like 'a number' is something inherent to inpatient, and even general NHS care. However, another said that despite having a very positive experience of the session, that afterwards they felt as though "*I was just a number…his or her job has been done, that's it, ticked off"* (P7).

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

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

Theme 1.2 On the same wavelength with the therapist

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

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

the therapist, and that there was a meaningful quality to their interaction.

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

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

Domain 2. Meaningful time spent

The second domain generated from the data encompassed a sense that the therapy session(s) had been meaningful time spent, something all participants endorsed.

Theme 2.1. Opportunity to reflect on thoughts and feelings

Seven participants emphasised how having time to reflect and think through their difficulties was important. P2 spoke about how this was not something that ward life allowed, which was also reflected in a quote from P1.

> "*You don't get time to reflect when you're involved in everything going on about you, but that gives you time to reflect" - (P2)*

> *"Talking things through - when you're on your own you try and figure things out in your head but you can't because you're all mucked up." - (P1)*

Three participants described how opportunities to think about the topics they

were talking about was beneficial.

> *"You actually stop and think about what you're saying and how you feel about what you've said. So it's beneficial" - (P8)*

> *"Makes you think about what, how you've come to that conclusions, what you've just said" - (P12)*

> *"I was able to reason and then talk about it" - (P13)*

Theme 2.2. In-depth session

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

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

Nine participants spoke in a favourable way about how they had discussed in-depth content, in a flowing manner, and that they were able to speak about "*a lot of things"* (P4). P4 spoke about the style of the session, indicating there may have been something about the MOL approach that was different.

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

One participant disagreed however, stating that she might have done more in

other sessions using another approach and that MOL "*didn't work for me*" (P10). Ten participants spoke about a variety of questions being asked and broad range of information was covered in the sessions. Two participants found the questioning style uncomfortable, although despite this, one of these thought it was helpful.

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

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

One participant felt the question style was like a questionnaire.

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

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

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

Differences in experience might reflect differences in how much participants led the session and how much the participant had to be prompted to focus on topics. Alternatively, it could reflect the questioning style of MOL whereby therapists ask lots

of questions in order to help the patient focus on what is going through their mind as they discuss the topics of importance to them.

Domain 3. Getting something from the session

Eight participants endorsed the theme of having gained something from the therapy whether this was in terms of a plan, feeling relieved, or a reminder of who they were. Nine participants endorsed a theme of having a new perspective following the session relating to staff, themselves and their problems.

Theme 3.1. Got something from the session

Four participants spoke in terms of having been able to make concrete plans following the session, and that this helped them to think about the future.

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

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

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

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

Five participants referenced things such as feeling more confident, strong, feeling more optimistic about the future and feeling better about themselves.

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

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

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

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

Theme 3.2. New perspective

A final theme generated from the data was one of having new or altered perspectives following the session, relating to changes in participants' attitude to help, their views about themselves, and insights into their problems. Four participants expressed a change in their attitude towards seeking help. One person said that the session had helped to "*see the benefit now*" (P1). Another said that *"[the session] encouraged me to speak to people more and reach out"* (P4). P7 said that the experience of therapy had changed her previously negative views about professionals.

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

In contrast, another participant (P10) said that she felt "*a bit strange about psychologists"* following her session and expressed uncertainty about whether they were helpful. She said she would have liked *"more answers"*. She concluded that despite not having had a helpful experience within the session because she had "*wanted [the therapist] to have an answer*", she thought that psychologists can "*help you help yourself*". The fact that P10 had spoken about how the style of questioning made her feel uncomfortable, and that she would have liked more answers indicates that there was something about the MOL approach in particular that changed her view

of professionals.

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

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

"Sometimes you have questions yourself that you don't ask yourself. Then someone else will ask you questions that you haven't thought of yourself – that's what I'd say [was helpful]. Another viewpoint" – (P2).

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

"*It's alright to say that you have a weakness. We all have to identify that we have a weakness. And my weakness is asking for help. I've never done it." - (P4).*

There was variation between participants regarding the nature of new perspectives they experienced during sessions. The commonality was that the experience of attending the sessions had been an important part of how these perspectives emerged. Earlier themes indicated that these sessions were experienced as a space where participants felt able to talk through difficulties, where thinking could take place and where they were asked questions they hadn't previously considered.

Discussion

This study investigated the feasibility of implementing an MOL therapy within

an inpatient setting and explored participants' experiences of the therapy. Referral data indicated that ward staff considered the MOL sessions to be an appropriate resource, given weekly referrals were consistently made prior to and during the study. Furthermore, the majority of patients who could be invited for therapy accepted this offer, indicating that opportunities to talk are sought after by the majority of patients. The majority of participants (60%) attended a second MOL session, indicating they found the approach acceptable. The remainder of patients were discharged before a further session could be attended so it is not possible to determine whether they would have attended further sessions.

All but two participants' statements were consistent with the interpretation that the MOL approach to therapy is acceptable. A theme woven throughout the data was one of patients' perception of being treated respectfully, without judgment and without intimidation. Participants spoke about reconnecting with the idea that they are human beings and that they felt worthy to talk about their thoughts and feelings. Participants highlighted the importance of feeling on the 'same wavelength' as the therapist and that they felt they could trust the person. The first subthemes focused on what could be considered generic therapeutic skills of the therapists and human connectedness between the participant and therapist, which numerous studies have found to influence outcomes and experience (Orlinsky, Rønnestad, & Willutzki, 2004). They were also highly consistent with other research on the patient experience of psychological therapy in an inpatient environment (Small et al. 2018).

The participants described a contrast between how they perceived themselves to be treated by the therapist and the wider multi-disciplinary team, including nursing staff, with some experiences of being "just a number" being prevalent in narratives of

their broader care. These findings are consistent with reports that mental health inpatients in the United Kingdom (UK) can perceive nursing care to be uncaring and inaccessible (Rose, Evans, Laker and Wykes, 2015). This conflicts with important values and capabilities in UK trained mental health nursing that are, for example, reflected in the Ten Essential Shared Capabilities (Department of Health, 2004) and the Nursing and Midwifery Council code of conduct (Nursing and Midwifery Council (NMC), 2018). These include working in partnership, identifying needs and patient centred care. These values are reflective of nurse training internationally (Kitson et al., 2013) and have a long tradition within mental health nursing (Gastmans, 1998). Given reports of low staffing levels in UK services (Johnson et al. 2011), which can disrupt core therapeutic tasks, supervision and staff rest periods, resource limitations are also undoubtedly a factor in this.

MOL is a trans-diagnostic approach, which does not entail detailed disorder specific formulations, instead being a process-focused approach involving the two key steps described earlier. Further research is needed on how best to train therapists in the approach for this setting. Given the comparative simplicity of MOL it is possible this could be done in a short skills focused programme. For this reason MOL seems well suited as an adjunct to usual care for nurses without specific preparation in delivering psychological therapies. This holds potential as a means of making one-to-one contacts more meaningful and useful for patients. As noted previously, increased resources for the necessary extended one-to-one contact and nurse training would be required and this would need to be shown to be cost effective.

Participants reported that having control within the session(s) was important and this differed from previous experiences with professionals. The opportunity to

talk about whatever topics they felt pertinent was contrasted with other previous experiences of talking to professionals. This is possibly because the MOL therapist is not seeking to educate or encourage patients to think about their problem in any given way. The experience of control and autonomy is consistent with the importance of patient control over care that has been emphasised in surveys of patient perspectives (BPS, 2017). Control is also a vital aspect of how core values of human equity, rights and a fair distribution of power are considered in the World Health Organisation report on the social determinants of health (Solar & Irwin, 2010).

The first aim of a MOL therapist is to facilitate a client talking, in order to sustain awareness on salient topics. Several participants described experiences consistent with sustained awareness and that this was beneficial. Additionally, some described how the in-patient environment made reflection difficult, which is again consistent with patient experiences of psychological therapies in inpatient care more broadly (Small et al. 2018). Furthermore, similar to past reports of psychological therapies in inpatient settings, (Small et al., 2018), many participants reported an experience of relief after talking about their difficulties. Some participants spoke about the value of being reminded who they are; others felt that having a plan following the session helped them to think differently about the future.

A small number of participants spoke about disliking the style of questioning. One participant wanted to be given 'more answers' by the therapist. This is consistent with a recent study of MOL in an early psychosis setting (Griffiths et al. 2019). It is also consistent with reports from qualitative research that patients value the perspective of the therapists in explaining how their difficulties had emerged (Small et al. 2018). Offering an understanding of patients' problems is also valued by

psychologists (Small et al. 2018) and the multidisciplinary team (Wood et al. 2018). The current research is partly consistent with this but also emphasises that patients do not *necessarily* require this aspect of therapy to be present for the experience to be beneficial. MOL therapists were not embedded into the multidisciplinary team and there was no attempt to incorporate other professionals into the approach. Some argue (Clarke & Wilson, 2009) that integration is essential for therapy to be useful. However, this position is questioned by the current findings, where patients felt they were gaining from the experience of talking therapy itself.

Over a quarter of referred patients could not attend therapy appointments because of other appointments, family visits, being asleep, or on leave. These circumstances reflect the busy and often unpredictable course of inpatient stays (Clarke & Wilson, 2009). The unpredictability of patient turnover also created challenges in enabling patients to access therapy; patients who had attended one session were often discharged by the following week. This emphasises the suitability of an MOL intervention that can be standalone in nature. Unplanned discharges restrict information about the acceptability of the approach. Further research should make efforts to gain consent to use recordings of sessions so that tapes could be co-rated by using fidelity scales designed for MOL (Carey & Tai, 2012). Additional to gaining a more reliable evaluation of adherence, qualitative information regarding what happened within sessions could be used to compliment the data gathered regarding participants' experiences.

Conclusion

Data suggests that MOL was acceptable to the majority of participants; two commented that the style of questioning was unsatisfactory and expressed desire for

more ideas from therapists. Participants valued the opportunity to think and consider their difficulties from a new perspective. More research investigating the efficacy of MOL is required, as is a larger scale feasibility and acceptability study to investigate whether MOL has lasting benefits beyond a constructive experience and opportunity to reflect.

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Declaration of interests

The authors report no conflict of interest.

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Table 1 *Demographic information*

P	Sex	Ethnicity	Primary Diagnosis	Length of Stay***	Length of therapy
1	M	White British	Bipolar disorder	10	3 session
2	DNC*	DNC	DNC	DNC	1 sessions
3	M	Asian British	Schizoaffective disorder	90	2 sessions
4	M	Asian British	Schizoaffective disorder	140	2 sessions
5	M	Asian British	Paranoid Schizophrenia	30	2 session
6	M	Black African	Bipolar disorder	10	2 session
7	F	Asian British	EUPD**; alcohol dependence	10	1 session
8	F	White British	Recurrent depression	10	4 sessions
9	F	White British	Bipolar disorder	10	1 session
10	F	White Eastern European	Schizoaffective disorder	80	2 sessions
11	M	Black African	Schizoaffective disorder	60	2 sessions
12	F	White British	Bipolar disorder	20	1 session
13	F	Black African	Schizoaffective disorder	10	2 sessions
14	F	White British	Depression; EUPD	110	1 session
15	F	White British	Bipolar disorder	20	1 session

Note. P = participant; *DNC = participant did not consent to demographic information being reported **EUPD = Emotionally Unstable Personality Disorder *** to the nearest 10 days

Table 2 Domains, themes and subthemes generated

	Domains and Themes		Subthemes
1.	**RESPECT AND CONNECTION**		
1.1	Being treated as a person	1.1.1	Feeling free to talk about what I want
		1.1.2	My feelings are important
		1.1.3	Gave me authority
1.2	On the same wavelength	1.2.1	Therapist was a real person
		1.2.2	Someone was interested and listened
2.	**MEANINGFUL TIME SPENT**		
2.1	Opportunity to reflect	2.1.1	Talk things through
		2.1.2	Stop and think
2.2	In-depth session	2.2.1	Cut to the core of the problem
		2.2.2	Lots of questions, lots came out
3.	**GETTING SOMETHING FROM THE SESSION**		
3.1	Got something from the session	3.1.1	Having a plan
		3.1.2	Relief
		3.1.3	Reminded me who I am
3.2	New perspective	3.2.1	Help can be good
		3.2.2	Feeling differently about myself
		3.2.3	New perspective on problems