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'Safer, Not Safe': Service Users' Experiences of Psychological Safety in Inpatient Mental Health Wards in the United Kingdom

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ABSTRACT

Research on patient safety in mental health settings is limited compared to physical healthcare settings. Recent qualitative studies have highlighted that patient safety is more than just physical safety but includes psychological safety. Traditionally, psychological safety has been defined as the belief that it is safe to take interpersonal risks, such as speaking up, without a fear of negative consequences. However, to date, it is not clear what constitutes psychological safety for service users of inpatient mental health settings. To understand this, we conducted 12 interviews with former inpatient mental health service users. Interviews were analysed with Reflexive Thematic Analysis, and five themes were developed. All themes had subthemes. Overall, we found that participants were more readily able to draw on situations where they felt psychologically unsafe, rather than safe. Psychological safety in service users was influenced by (1) healthcare staff attitudes and behaviours towards them, (2) their relationships with other service users, (3) whether they felt they had any control over their environment and medical decision-making regarding their care, (4) their experiences of physically safety, feeling listened to and believed and (5) access to meaningful occupation on the wards. These findings suggest that changes are needed to enhance inpatient mental health service users' general experiences of psychological safety. Further research will need to (1) further develop understanding of the concept of psychological safety for service users and (2) identify interventions, and such interventions should be co-designed with service users.

1 | Introduction

Research on patient safety in mental health settings is limited compared to physical healthcare settings (Berzins et al. 2020; Thibaut et al. 2019; Veale et al. 2023). While there is some overlap in safety outcomes (medication errors, misdiagnoses and readmissions), there are important differences. For example, in mental health settings, the presentation and experience of mental health distress, which includes self-harm, suicide attempts or violence, can put patients at risk of harm (Felton and Stickley 2018). Furthermore, the management or prevention strategies deployed (e.g., restraint and forced medication), can also be a cause of

harm. While, at times, restraint can prevent physical injury, it can also have negative psychological consequences for service users, the staff delivering them and for the witnesses of the restraint (Cusack et al. 2018; Mariyati and Novy 2018; Sequeira and Halstead 2004; Shields, Stewart, and Delaney 2018). Thus, mental health distress complicates patient safety in inpatient mental health settings (Shields, Stewart, and Delaney 2018), and generalisability from research in physical healthcare settings cannot be assumed (Short, Marr, and Wright 2019).

It is also important to recognise that patient safety constitutes more than physical safety. The construct of psychological safety is now recognised as an important factor in patient experiences and to the wider concept of patient safety in healthcare (Berzins et al. 2020; Hunt et al. 2021; Shields, Stewart, and Delaney 2018; Thibaut et al. 2019; Veale et al. 2023). However, the concept of psychological safety has received little attention in mental healthcare services, or in patients in any healthcare setting.

2 | Background

The term 'psychological safety' was originally coined in the occupational psychology literature in relation to workplace experiences; referring to the belief that it is safe to take interpersonal risks, without a fear of negative consequences (Edmondson 1999). The concept of 'risks' is defined broadly and includes highlighting bad practice or making suggestions for improvements. Psychological safety is sometimes used interchangeably with the term 'emotional safety' (Veale et al. 2023); however, there remain discrepancies in whether, and how, these terms differ from each other, or whether they refer to the same concept and feelings. Thus, the current paper will only use the term 'psychological safety'. Psychological safety is thought to be especially important in the workplace and within work teams (Edmondson 1999; Grailey et al. 2021; Hunt et al. 2021; Kahn 1990; Newman, Donohue, and Eva 2017). In addition, increased psychological safety has been linked with numerous positive outcomes, including knowledge-sharing, quality improvement, better delivery of patient-centred care, reductions in patient safety events and also better well-being outcomes, such as decreased depression or burnout (Grailey et al. 2021; Jung and Oh 2022). However, there is a lack of research into psychological safety in mental health services. Given its importance in the well-being of physical healthcare professionals, it is possible that such a factor could have important implications for well-being and recovery in mental health service users.

While there are some studies investigating the concept of 'safety' within inpatient mental healthcare units more broadly (Cutler et al. 2021; Kanerva, Lammintakanen, and Kivinen 2013), there is only limited research investigating psychological safety in inpatient mental health settings. Of the two studies which have been conducted (Asikainen et al. 2023; Berzins et al. 2020), neither specifically focused on psychological safety, but identified psychological safety as an important aspect when investigating safety culture more generally. One study recruited former service users and carers from the United Kingdom (UK) (Berzins et al. 2020), while the other recruited current service users from a forensic hospital in Finland (Asikainen et al. 2023). Both studies highlight that inpatient mental healthcare is not always psychologically safe, and that physical safety plays a role in this. In Berzins et al.'s (2020) study, service users explained that physical safety was often achieved at the expense of psychological safety, which is poignantly illustrated by the following participant quote: 'How I'm feeling psychologically or mentally really isn't important, as long as I'm not dead, as long as I get discharged alive, it doesn't matter what's happened to me....' (Berzins et al. 2020, p. 552). This is the first study to show that psychological safety, in the context of inpatient mental healthcare experiences, may go beyond feeling able to speak up or make suggestions. However, as neither study focused on psychological safety, they do not further elaborate on the relationship between physical and psychological safety or identify other contributing factors to psychological safety.

In a recent study with healthcare staff working in inpatient mental health settings, the relationship between psychological safety and physical safety was described as both conditional and hierarchal, meaning staff members reported needing to feel psychologically safe before they could feel physically safe (Vogt et al. under review). Other important contributors were also identified, including feeling valued by senior management and being able to develop positive relationships with colleagues, and service users. Thus, there is a need to further explore the relationship between physical and psychological safety in service users, and to identify which other factors may be important in contributing to psychological safety as perceived by this group. To address these gaps, a qualitative research design was chosen, to allow an exploration of what psychological safety means to service users in inpatient mental health wards and to identify which factors contribute to it.

3 | Methods

3.1 | Design

A qualitative study, with semi-structured interviews, was chosen. A topic guide was developed, based on the collective expertise of the research team, and the literature. Interviews took place online, via the platform Zoom. Questions centred around the perceptions of psychological safety, how aspects of the ward environment affect psychological safety and how to improve psychological safety (Appendix).

3.1.1 | Ethical Approval

Ethical approval for this study was granted by the University of Leeds, School of Psychology Ethics Committee.

3.2 | Recruitment

Adults, aged 18 and above, who had prior experience as inpatients in psychiatric wards in the UK were eligible to participate. Participants with experience in forensic settings were not eligible to participate. Forensic settings are distinctly different from acute mental health settings, regarding legal frameworks, risk and patient characteristics (Galappathie, Khan, and Hussain 2017); it would not have been appropriate to have a

mixed forensic and non-forensic sample. Individuals who only had experiences of child/adolescent inpatient mental health wards were also not eligible to participate. We did not recruit participants who were currently in inpatient psychiatric care. Twelve participants were recruited (Table 1) who had a mean age of 46 (range: 29–62). Participants predominantly identified as women ($n = 10$), with one person identifying as a man ($n = 1$) and one as non-binary ($n = 1$). No participants were excluded from participation or from analysis.

Information power was used as a criterion for recruitment; information power relates to the quality of data collected, and its depth in relation to the research question—rather than the number of interviews conducted (Malterud, Siersma, and Guassora 2016). Where questions are more focused or where participants have more data to share in relation to the research question, fewer participants are needed. The research team agreed that information power was reached after 12 interviews, and the recruitment was stopped.

3.3 | Procedure

Study advertisements were shared on social media, via X (formerly Twitter), to recruit a volunteer sample. Interested participants were asked to email for more information. They were then sent an information sheet and given opportunity to ask questions. Once a participant agreed to participate, they were sent an online consent form and a range of dates/times for interview. Participants selected their interview slot. Interviews took place on Zoom. Following their interview, a debrief sheet (containing contact numbers for support services), and a £30 shopping voucher, were emailed to participants. They were transcribed verbatim by Zoom, and edited by the researchers who listened back to the interviews for accuracy.

3.4 | Analysis

Braun and Clarke's six-step Reflexive Thematic Analysis (RTA) (Braun and Clarke 2006, 2019, 2021) was chosen as the most suitable analysis method. RTA enables analysis of data without reliance on a pre-determined framework, unlike alternatives, such as grounded theory (Achora and Matua 2016). The rationale for using RTA was that its aim is not to develop a unified theory of a concept, but rather to provide a contextual and situational reflection of an experience of phenomena (Joy, Braun, and Clarke 2023). The use of RTA also allowed the multidisciplinary researcher team to reflect on their positions within the data.

Both latent and semantic coding was used, with neither giving prioritisation by the researchers. The types of coding were used when deemed appropriate, to capture meaning in the data. KSV coded the interviews and developed the themes; JJ and JB reviewed the themes. All other authors provided feedback. The authors acknowledge the subjectivity embedded in the use of RTA and have attempted to minimise this by (1) having open discussions within the research team about the data about potential preconceptions or expectations of what the data might show; (2) having multiple authors review the generated themes against the data; and (3) including service user representatives in the authorship.

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4 | Results

Five themes were developed (Figure 1). All themes have subthemes.

4.1 | Theme 1: The Role of Staff in Service Users' Psychological Safety

The most salient theme was the role that healthcare staff have for the psychological safety of patients.

4.1.1 | Subtheme 1.1: Psychologically Safe Versus Unsafe Staff Members

Participants differentiated 'psychologically safe' from 'psychologically unsafe' staff members. Staff members who invested time in getting to know service users, were permanent staff members, were supportive, were caring and empathetic, as well as perceived as competent at managing risk, were those who instilled a sense of psychological safety.

> [Psychologically safe staff member]...asked how you were, they picked up on signs when you weren't okay, even when you didn't really want to talk about it, or they knew the right intervention at that time - be it talking, distraction, taking you some quiet, offering you something they knew that would particularly sort of calm you down... unsafe [staff members] they just go around, checking on everyone every 15 minutes, look through the window or the door, you're sat on the floor crying... they just look at you and walk away.
>
> Yzzy

Participants explained that having 1–1 time or meaningful interactions with staff members was infrequent. This led participants to feel hopeless, lonely and low in mood. They felt that they lacked the supportive relationships which they needed to manage the psychological distress they were experiencing, which in turn, led them to feel psychologically unsafe.

> you feel that people don't care, you- your negative trajectory in your head... you feel like a burden, and you feel like no one cares, and I think that spiral going down when you should be in a place that's keeping you safe, it's worsening that impact.
>
> Yzzy

TABLE 1 | Participant overview.

ID	Gender	Age	MH condition	Occupation	Other	Duration of interview
Grace	Female	40	Type 1 diabetes disordered eating	Nurse		35
Penny	Female	Missing	Borderline personality disorder (does not agree with diagnosis; argues for bipolar and complex PTSD)	Does not work	Wheelchair user	34
Red	Non-binary	61	Complex PTSD, previously borderline personality disorder	Does not work		65
Sandy	Female	39	Autism, anorexia nervosa and depression	Occupation not disclosed		37
Tessa	Female	41	Does not have a formal diagnosis	Does not work	Wheelchair user	55
Conny	Female	40	Bipolar	Does not work		29
Bella	Female	26	Anorexia nervosa, depression and anxiety	Student		30
Yzzy	Female	42	Anorexia nervosa and depression	Nurse		31
Olive	Female	26	Anorexia nervosa and depression	Doctor		78
Whitney	Female	27	Does not agree with diagnosis of BPD, but identified as autistic	Operational trainer		35
Polly	Female	33	Eating disorder, depression and self-harm	Teacher	33	36
Gabe	Male (FTM)	30	Anorexia nervosa, depression and anxiety, obsessive compulsive disorder (OCD)—previous suggestion of borderline personality disorder	Mental health nurse	30	82

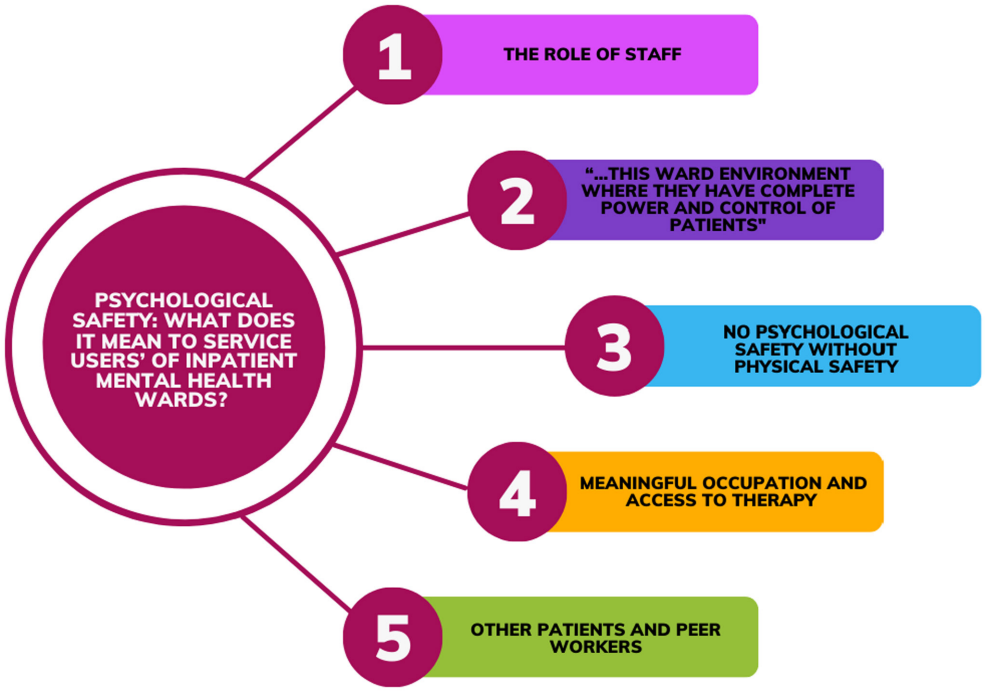

FIGURE 1 | Thematic map.

Participants readily drew on situations where they had encountered unsupportive staff and been met with hostility by staff.

> really scary where you're just in a situation where people are... horrible towards you, and you don't really understand why they have such an issue with you.
>
> Sandy

4.1.2 | Subtheme 1.2: The Importance of Being Believed and Listened to

Furthermore, participants explained that, due to being inpatients in mental health wards, staff members 'don't always listen... and believe you' (Sandy), and that there is often the view among staff that patients are 'inherently... unreliable narrators' (Tessa). Feeling that their experiences, feelings or opinions were invalidated by staff, led participants to feel psychologically unsafe. Participants described instances where they were not listened to (about what needs they had, or what support they needed), or believed about their diagnoses, their experience or trauma history. This led them to feel psychologically unsafe.

> When you don't feel they're hearing or understanding what you're saying - that again makes you frightened because they've got so much control over your life, that if they if they're not hearing what you're saying, then, then you feel unsafe, emotionally.
>
> Conny

4.1.3 | Subtheme 1.3: The Importance of Trauma-Informed Staff

Participants described encountering staff who were not delivering trauma-informed care, which led them to feel psychologically unsafe ('the word trauma-informed, [...] services are... definitely not'. – Red). Many also described being '(re-) traumatised' (Gabe, Red) due to actions taken by staff members. For example, one participant with a history of sexual abuse by men, described being restrained by male healthcare staff, despite her care plan detailing that she was not to be restrained by males. Thus, a lack of adherence to care plans, and lack of acknowledging past trauma, led participants to feel psychologically unsafe.

> a lot of the things that happen in hospital remind me of what happened in my childhood, so feeling powerless, feeling silenced, being held down, being invalidated, not being believed... it's all very triggering.
>
> Red

4.1.4 | Subtheme 1.4: Staff Contagion and Psychological Safety

There was a sense of contagion among service users regarding psychologically unsafe practices, and that staff would copy each other's negative behaviours regarding how they treated, and responded to, service users.

> how people act and behave towards patients can be picked up and followed by other staff... unless you've

> got someone, or a group that are experienced, that are aware of how to manage their own emotions and also how to work with people who are psychologically distressed, people pick up these kind of bad habits and they happen everywhere [...]
>
> Grace

> I remember distinctly saying to the staff 'nobody has spoken a word to me in 48 hours', like nobody has said a word to me, nobody has said 'hi, how are you, how are feeling?' Not a single word... Some were student nurses, and I found that really sad that student nurses were learning this role modelling.
>
> Yzzy

Some participants explained how 'good staff' (psychologically safe staff) would leave wards where the culture was toxic, and moved to units, where they felt like-minded, other 'good' staff were based. This led to a polarisation between psychologically safe and psychologically unsafe wards. More, and better staff training, as well as increased scrutiny of care delivered, were suggested by participants as ways to make care psychologically safer.

> ... well known that all the good staff drifted towards that ward because they knew it was good, so it's sort of a vicious circle sort of thing.
>
> Conny

4.2 | Theme 2: '... This Ward Environment Where They Have Complete Power and Control of Patients'

This second theme links with Theme 1 but extends the theme by highlighting the specific roles that power and control play in the context of psychological safety. Participants viewed themselves as powerless, while viewing staff as having power, within the ward environment, and control over patients. Feelings of powerlessness made participants feel psychologically unsafe.

4.2.1 | Subtheme 2.1: (Lack of) Power and Control Over Medical Decision-Making

Participants felt psychologically unsafe when they were not involved in medical decision-making, were not told which medications they were given or when medical decisions were made based on staffs' interpretations of patient behaviours, especially when staff did not know the patients or when it was the interpretations of staff members with whom the participants had conflict with. Participants also explained that a lack of scrutiny or transparency about what staff wrote in patients' notes about them, led them to feel psychologically unsafe, as 'once a staff member wrote something down in the record, it was unquestionable' (Tessa).

> ...this ward environment where they have complete power and control of patients.
>
> Tessa

> The amount of control staff have over your life... undermines psychological safety... especially if the staff aren't ones you get on with.
>
> Conny

4.2.2 | Subtheme 2.2: Lack of Communication and Predictability

Participants described staff as holding power and control over what was communicated to patients, for example, if/when ward rounds happened. This meant that participants often felt psychologically unsafe due to the lack of predictability. Measures, such as visual timetables and communication about the scheduling of ward activities, increased predictability (and concomitantly, increased feelings of psychological safety) by helping them know what to expect, and when.

> it's not like psychologically safe... you might be going into lunch, and then it's 'alright come and see psychiatrist now', or you might be asleep and they're like 'come now' and you're still in your pyjamas and everything and you're sitting there in your, in your nightie, your hair unbrushed, with all these professionals around... it just maximizes those power imbalances.
>
> Conny

4.2.3 | Subtheme 2.3: Ignoring Patient Concerns

Many participants recalled incidents where they were not listened to by staff members, and the toxic culture this created for patients, whereby they felt powerless and psychologically unsafe. This links with the idea that patients are 'inherently... unreliable narrators' (Tessa) described in Theme 1. For example, participants reported instances of medication errors, and that staff, when challenged about administering the wrong medication, did not always react appropriately. Instead of listening or checking, participants reported that staff used coercive practices or became confrontational by accusing participants of refusing medication.

> You'd get lots of people trying to give you someone else's medication and you say no, this isn't my medication, and they're saying 'you've got to take it you're under section', you just looking at this handful of pills thinking, what on earth is this? ... You... feel such a lack of control in these situations.
>
> Olive

Further, staff were seen to be failing their responsibilities when they disregarded complaints about colleagues. Participants also described a culture whereby staff would side with other staff in incidents, and not put patients' best interests at the forefront of decisions.

> other staff aren't a protection from abuse from staff. That means that you don't even have the protection

> of running to another staff member, if somebody decides to start smacking you or something.
>
> Conny

4.3 | Theme 3: No Psychological Safety Without Physical Safety

Participants discussed that physical safety and psychological safety were separate, and that being admitted to wards affected both their psychological safety and physical safety.

> There was quite high level of acuity on the ward and there were lots of incidents [...], self-harm, but also like incidents of violence and aggression, and so it also felt physically safer to just stay out of the way, away from everyone.
>
> Gabe

4.3.1 | Subtheme 3.1: The Physical Ward Environment as Detrimental to Psychological Safety

The physical ward environment was discussed as having an impact on psychological safety. Most participants described the wards as clinical, cold and often overwhelming with noise. Both participants with and without sensory sensitivities discussed how alarms or hearing other people self-injuring via head-banging, for example, led them to feel psychologically unsafe.

Participants acknowledged that while these wards were hospital areas and designed to keep people safe but suggested that the emphasis on physical safety within the ward environment came at a detriment to psychological safety. Not having privacy when going to the toilet (due to no doors, or being on constant 1–1 supervision) for example, was especially detrimental to psychological safety.

> If you're talking about psychological safety .... you're thinking about your surroundings being nice being comfortable, obviously a ward is relatively clinical, and I think there are obviously certain things that they have to have in place which can make it feel less comfortable...
>
> Polly

> ... more homely environment [to increase psychological safety] but I mean, I really don't know how that would happen when you've not even got a toilet door in... your bedroom.
>
> Red

Participants who had their own bedrooms (rather than bays in dormitories), and their own bathrooms with doors, reported increased feelings of psychological safety. However, even having private rooms did not always ensure psychological safety, as many participants reported other patients came into their room and disturbed them, especially at night, which led them to feel psychologically unsafe.

When wards and hospital environments were 'really grotty run-down place[s]' (Red), this led participants to 'feel worse ... and less reassured about the state of everything' (Conny).

> the bathroom was just disgusting, it was like - people were constantly smoking in it, had left their self-harm wound covers, like their plasters and things like that - like that environment was generally quite dirty.
>
> Yzzy

Many participants described using physical coping strategies, such as withdrawing to their rooms, hiding under the blankets or even escaping from the ward, to increase feelings of physical and psychological safety in the face of the challenges associated with the ward environments, such as those outlined above.

> It comes down to some of the physical things I might do, like, I might take myself away, wrap myself up in a blanket and just kind of pretend that I'm not where I am.
>
> Penny

Participants felt that staff lacked insight into the impact of the ward environment on patients' feeling of psychological safety. They suggested that staff did not realise that this intrusive environment might lead them to withdraw to their rooms to seek peace and safety.

4.3.2 | Subtheme 3.2: Containment and Psychological Safety

Participants were divided about the impact of locked ward doors on psychological safety. Some stated it led them to feel psychologically unsafe, due to being unable to leave the ward environment, which included staff and other patients. However, others discussed that knowing they were safe and contained within the ward, as well as unable to hurt themselves led them to feel psychologically safe.

> I felt really agitated knowing that there's a locked door and I can't just go out. So, it's just led to me feeling a lot more worked up, and also a lot more anxious.
>
> Gabe

> There's almost a nurturing, to feel contained, to feel [physically] safe because there's a lot of time when you don't feel [psychologically] safe because of maybe your thoughts or, or your behaviour, and I think containment was quite important for me, not that it was there, just because it's not always possible.
>
> Bella

4.3.3 | Subtheme 3.3: Unmet Physical Health Needs

Participants with unmet physical needs reported feeling psychologically unsafe. One wheelchair user, for example, described not being able to bathe or shower during her entire inpatient admission, as there was no suitable bath or shower accessible to her (Penny).

Participants described that even if their physical health needs were directly linked to their mental illness, these needs were not always met. Participants with eating disorders, who were admitted to a general mental health acute ward (instead of specialised ED units), reported that those acute wards were not equipped to support them at mealtimes to encourage them to eat. Consequently, these participants described not eating during their stay, leading to further weight loss and exacerbation of both physical and psychological problems.

Another patient, who had Type 1 diabetes disordered eating, recounted instances when non-qualified staff attempted to administer insulin incorrectly, which led to an exacerbation of her negative feelings around taking insulin.

> ... that experience... I still hold on to that now, that that psychological impact that that had because I then believed that like staff don't know what they are doing – this is crazy. [...]. I... didn't feel physically or psychologically safe...
>
> Grace

4.4 | Theme 4: Meaningful Occupation and Access to Therapy as Sources of Psychological Safety

Participants expressed that they often felt psychologically unsafe due to their own thoughts, but that having something meaningful to do, or access to psychological therapy, helped them to feel more psychologically safe. However, both meaningful occupation on wards as well as access to therapy was the exception rather than the norm ('[on acute wards]... there is a huge reliance... on medication [rather than therapy]'—Yzzy).

> I often think what Joe public thinks happens when somebody needs to go to psychiatric hospital, do they think we have therapy or something? Do they think it's all lovely? No, I've never seen a psychologist at all on a ward. I've never had any therapy on a ward.
>
> Red

Participants also discussed that the activities offered were often perceived as infantilising (e.g., colouring) or biased towards gender-specific activities (e.g., nail painting or crochet). There was also a sense that participants wanted a choice regarding what was offered.

> We often get given a bunch of colouring and a colouring in sheet. I'm not four [years old]. I enjoy colouring as much as the next person but I'm not four.
>
> Penny

4.5 | Theme 5: The Role of Other Patients and Peer Workers

Participants explained that their feelings of psychological safety were affected by other patients. Mutually supportive peer relationships made participants feel psychologically safe.

> everyone kind of acknowledged that everyone else was struggling and having a bit of a shit time but like when you were together you just kind of tried to cheer each other up.
>
> Olive

However, having conflict with other service users or witnessing self-harm or aggression, made them feel psychologically unsafe.

> I was next door to this man ... he would scream obscenities at me all day and all night. You had to walk past his room... to get some of the therapy rooms, he would masturbate openly and throw faeces. I was in a room next to him for a couple of months– he was terrifying. I mean I was 19, it was really, really scary....
>
> Olive

> You see a lot of self-harm, you see a lot of attempted suicide, so that all makes you feel psychologically unsafe, whether it is overall 'oh god I feel unsafe, because I don't know what's to happen in this unit environment' or if that then can put unhelpful thoughts in your head.
>
> Bella

There was also a sense among participant that staff did not seem to understand the effect other patients can have on feelings of psychological safety for service users. Not receiving any acknowledgement of the trauma of witnessing other people self-harm or be restrained, was described as detrimental to psychological safety. Staff taking time to debrief after such incidents happen, or are witnessed, was discussed as essential in increasing feelings of psychological safety.

> I don't think there's necessarily enough acknowledgement that your experience isn't in isolation. When you're in hospital like it is affected by everything that's going on around you. [...] There was kind of this expectation that you would just be able to ignore it or get on with it. And just that those things shouldn't affect you because it's not got anything to do with you, but when you are living in this environment, it does.

Polly

Some participants also discussed the role of peer-support workers. Peer-support workers are individuals with lived experience of mental health distress whose work is to support current service users in their recovery, and 'provide inspiration for their recovery' (Health Education England 2020). While some participants described that seeing people recovered from, or living successfully, with their mental illness was 'instilling hope' (Gabe), others expressed concerns about peer support workers, such as that once a *'recovered'* patient becomes a staff member, they take on the role of staff and have associated power over service users, which links with Theme 2.

> ... if they're in that staff role, there is already that power imbalance created [...] You're not my peer in this environment, because you're a member of staff, and [...] you go back and you report on me in handovers [...] I actually find it I always feel quite- a bit gaslit when they're kind of called my peer because it, it, it kind of obscures that power imbalance a bit.
>
> Conny

5 | Discussion

Participants often felt psychologically unsafe when on wards and reported more instances where they felt psychologically unsafe than safe. Psychological safety was affected by the people around them, which included staff and other service users, the physical ward environment and whether service users had access to meaningful occupation, including therapy. The current study makes novel additions to the current research and extends the literature in two main ways.

Firstly, this is the first study to directly explore psychological safety in service users in inpatient mental health services (and the first with service users more generally). The findings suggest that service users could easily connect with the idea of 'psychological safety' as a concept, and discuss it in depth, giving it face validity as a relevant concept. This expands on the two previous studies which indirectly identified it when investigating patient experiences more broadly (Asikainen et al. 2023; Berzins et al. 2020).

Our findings in this respect suggest that there is a deficit in psychological safety on the wards and service users believe steps need to be taken to improve it. Indeed, one of the most striking findings was that participants were more readily able to draw on situations where they felt psychologically unsafe, rather than safe. These findings are consistent with the wider literature suggesting that service users can have harmful experiences in these settings, including re-traumatisation. However, further research would be needed to ascertain the extent of the problem.

Secondly, these findings add to the literature by identifying key factors which influence psychological safety. Behaviour and qualities of healthcare staff appeared one of the most significant predictors of whether service users felt psychologically safe, or not. Psychological safety was fostered when staff were empathetic, respectful and listened to service users, while a failing to respond to patient concerns, and lack of communication were barriers to psychological safety. Previous literature has reported that staff–service user relationships are crucial to recovery (Bacha, Hanley, and Winter 2020), and has linked staff burnout with poorer patient safety (Al Ma'mari, Sharour, and Omari 2020; de Lima Garcia et al. 2019; Hall et al. 2016; Johnson et al. 2018).

The current study expands this by suggesting that staff characteristics are not only associated with patient physical safety, but also psychological safety. Indeed, it could be suggested that these functions might overlap, for example, burnout has also been linked with poorer attitudes and empathy towards service users (Reynolds et al. 2021; Sturzu et al. 2019). Interestingly, we found a 'contagion' effect, whereby service users observed that when staff began demonstrating negative attitudes towards service users, this could spread. Negative attitudes towards service users can be considered an aspect of 'cynicism' or 'disengagement', which is one of the two main aspects of burnout, alongside 'emotional exhaustion' (Demerouti and Bakker 2007). The observation that burnout can be contagious has previously been reported by studies in critical care nurses (Bakker, Le Blanc, and Schaufeli 2005), general practitioners (Bakker et al. 2001) and teachers (Bakker and Schaufeli 2000) among others. Our findings extend these by showing that this effect may occur in mental health settings too, and further highlight the potential benefits of taking an organisational approach to addressing burnout, rather than solely person-directed approaches (Panagioti et al. 2017).

Thus, the current results build the evidence base suggesting that well-supported, psychologically healthy staff teams are crucial to high-quality safe patient care.

Feeling physically safe also increased feelings of psychological safety for service users. To date, the literature had suggested that psychological safety is an important factor which is linked with, but separate from physical safety (Asikainen et al. 2023; Berzins et al. 2020). The current study extends these findings by delineating the relationship between these two concepts, suggesting that things which contribute to physical safety (e.g., containment, such as locked doors on wards), can enable service users to feel psychologically safe. For example, in a qualitative study conducted by Cutler et al. (2021) in the United States, participants reported that having access to meaningful activities made them feel safe. As the study did not distinguish between feelings of psychological and physical safety, but focused on 'safeness' as a whole, the nuances of different types of safety were not further explored and could have yielded important insights into what constitutes the concept of safety in these settings.

Feeling powerless has been reported as common for individuals admitted to, and detained on, mental health wards (Bacha, Hanley, and Winter 2020; Murphy et al. 2017), but this is the first study to specifically link (perceived) lack of power to a lack of psychological safety. It is important that organisations try to implement structures, such as those suggested by the participants including the use of visual timetables and

transparent communication with service users, to increase feelings of control, and consequently, feelings of psychological safety.

While previous studies have highlighted the importance of meaningful occupation and access to psychological treatment for service users on inpatient wards (Clarke, Stack, and Martin 2018; Lim, Morris, and Craik 2007), this study also highlights their important contribution to psychological safety. Thus, it is important that service users are offered both access to activities, which are varied and not infantilising, and therapeutic modalities.

These findings will be important when designing interventions to improve psychological safety. It is important that these are co-designed by service users, and must include, at the very least, staff training.

6 | Relevance for Research

There are three main points for future research to consider:

Firstly, the study has highlighted that service users of inpatient mental health services can relate to the concept of psychological safety and are able to differentiate it from physical safety. Future research must take this into account and go beyond investigations of 'safety' but differentiate which types of safety they are investigating.

Secondly, future research must also develop a questionnaire measure of psychological safety in inpatient mental health services, that saliently captures the service user experience.

Thirdly, future research must also design and evaluate interventions to improve psychological safety on inpatient wards. Both the questionnaire and interventions must be co-designed with service users of inpatient mental health services, to ensure they are relevant and meaningful to the population they are developed for.

Fourth, there is a need for more accurate measurement of psychological safety in inpatient wards in order to enable monitoring, improvements and measurement of the impact of interventions designed to promote psychological safety in inpatients in these settings. Future research should consider this and address this.

7 | Limitations

There are several limitations. The first number pertains to the sample: due to recruiting former (rather than current) inpatients, there may be some recall bias. The volunteer sample may also have meant that more participants with negative experiences regarding psychological safety may have volunteered, as they felt strongly about the topic. There were also no patients with psychotic illnesses or substance use included, and men were under-represented. In addition, while participants also had experiences of different wards, we did not record the specific types, which limits conclusions being drawn in relation to the impact of ward type on psychological safety. A final limitation pertains to the study design: The limitation of qualitative research is that due to small sample sizes, findings may not generalise to other populations. However, generalisability of results is not an aim of the qualitative research paradigm, rather, it aims to provide a valid, rich insight into participants (Leung 2015).

8 | Conclusions

In conclusion, many participants reported feeling psychologically unsafe when they were inpatients in mental health wards. Psychological safety was heavily influenced by healthcare staff attitudes and behaviours towards service users, their relationships with other service users, whether service users felt they had any control over their environment and in medical decision-making, felt physically safe, were listened to and believed and had access to meaningful occupation while on the wards. There is an urgent need to make inpatient mental health services more psychologically safe, to support service users of inpatient mental health wards in their recovery.

Interventions to achieve this, should be co-designed with service users.

9 | Relevance for Clinical Practice

This study is the first to investigate what psychological safety means to (former) service users of inpatient mental health services. The results show that, often, service users feel neither psychologically nor physically safe when being on inpatient mental health wards, and that interventions are urgently required. The results also show the important role that staff can play in helping service users feel psychologically safe, but also highlights poor practice and inadequate care as detrimental for psychological safety. Healthcare staff on inpatient mental health wards must be educated about the concept of psychological safety, its importance and how staff members can help service users to feel more psychologically safe in the inpatient environment. These results also support the need for co-designed interventions to support service users' psychological safety when admitted to acute mental health wards.

Author Contributions

The idea for this study was developed by K.S.V., J.J. and J.B. The Principal Investigator for this study was K.S.V. K.S.V. conducted all interviews. B.L.G. and H.S. transcribed the interviews. K.S.V. led the analysis, wrote the first draft of the analysis and the paper, for which J.J., J.B., E.M. and S.K. subsequently contributed. All authors have had opportunity to read and contribute to the manuscript prior to submission.

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Ethics Statement

Ethical approval for this study was granted by the University of Leeds (Reference: PSYC-604, approval date 21 October 2022). Participants gave full informed consent before participation.

Consent

Participants consented that they understood that the experiences shared in the interviews will contribute to the paper, and that direct quotes will be used—but that material would be made as unidentifiable as possible.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

Due to the sensitive nature of the interview data, data are not made available.

References

Achora, S., and G. A. Matua. 2016. "Essential Methodological Considerations When Using Grounded Theory." *Nurse Researcher* 23, no. 6: 31–36. https://doi.org/10.7748/nr.2016.e1409.

Al Ma'mari, Q., L. A. Sharour, and O. A. Omari. 2020. "Fatigue, Burnout, Work Environment, Workload and Perceived Patient Safety Culture Among Critical Care Nurses." *British Journal of Nursing* 29, no. 1: 28–34. https://doi.org/10.12968/bjon.2020.29.1.28.

Asikainen, J., Katri Vehviläinen-Julkunen, Eila Repo-Tiihonen, and Olavi Louheranta. 2023. "Patients Perceptions of Safety and Debriefing in Forensic Mental Health Care in Finland." *Journal of Forensic Nursing* 19: 187–196. https://doi.org/10.1097/JFN.0000000000000436.

ATLAS.ti Scientific Software Development GmbH. 2022. "ATLAS.ti Scientific Software Development GmbH [ATLAS.ti Web, v3.15.0]. [Computer Software].".

Bacha, K., T. Hanley, and L. A. Winter. 2020. "'Like a Human Being, I Was an Equal, I Wasn't Just a Patient': Service Users' Perspectives on Their Experiences of Relationships With Staff in Mental Health Services." *Psychology and Psychotherapy: Theory, Research and Practice* 93, no. 2: 367–386. https://doi.org/10.1111/papt.12218.

Bakker, A. B., P. M. Le Blanc, and W. B. Schaufeli. 2005. "Burnout Contagion Among Intensive Care Nurses." *Journal of Advanced Nursing* 51, no. 3: 276–287. https://doi.org/10.1111/j.1365-2648.2005.03494.x.

Bakker, A. B., and W. B. Schaufeli. 2000. "Burnout Contagion Processes Among Teachers." *Journal of Applied Social Psychology* 30, no. 11: 2289–2308. https://doi.org/10.1111/j.1559-1816.2000.tb02437.x.

Bakker, A. B., W. B. Schaufeli, H. J. Sixma, and W. Bosveld. 2001. "Burnout Contagion Among General Practitioners." *Journal of Social and Clinical Psychology* 20, no. 1: 82–98. https://doi.org/10.1521/jscp.20.1.82.22251.

Berzins, K., J. Baker, G. Louch, and A. Albutt. 2020. "A Qualitative Exploration of Mental Health Service User and Carer Perspectives on Safety Issues in UK Mental Health Services." *Health Expectations* 23, no. 3: 549–561. https://doi.org/10.1111/hex.13025.

Braun, V., and V. Clarke. 2006. "Using Thematic Analysis in Psychology." *Qualitative Research in Psychology* 3, no. 2: 77–101.

Braun, V., and V. Clarke. 2019. "Reflecting on Reflexive Thematic Analysis." *Qualitative Research in Sport, Exercise and Health* 11, no. 4: 589–597. https://doi.org/10.1080/2159676X.2019.1628806.

Braun, V., and V. Clarke. 2021. "Can I Use TA? Should I Use TA? Should I Not Use TA? Comparing Reflexive Thematic Analysis and Other Pattern-Based Qualitative Analytic Approaches." *Counselling and Psychotherapy Research* 21, no. 1: 37–47. https://doi.org/10.1002/capr.12360.

Clarke, C., C. Stack, and M. Martin. 2018. "Lack of Meaningful Activity on Acute Physical Hospital Wards: Older People's Experiences." *British Journal of Occupational Therapy* 81, no. 1: 15–23. https://doi.org/10.1177/0308022617735047.

Cusack, P., F. P. Cusack, S. McAndrew, M. McKeown, and J. Duxbury. 2018. "An Integrative Review Exploring the Physical and Psychological Harm Inherent in Using Restraint in Mental Health Inpatient Settings." *International Journal of Mental Health Nursing* 27, no. 3: 1162–1176. https://doi.org/10.1111/inm.12432.

Cutler, N. A., E. Halcomb, J. Sim, M. Stephens, and L. Moxham. 2021. "How Does the Environment Influence Consumers' Perceptions of Safety in Acute Mental Health Units? A Qualitative Study." *Journal of Clinical Nursing* 30, no. 5–6: 765–772. https://doi.org/10.1111/jocn.15614.

de Lima Garcia, C., L. de Abreu, J. Ramos, et al. 2019. "Influence of Burnout on Patient Safety: Systematic Review and Meta-Analysis." *Medicina* 55, no. 9: 553. https://doi.org/10.3390/medicina55090553.

Demerouti, E., and A. B. Bakker. 2007. "The Oldenburg Burnout Inventory: A Good Alternative to Measure Burnout (and Engagement)." https://www.isonderhouden.nl/doc/pdf/arnoldbakker/articles/articles_arnold_bakker_173.pdf.

Edmondson, A. 1999. "Psychological Safety and Learning Behavior in Work Teams." *Administrative Science Quarterly* 44, no. 2: 350–383.

Felton, A., and T. Stickley. 2018. "Rethinking Risk: A Narrative Approach." *Journal of Mental Health Training, Education and Practice* 13, no. 1: 54–62. https://doi.org/10.1108/JMHTEP-06-2017-0043.

Galappathie, N., S. T. Khan, and A. Hussain. 2017. "Civil and Forensic Patients in Secure Psychiatric Settings: A Comparison." *BJPsych Bulletin* 41, no. 3: 156–159. https://doi.org/10.1192/pb.bp.115.052910.

Grailey, K. E., E. Murray, T. Reader, and S. J. Brett. 2021. "The Presence and Potential Impact of Psychological Safety in the Healthcare Setting: An Evidence Synthesis." *BMC Health Services Research* 21, no. 1: 773. https://doi.org/10.1186/s12913-021-06740-6.

Hall, L. H., J. Johnson, I. Watt, A. Tsipa, and D. B. O'Connor. 2016. "Healthcare Staff Wellbeing, Burnout, and Patient Safety: A Systematic Review." *PLoS One* 11, no. 7: 1–12. https://doi.org/10.1371/journal.pone.0159015.

Health Education England. 2020. *The Competence Framework for MH PSWs*. Health Education England. https://www.hee.nhs.uk/sites/default/files/documents/The%20Competence%20Framework%20for%20MH%20PSWs%20-%20Part%201%20-%20Supporting%20document_0.pdf.

Hunt, D. F., J. Bailey, B. R. Lennox, M. Crofts, and C. Vincent. 2021. "Enhancing Psychological Safety in Mental Health Services." *International Journal of Mental Health Systems* 15, no. 1: 33. https://doi.org/10.1186/s13033-021-00439-1.

Johnson, J., L. H. Hall, K. Berzins, J. Baker, K. Melling, and C. Thompson. 2018. "Mental Healthcare Staff Well-Being and Burnout: A Narrative Review of Trends, Causes, Implications, and Recommendations for Future Interventions." *International Journal of Mental Health Nursing* 27, no. 1: 20–32. https://doi.org/10.1111/inm.12416.

Joy, E., V. Braun, and V. Clarke. 2023. "Doing Reflexive Thematic Analysis: A Reflexive Account." In *Research Methods for Education and the Social Disciplines in Aotearoa New Zealand*, edited by F. Meyer and K. Meissel. Wellington, New Zealand: NZCER Press.

Jung, G., and J. Oh. 2022. "Factors Affecting Health-Related Quality of Life Among Healthcare Workers During COVID-19: A Cross-Sectional Study." *Medicina* 59, no. 1: 38. https://doi.org/10.3390/medicina59010038.

Kahn, W. A. 1990. "Psychological Conditions of Personal Engagement and Disengagement at Work." *Academy of Management Journal* 33, no. 4: 692–724.

Kanerva, A., J. Lammintakanen, and T. Kivinen. 2013. "Patient Safety in Psychiatric Inpatient Care: A Literature Review." *Journal of Psychiatric and Mental Health Nursing* 20, no. 6: 541–548. https://doi.org/10.1111/j.1365-2850.2012.01949.x.

Leung, L. 2015. "Validity, Reliability, and Generalizability in Qualitative Research." *Journal of Family Medicine and Primary Care* 4, no. 3: 324–327. https://doi.org/10.4103/2249-4863.161306.

Lim, K. H., J. Morris, and C. Craik. 2007. "Inpatients' Perspectives of Occupational Therapy in Acute Mental Health." *Australian Occupational Therapy Journal* 54, no. 1: 22–32. https://doi.org/10.1111/j.1440-1630.2006.00647.x.

Malterud, K., V. D. Siersma, and A. D. Guassora. 2016. "Sample Size in Qualitative Interview Studies: Guided by Information Power." *Qualitative Health Research* 26, no. 13: 1753–1760. https://doi.org/10.1177/1049732315617444.

Mariyati, A., and H. Novy. 2018. "The Experience of Restraint-Use Among Patients With Violent Behaviors in Mental Health Hospital." *Enfermeria Clinica* 28: 295–299.

Murphy, R., D. McGuinness, E. Bainbridge, et al. 2017. "Service Users' Experiences of Involuntary Hospital Admission Under the Mental Health Act 2001 in the Republic of Ireland." *Psychiatric Services* 68, no. 11: 1127–1135. https://doi.org/10.1176/appi.ps.201700008.

Newman, A., R. Donohue, and N. Eva. 2017. "Psychological Safety: A Systematic Review of the Literature." *Human Resource Management Review* 27, no. 3: 521–535. https://doi.org/10.1016/j.hrmr.2017.01.001.

Panagioti, M., E. Panagopoulou, P. Bower, et al. 2017. "Controlled Interventions to Reduce Burnout in Physicians a Systematic Review and Meta-Analysis." *JAMA Internal Medicine* 177, no. 2: 195–205. https://doi.org/10.1001/jamainternmed.2016.7674.

Reynolds, M., A. McCombie, M. Jeffery, R. Mulder, and F. Frizelle. 2021. "Impact of Burnout on Empathy." *The New Zealand Medical Journal* 134, no. 1530: 12–20.

Sequeira, H., and S. Halstead. 2004. "The Psychological Effects on Nursing Staff of Administering Physical Restraint in a Secure Psychiatric Hospital: 'When I Go Home, It's Then That I Think About It'." *The British Journal of Forensic Practice* 6, no. 1: 3–15. https://doi.org/10.1108/14636646200400002.

Shields, M. C., M. T. Stewart, and K. R. Delaney. 2018. "Patient Safety in Inpatient Psychiatry: A Remaining Frontier for Health Policy." *Health Affairs* 37, no. 11: 1853–1861. https://doi.org/10.1377/hlthaff.2018.0718.

Short, B., C. Marr, and M. Wright. 2019. "A New Paradigm for Mental-Health Quality and Safety: Are We Ready?" *Australasian Psychiatry* 27, no. 1: 44–49. https://doi.org/10.1177/1039856218797423.

Sturzu, L., A. Lala, M. Bisch, M. Guitter, D. Dobre, and Raymund Schwann. 2019. "Empathy and Burnout – A Cross-Sectional Study Among Mental Healthcare Providers in France." *Journal of Medicine and Life* 12, no. 1: 21–29. https://doi.org/10.25122/jml-2018-0050.

Thibaut, B., L. H. Dewa, S. C. Ramtale, et al. 2019. "Patient Safety in Inpatient Mental Health Settings: A Systematic Review." *BMJ Open* 9, no. 12: e030230. https://doi.org/10.1136/bmjopen-2019-030230.

Veale, D., E. Robins, A. B. Thomson, and P. Gilbert. 2023. "No Safety Without Emotional Safety." *The Lancet Psychiatry* 10, no. 1: 65–70. https://doi.org/10.1016/S2215-0366(22)00373-X.

Appendix

Topic Guide

- □ Can you tell me a little bit about yourself please?
  - ○ Cover time spent in mental health wards (including frequency and recency), diagnoses, age and occupation if any.
- □ What do you think psychological safety is?
- □ What makes a ward psychologically safe in your view?
  - ○ Prompt: ... or unsafe?
- □ Can you tell me about an incident, or incidents that made you feel psychologically unsafe?
  - ○ People? Yourself? Feelings? Context? Staff?
- □ Can you tell me about a time that made you feel psychologically safe?
  - ○ People? Yourself? Feelings? Context? Staff?
- □ What is the biggest thing that stops wards being psychologically safe?
- □ Are there any things that you think need changing to make wards more psychologically safe?
- □ Have you ever done anything while on the ward to make yourself feel psychologically safer?
- □ Anything else?