Exploring the experience of acute inpatient mental health care from the perspective of family and carers of people experiencing psychosis: A qualitative thematic analysis study conducted during the COVID-19 pandemic.

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Abstract

Family and carers play an important role in supporting service users who are in receipt of acute mental health inpatient care but they can also be significantly emotionally and physically impacted. The aim of this study is to examine their needs and priorities during this time. Fourteen family and carers of inpatients experiencing psychosis completed semi-structured interviews examining their experiences of inpatient care during the COVID-19 pandemic. Thematic analysis was used to analyse data. Four key themes were identified "A turbulent journey to hospital admission", "I need information and support", "maintaining my relationship with my loved one", and "inpatient care is a mixed bag". Each theme comprised four or five sub-themes. The findings demonstrated that family and carers feel excluded from inpatient care and struggled to maintain contact with their loved ones, which was exacerbated by COVID-19. Communication and being regularly informed about their loved one's care, as well as visiting loved ones was particularly problematic. Inpatient care needs to be more inclusive of family and carers and ensure they are kept in mind at every stage of the admission.

Introduction

Acute psychiatric inpatient units provide care to people in mental health crisis with often high risk behaviours across the UK (Royal College of Psychiatrists, 2015). The presentation of the inpatient population has changed dramatically over the last century due to the widespread closure of large asylums and significant reductions made in numbers of beds, particularly in the last 10 years, and a move towards community care (The Kings Fund, 2017). As a result, inpatient services now only take on the most high-risk patients. A recent systematic review and meta-analysis has demonstrated that psychiatric inpatients are at significantly more risk of suicide compared to those in the community (Walsh, Sara, Ryan, & Large, 2015). People who experience psychosis make up to one-third to one-half of patients currently admitted to UK psychiatric hospitals (NHS Digital, 2020). A total of approximately 27,000 people with psychosis are admitted to psychiatric hospitals each year and have the longest inpatient admissions (Thompson et al., 2004). This presents a challenge given the potentially high risk and complex patients with psychosis being admitted to acute psychiatric inpatient wards.

Carers save the UK economy £132 billion pounds a year and play a vital role in supporting a loved one with a physical or mental health difficulty (Carers UK, 2021). This is also evident for family and carers of service users experiencing psychosis who are in receipt of acute mental health inpatient care. They often play a role in the service user's admission to hospital, and provide important emotional and practical support to service users (Bird et al., 2010). If family members are involved in therapeutic interventions, it has been demonstrated that it can reduce a service user's rate of relapse and rehospitalisation (Eassom, Giacco, Dirik, & Priebe, 2014). Moreover, if a family member or carer is involved in a service user's treatment, the impact of the treatment last longer and therefore improved outcomes are maintained (Bird et al., 2010). However, the positive impact that family and carer involvement can have on service user outcomes often comes at a cost for the family member or carer. Research has demonstrated that family and carers are detrimentally impacted upon by having a loved one experiencing mental health difficulties. For example, a large epidemiological population study demonstrated that carers experience significantly more physical and mental health problems compared to a non-caring population (Stansfeld et al., 2014). Moreover, eight out of ten carers have said that they feel lonely or isolated (Carers UK, 2021). Thus, family and carers also have important needs that need consideration and should also be offered appropriate support.

As outlined, due to the reduction in beds, acute mental health inpatient care only takes those at highest risk of harm to themselves and others (Kings Fund, 2015; The Kings Fund, 2017), and therefore family members and carers will likely be caring for a loved one who is in a highly distressed and risky state and the challenges for family members and carers is heightened in this care setting. Research has

demonstrated that carers report it as being a time of elevated stress, confusion and worry (Giacco, Dirik, Kaselionyte, & Priebe, 2017). They also report experiences of shame and guilt about having a loved one in hospital (Jankovic et al., 2011). A number of qualitative studies have been conducted to examine family and carer's view of inpatient care and they have identified family and carers feel excluded from treatment decisions, and not kept updated (Giacco et al., 2017; Patk & Lee, 2017; Fernandes Moll et al., 2016). However, none have been conducted to understand the specific experience of family and carers of people experiencing psychosis who are currently accessing acute mental health wards in the current context of brief admission, high acuity and COVID-19.

COVID-19 brings new challenges to the delivery of mental health care, particularly inpatient mental health care where service users are cared for in close proximity of staff and service users alike. A recent mixed-methods survey identified a number of key challenges to the delivery of mental health services during the COVID-19 pandemic (Johnson et al., 2020). These included the risk that it will spread between service users, a lack of activities/increased boredom, the risk of transmission to staff, having to adapt too quickly to new ways of working, and difficulty discharging people due to the lack of available community services (Johnson et al., 2020), which are all highly relevant to acute mental health inpatient settings. It is likely that the COVID-19 pandemic and related service changes will have impacted upon the accessibility and quality of service delivery and therefore impact upon family and carer experiences of acute mental health inpatient care. It is essential to understand what impacts the COVID-19 has had on the experiences of family and carers of inpatient care.

In summary, people experiencing psychosis form the largest majority of patients in acute mental health inpatient care and thus the experiences of their family and carers is important to understand. Understanding their priorities and needs is extremely important in the effective delivery of any acute mental health inpatient care pathway, interventions and treatments. The aim of this study is to examine the priorities and needs of family and carers of acute psychiatric inpatients who experience psychosis within the context of the COVID-19 pandemic. Family and carer experiences were explored from admission through to discharge.

Method

Design and ethics

This is an exploratory, naturalistic, qualitative study using semi-structured interviews to explore the study aims, which is recommended for thematic analysis (Braun & Clark, 2006). The study received NHS Health Research Authority (HRA) and Research Ethics Committee approval (West Midlands-South Birmingham REC; 19/WM/0321) and sponsorship from North East London NHS Foundation Trust. The study is reported in line with the Consolidated Reporting for Qualitative Research (COREQ) guidelines (Tong, Sainsbury, & Craig, 2007)

Service context

Recruitment was conducted during May to August 2020 during the COVID-19 pandemic from an outer London hospital. Six acute mental health wards were the target site for recruitment. Two were assessment wards (one male and one female) and four were treatment wards (two male and two female). The assessment wards were newly formed wards due to the COVID-19 pandemic (they were previously acute mental health treatment wards). The assessment wards cared for patients for the first 7 days of their admission whilst they were assessed for their mental health and swabbed for COVID-19. If they required further treatment, they would be sent to one of the four treatment wards or otherwise discharged. If they tested positive for COVID-19 they would be transferred to a dedicated COVID-19 mental health ward for mental health treatment.

The average length of stay on the wards is 31 days and during this time service users are offered assessment and treatment for their acute mental health crisis (NHS Benchmarking, 2019). An estimated two thirds of service users are admitted under section of the Mental Health Act, with black service users four times more likely to be admitted under section that their white counterparts (NHS Digital, 2020). The recruiting population is very culturally diverse with approximately half of service user's being from a black, Asian and minority ethnic background. Service users are offered multidisciplinary care from psychiatrists, psychologists, occupational therapists, nursing staff and pharmacists. Service users are admitted via a number of avenues, for example, via the crisis home treatment team, police or ambulance under section 135 or 136, and A&E.

Participants and eligibility

Participants were included if they were: (a) aged 18 and above, (b) had a relative currently admitted to an acute psychiatric inpatient unit (on section or informally), (c) had a relative that meets criteria for a schizophrenia-spectrum diagnoses, or threshold for early intervention services (to allow for diagnostic uncertainty), (d) had the capacity to give informed consent, (e) able to complete the study in English. No exclusion criteria were specified.

Recruitment and procedure

The study was advertised to family and carers via the ward clinical staff who would contact eligible candidates to inform of the study If they were interested, they would either pass on their number for the researcher to contact them or contact the research directly. Interviews were either conducted face to face (n=1) or remotely (e.g. via zoom or phone; n = 13) dependent on participant preference by all authors (n= 4 – 5 each). The participants were asked questions on theirs and their loved one's experiences of: hospital admission, goals/needs during their psychiatric hospital admission, the match between what has been offered and what was wanted, examples of good and bad practice, the impact of COVID-19 on inpatient care, and, if applicable, their experiences of psychological therapy. The team were interested in family and carer involvement in the psychological therapy process as this is an important opportunity for them to be therapeutically involved in their loved one's care.

The researchers comprised a clinical psychologist and two assistant psychologists who all had experience of working in the acute mental health inpatient wards where recruitment took place. We acknowledge that by being embedded in the system we bring out biases and experiences of how the inpatient system operates. We ensured we did not interview any participants that had received care from any of the wards from which we were based.

Analysis

Interviews were transcribed verbatim by CC and AB and analysed using thematic analysis (Braun & Clarke, 2006) by LW. The analysis was conducted on NVivo software (2017). Braun and Clarke (2006) outline that a number of key decisions need to be made by the researcher in order to undertake the analysis. Therefore, the researcher adopted a critical realist position which states that psychological and social constructs exist but are experience by individuals idiosyncratically, and took an inductive approach to analysis which was data led, and identified both semantic and latent codes. It was conducted following three key stages; firstly line by line coding was undertaken of individual interviews by LW, then codes were then translated across interviews, and finally analytical themes were developed and agreed upon by the research team.

Results

A total of 18 potential participants were approached to take part in the study and four refused as they did not want to undertake and interview about their experiences of inpatient care. A final total of 14 participants took part, four male and ten females, and the average age was 54.29 years. Further demographic details can be found in table 1.

[INSERT TABLE 1 HERE]

A total of four themes and sixteen subthemes were identified and are outlined in table 2. The four themes were "A turbulent journey to hospital admission", "I need information and support", "maintaining my relationship with my loved one", and "inpatient care is a mixed bag".

[INSERT TABLE 2 HERE]

A turbulent journey to hospital admission

This theme outlines how the journey to admission was a very turbulent and challenging one with things having to escalate before help is given. This was often cited as the most difficult and part of the inpatient care journey.

A struggle to get help

The majority of participants described extreme difficulty in getting help prior to admission. Participants often described having to access multiple services and being passed between services before getting the help their loves one needed. This was often a frustrating and exhausting process and ultimately led to things escalating. This was exacerbated by COVID-19 due to services not operating at their usual capacity.

"the original erm going into [General Hospital] and basically it was like talking to a brick wall about it, and… the, the team from [MH Hospital] did say that it was very bad that she was let out in the state she was let out, erm, that is … But obviously he [General Hospital Consultant] was unaware of the erm severity of her, her… paranoia, hearing voices so… but he obviously, he didn't speak to the other team at [Outreach Team]" (participant 5)

Things have to get worse before they get better

The majority of participants described that things had to escalate before they could get help. Participants described a lack of community services support, partly explained by COVID-19 related closures, and that their loved one's presentation had to be at high risk before they got admitted to hospital. They

described having to personally manage high risk behaviours before they got help which was extremely distressing.

"this went on for 10 days, until it was it was dangerous, I couldn't stay in the house, his brother's girlfriend couldn't stay in the house, we [inaudible] all the knives, he, you know, he, he, did various things. So erm… the EIP [Early Intervention in Psychosis team] were trying to get erm er something to go through to get get him back into hospital, but it was taking a very long time so erm again we called the paramedics and ambulance, he went back into hospital" (participant 10)

Distressing psychosis and behaviours

Participants described that their loved one presented with distressing experiences of psychosis, confusion, and high-risk behaviours prior to admission. Participants described their loved one as being very aggressive towards them or at high risk of harming themselves. Despite these difficult experiences, participants often explained that their loved one did not believe they needed mental health care or support.

"she went to hospital herself to say that she is seeing things, she may have been hearing voices to jump over the balcony of her flat and so in the end she got admitted anyways after going through three different hospitals" (participant 7)

Emergency services involvement in admission

A large majority of participants described having emergency services (police and ambulance) involved in their loved one's admission. This was seen as a traumatic and stigmatising experience due to their loved one's neighbours witnessing them being taken away by the emergency services.

"mum's just moved into this new residential place, and she's been there like two years … and, you know for the police to have been outside her house, the ambulance, and for them to hear how she… she was carrying on, it's, it's, to come back to that, … it's like um an older people's block and you know people like to talk. So… I just think it's gonna be quite upsetting for her…" (participant 2)

"so then we had to wait for the police to come… cos she wouldn't come out of her house, so we had to wait for the police to come… she was screaming and carrying on when the police tried to take her out so they said no it was gonna be too much, so they had to get erm some, another paramedic to come and give her a sedative to get her into the chair which then, erm… they took her to the hospital" (participant 6)

I need information and support

This theme outlines how the participants' key priorities were to be informed and have access to support, which was rarely given.

Limited communication and left wanting more

The majority of participants described that they had minimal contact with staff and did not get access to relevant information on their loved one's care. Ward round, which was conducted remotely due to COVID-19, was often the only opportunity to get an update. Participants felt that the lack of communication was impacted upon by COVID-19 and stretched NHS resources and were understanding of this but still felt that more needed to be done to keep them updated. This lack of contact was upsetting and frustrating for participants. However, a small handful of participants felt that they were adequately kept up to date.

"they were just saying sort of erm took her to the hospital, which we were very relieved about but erm in the early days I think with the COVID-19 happening erm we didn't get a chance to have that you know first meeting like we've admitted her we think this is what's happening and we going to try this medication and this kind of thing, so it was all information wasn't given to us straight away" (participant 9)

The majority of participants were keen to be heavily involved in their loved one's care and wanted to keep up to date with care plan and progress. However, participants often described having to constantly calling the ward and feeling like their contact was unwanted. One participant described feeling forgotten and abandoned.

"[I would like information on]…how she's doing, and I guess maybe when they are thinking of potentially – that she'll leave the hospital, just because of accommodation after, whether she'll go back to her original home or whether she'll go to a residential home, so, keeping updated on that, cos one thing – obviously I work, so I wouldn't want it sprung on me, a decision" (participant 1)

"you don't get the proper information, you don't get care plans, you don't even get any input into it, which I think it would be useful if I did and so you kind of feel used and abused, forgotten and abandoned, picked up again" (participant 11)

Psychoeducation and clear information on mental health care needed

Participants described wanting more knowledge on the Mental Health Act (MHA), mental health diagnoses, and mental health care but did not feel that the hospital staff provided them with this. Participants often described having to research this information themselves to ensure they were empowered and able to meaningfully contribute to discussions about their loved one's care.

"but it feels like you need something for families just so that they can erm just have somebody they can talk to to go, right this has happened so what does this mean? Erm like the difference between section 2 and section 3, and erm what is it section 5 or some – whatever the other one is, the temporary one" (participant 12)

"I wasn't going to be one of these people that would sit there and be told, you know I you know I was very proactive in researching the right questions, what sort of medications is she on, why have you given her that medication, how many milligrams, how many times a day, have that all written down" (participant 13)

Carers need support too

Participants understandably found their loved one's admission an upsetting experience with lots of conflicting emotions. Participants also described the challenges of having to manage difficult and aggressive behaviour from their loved one. They described lasting impacts of having a loved one with significant mental health difficulties and identified that they needed support too. A number of participants reported having their own therapy in the past.

"I am a distressed mother, I have never experienced this before, everything is very very strange, everything is quite a challenge, everything is quite scary" (participant 13)

"I was offered some therapy, think it was during the winter this year yeah from about November to January" (participant 10)

Maintaining my relationship with my loved one

The next theme outlined the importance of maintaining contact and building their relationship with their loved one.

Visits and telephone contact are a lifeline but extremely challenging

Visits and contact with their loved one was the participants' number one priority however there were always challenges with having this contact.

"for the first week I didn't see her, then I saw her for the first time after a week, and erm I want to see her as often as I could, because er you know, just to try and keep her spirits up, erm let her know I am still thinking of her" (participant 2)

Participants reported that visits were limited to one weekly due to COVID-19 restrictions and could only book one visit a week but had significant problems with the booking system.

"The communication is – and then another thing they didn't tell me that she was only allowed one visit a week, so then, my son then tried to book a visit, and then they said oh no, she's already had a visit this week. So it's like they could have at least told me like the erm… Why do we have to find out after we've already tried to see her or go and visit her, you know?" (participant 6)

Riding the wave of inpatient care and the impacts on the relationship
Participants described having a number of ups and downs in their relationship with their loved one. The admission experience was a particular challenge to the relationship with a number of participants describing that their loved one blaming them for their admission. However, generally participants described that their relationship improved during the course of inpatient care.

"She was a bit pissed off when she the day she got to the hospital, she phoned us, she said I'm really upset with you and [other family member] because you were there with the doctors and you're the ones who sent me away so she was upset, then the next day when we went to see her she was fine" (participant 14)

Offering flexible support and being there
Participants described their role as providing flexible support and being there for their loved one. This included emotional support, practical support and bringing in supplies and being an advocate for their loved one.

"So I've been her carer. I've had to take her food while she was there, erm had to encourage her when she was crying, had to be her comforter, you know just all the things a normal mother would be" (participant 3)

Inpatient care is a mixed bag
This theme outlines the conflicting reports from participants about the inpatient care experience where both positive and negative experiences were identified. Participants often personally felt conflicted about hospital care and often felt a sense of relief but were also concerned about the care and treatment their loved one was receiving.

Medication is the primary treatment

Medication was outlined as the primary treatment option in inpatient care, which had its positive and negative aspects. Some participants felt that medication was a lifeline and crucial to their loved one's recovery, whereas some felt that the ward needed to go beyond this to help their loved one along a path of recovery.

"you know because the medication is given and by the grace of god erm you know I can say I have got my daughter back" (Participant 13)

"I've always thought it's, I've I've always seen the medication's just a sticking plaster. Erm there's only so much it can do, erm and you don't want to be on it forever because some of them have" (participant 12)

Holistic care wanted but not always received

Participants wanted their loved one to have a holistic care package which included a schedule of meaningful and therapeutic activities that they could access but most participants were not satisfied with what was on offer. Some cited that they believed COVID-19 restrictions were partly to blame, for example all service users had to self-isolate for their first seven days of admission or until a negative test result was return, which impeded their ability to access activities, and less group activities were running due to social distancing measures.

"I think erm the food she she was actually happy with towards then end before she wouldn't even touch the food, but the food she was enjoying, also the activities like the knitting, erm likes my she's knitted before but she hasn't knitted like for a long time" (participant 9)

"I was saying to her do, do, do you lot not get any therapy? You know because my mum was talking so much, and the things she was coming out with was from way like the past, she was talking about erm like me when I was a baby, she was talking about things on her childhood, all different things and I said maybe she needs like, talking therapy, some sort of therapy" (participant 6)

The importance of staff continuity and relationships

Participants valued having caring and patient staff who had been able to build meaningful relationships with their loved one. Unfortunately, these were few and far between and participants described the majority of staff as uncaring and unknowledgeable about their loved one's needs.

"We've been very lucky with that, erm, there was only one time she had a different one and that's cos she was on a different ward, erm we we know we've lucked out being able to get the same ward five

times out of six. Erm so that's helped because the staff have got to know her very well and they've got to know me very well, and that has helped a lot" (participant 12)

Is my loved one in a safe therapeutic environment?

Participants understandably described wanting their loved one to be in a safe therapeutic environment where their basic needs were met. However, the majority of participants described the inpatient environment as untherapeutic and unsafe due to restrictive practices, difficult peer relationships, and poor environmental resources (e.g. lack of a private working shower and toilet).

"yeah it was during the time of the fighting because because she had a fight with, with somebody there so that was a bit worrying and difficult for me to understand why didn't she go and report, why did I revenge you know because if you revenge you" (participant 7)

"then this year he was on a section 2 at [MH Hospital] for a month, and erm in his words erm that's just he said that's just, it's a prison mum, it's a holding station" (participant 10)

Collaborative discharge planning is essential

Finally, an important part of inpatient care was collaborative discharge planning, however again a large number of participants did not feel that this was the case. They often were either not informed about discharge or were informed last minute. Also, they did not feel that their loved one's longer term needs were considered.

"just keeping me up to date on things, and who's sorting out what – um so whether it's the hospital or if I need to do that or someone else needs to do that, and who to contact and all that sort of stuff. And I guess, ongoing support if she is discharged, so will she have a social worker will she be monitored and those sorts of things, so I guess it's more the after plan and what's in place and the numbers I need to ring and all that sort of stuff" (participant 1)

Discussion

This study aimed to qualitatively examine the needs of family and carers of people experiencing psychosis and receiving acute mental health inpatient care conducted during the context of the COVID-19 pandemic.

The first theme "a turbulent journey hospital" highlighted that things had to get significantly worse before help was given. Participants had extreme difficulty accessing support in the community and largely managed to access hospital via emergency services or via a general hospital admission. This appeared to be exacerbated by COVID-19 restrictions. Participants' loved ones had to present with highly risky behaviours, such as physical violence or suicide, before help was given, which was very distressing for carers. It has been identified in previous qualitative literature that the days building up to a hospital admission is extremely overwhelming and distressing for carers (Wilkinson & McAndrew, 2008; Jankovic et al., 2011).   However, the findings from this may reflect that the threshold for admission is even higher for service users to be admitted to the ward, with only those with the highest risk of harm to self and others being admitted (Kings Fund, 2015). This threshold has since increased in recent months with inpatient wards trying to keep occupancy at a lower rate to manage COVID-19. Another interpretation is that people experiencing psychosis may have more difficult accessing appropriate help therefore leading to more restrictive forms of practice and sectioning due to the perceptions of unpredictability and high risk, which has been demonstrated in previous research particularly for ethnic minority service users (Halvorsrud et al, 2018).   Nevertheless, a result of this situation is family and carers having to manage very risky behaviour with limited support.   This demonstrates a need to improve support given to family and carers of service users with psychosis from crisis home treatment team service when service users are experiencing a crisis but not meeting the threshold for admission. This may demonstrate that more intensive crisis home support is required for this population.

The theme "I need information and support" outlined the importance participants placed on being kept up to date and included in their loved one's care, as well as their need to be supported. However, most participants felt that this was not the case, which is in line with previous research outlining the family and carers often feel excluded from their loved one's care (Giacco et al, 2017; Hickman et al, 2016; Stuart et al., 2020) . This appeared to be exacerbated by COVID-19 where communication and opportunities to be involved were further limited and undertaken remotely. This demonstrates the importance of carers being as involved as possible within their loved one's care, particularly when key decisions are being made, and regularly updated on progress, which support recommendations from previous research (Wilkinson & McAndrew, 2008; Olasoji et al., 2020). Further research should examine interventions to improve carer involvement in inpatient care to ensure it is an integrated part

care delivery. A recent study identified that it was feasible to integrate structured clinical procedures for carer involvement in inpatient care (Kaselionyte, Conneely, & Giacco, 2019) but further large scale research is needed.

Carers also wanted opportunities to gain some support for themselves but this was not available to them demonstrating that inpatient care should offer a carer support and information service. This again supports previous literature which outlines that carers do not feel adequately supported with their own mental health and emotional needs (Jankovic et al., 2011; Stuart et al., 2020) and the importance of offering this during a loved one's inpatient admission (Jankovic et al., 2011; Hickman et al., 2016) . The theme "managing my relationship with my loved one" highlighted the importance of maintaining contact with their loved one and (re)building their relationship throughout inpatient care, which was a challenging process mainly due to practical restraints such as having difficult phoning the ward and limited visitations. This demonstrates the importance of the wards prioritising contact between service users and their family as it was highly valued when this was facilitated, which again has been highlighted in a previous systematic review on this topic (Stuart et al, 2020).

Finally, the theme "inpatient care is a mixed bag" demonstrates the positive and negative components of inpatient care with participants feeling very concerned about the quality of inpatient care. This is in line with previous research which has demonstrated that carers often have conflicting experience and emotions about inpatient care (Stuart et al., 2020). There were a number of examples of positive practices but these were overshadowed by negative and unprofessional practices from inpatient staff. Participants were very clear on what needed to be put in place including a holistic care package, regular activities for service users, meaningful and caring relationships with staff, and collaborative discharge planning. These are all essential components of inpatient care as outlined by the Accreditation for Inpatient Mental Health Settings (AIMS) criteria (Royal College of Psychiatrists, 2010), however there appear to be clear implementation issues with the delivery of these components of care, which are likely to be impacted upon by COVID-19. However, further research should be undertaken to examine the implementation issues related to the delivery of inpatient care.

Recent COVID-19 related research has demonstrated significant impacts of COVID-19 on mental health services, which was evident throughout the whole analysis. As outlined in the introduction, a recent large-scale mixed methods survey demonstrated that UK NHS mental health services had to go through rapid adaptations to respond to the COVID-19 crisis including ensuring inpatient care was in line with current infection control procedures, and remote working (Johnson et al., 2020). NHS workers reported a number of challenges as a result including concerns that COVID-19 will spread between service users, a lack of activities/increased boredom, the risk that staff will be infected, having to adapt too quickly to new ways of working, and difficulties discharging because of less services being available

in the community. In this research, it was clear that COVID-19 had impacts on care access, care quality, and contact with their loved one mirroring these concerns. Further research which explicitly focuses on the impact of COVID-19 on inpatient care should be conducted.

The are a number of strengths to the study. It is the first study that we are aware to have interviewed family and carers of people experiencing psychosis and receiving inpatient care during the COVID-19 pandemic. It was able to identify key challenges that family and carers have faced from inpatient care during this time. Moreover, we were able to purposively recruit a representative and adequately sized sample from a wide age range and ethnic backgrounds, which is reflective of the inpatient population. However, we were reliant on the ward staff for referrals which may have meant that views from families and carers with poorer relationships with the team may not have been identified. The study also followed the COREQ (Tong et al., 2007) best-practice guidelines for conducting qualitative research. In regard to limitations, this study had to conduct the interviews in a number of different formats including face to face, by phone and via video, which may have impacted on the quality of information gathered. There were some connection issues which impeded the flow of the interviews. Moreover, we were dependent on very busy staff for recruitment and therefore recruited mainly from two key wards. Therefore, the participants' reports were limited to only a couple of inpatient settings. In addition, we recruited from a diverse population but our aim was not to examine difference in experience across ethnicity, therefore we cannot determine if service users from different ethnic backgrounds had different experiences of inpatient care. This should be further examined in future research.

In summary, inpatient care is a necessary service which provides intensive care to those as high risk of harm. However, it is clear that family and carers do not feel included in this care provision despite being extremely important to the care outcomes of service users. COVID-19 appeared to exacerbate difficulties the family and carers experienced but nevertheless this research outlined key areas of service improvement required to ensure it meets the needs of service users and family alike.

Relevance for Clinical Practice

This study demonstrates how family and carers largely feel excluded from acute mental health inpatient care and this appeared to be exacerbated by the COVID-19 pandemic. This is concerning given that recent policies such as the National Carers Strategy and NHS Triangle of Care outline the importance of collaborating and supporting family and carers (Department of Health, 2010). Moreover the AIMS criteria explicitly identify that carers should be involved in processes such as treatment decision making and discharge planning and be offered carers support (Royal College of Psychiatry, 2015). This study demonstrated that family and carers prioritised having positive working relationships with staff, being kept informed and up to date on their loved one's inpatient care and being able to keep in regular contact with their loved one even if it was by remote means. These are things the acute mental health inpatient

staff should be prioritising for service user's family and carers.

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Tables

Table 1: Demographic information of sample

Demographic Information		X (range)
Age		54.29 (23 – 88)
Category	**Sub-category**	**N (%)**
Gender	Male	4 (28.6%)
	Female	10 (71.4%)
Ethnicity	White British	6 (42.9%)
	Black African or Caribbean	6 (42.9%)
	British Asian – Chinese	1 (7.1%)
	Other	1 (7.1%)
Relationship to service user	Partner	3 (21.4%)
	Parent	5 (35.7%)
	Niece/Nephew	2 (14.2%)
	Sibling	1 (7.1%)
	Aunt/uncle	1 (7.1%)
	Son/daughter	2 (14.2%)
Service user diagnosis	Psychosis	4
	Schizophrenia	6
	Depression with psychosis	2
	Schizoaffective disorder	1
	Not known	1

Table 2: Superordinate and subordinate themes

A turbulent journey to hospital admission	I need information and support	Maintaining my relationship with my loved one	Inpatient care is a mixed bag
A struggle to get help Things have to get worse before they get better	Limited communication and left wanting more Seeking involvement and feeling like a burden	Visits and telephone contact are a lifeline but extremely challenging Riding the wave of inpatient care and the	Medication is the primary treatment Holistic care wanted but not always received

Distressing psychosis and behaviours Emergency services involvement and sectioning	Carers need support too	impacts on the relationship Offering flexible support and being there	The importance of staff continuity and relationships Is my loved one in a safe therapeutic environment? Collaborative discharge planning is essential