ORIGINAL RESEARCH

Enhancing the therapeutic interaction skills of staff working in acute adult inpatient psychiatric wards: Outcomes of a brief intervention education programme

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ABSTRACT

Background and objective: Clinical practice in acute inpatient environments is complex and demanding for clinical staff. To facilitate service user recovery, it is essential that personnel working in these environments are competent and confident in a range of therapeutic interaction skills, which can have impact in a brief period. This paper describes an exploratory study which determined the outcomes of a brief therapeutic engagement education and training short course for staff working in adult inpatient acute wards. As far as we know this was the first time, based on evidence from earlier research involving service users that Heron's Six Category Intervention Analysis and solution focused brief therapy (SFBT) have been combined in an education and training short course that was coproduced and delivered in partnership with service users for staff working in acute environments.
Methods: The short course explored the myriad applications of the six categories of intervention initially proposed by Heron and the widespread applicability of SFBT. The programme evaluation adopted focus group methodology and examined: (1) how useful the training content was to daily practice and how relevant the skills learn were to interactions with service user residing on the ward; (2) the factors than helped enable the transference of the learning to the ward environment as well as any barriers; (3) personal learning; and (4) strengths of the learning experience and suggestions for improvement to the training and learning experience.
Results: Feedback from participants reflected a high degree of skill and knowledge acquisition and enhancement. Staff found the content of the training useful and helpful to their daily practice as it aided in increasing confidence, therapeutic interventions and care-planning. Skills learnt by the trainees were considered relevant to interactions with service users residing on the ward. Factors that helped to enable encounters with service users, as well as the barriers, when transferring the learning to the ward environment were discussed and included managerial support, demand for beds, time, opportunity and staffing shortages. Regarding personal learning, staff reported feeling more able to connect with service users when employing SFBT techniques and Heron's intervention approaches and felt that the training validated their current working practice.
Conclusions: The SFBT training appears to have provided an interactional communication toolkit for healthcare professionals and could be further embraced given the right circumstances e.g. managerial support and attitude change of nursing staff in general. Further research is needed to gain an understanding of the effect of short and concentrated education and training programmes aimed at staff members working within adult acute inpatient mental healthcare settings, as well as measuring whether the activity, i.e. healthcare professional–service user interactions, is meaningful to service user outcomes.

Key Words: Focus groups, Healthcare professionals, Heron's Six Categories of Intervention, In-patient, Mental health nursing, Service users, Solution-focused brief therapy, Therapeutic engagement

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1. INTRODUCTION

Working in acute inpatient environments is a challenging position for staff given the elevated level of acuity of service users, demands on staff time, variability of staff's skill mix and use of agency nursing staff. To enhance service user recovery, it is important that they have access to treatment, interventions that will enhance their coping skills and make best use of their current coping mechanisms. Given the acute nature of in patient environments, it is essential that all staff are highly skilled, can intervene quickly and offer hope to service users to prepare them for the future. Partnership working is an important part of therapeutic engagement in the recovery process where service users are equal contributors to their journey. For this reason, it is necessary for staff to have skills that demonstrate this.

The rudimentary skills of solution focused brief therapy (SFBT) can be learned fast and offers a charter for healthcare professionals' interactions.[1] Acquiring SFBT skills means that care staff-service user interactions will be more purposeful, positive and make aspirations seem more achievable. The ideology can enable service users to be directional in their thinking and empower them to chart their progress towards recovery in partnership with healthcare professionals.

There are some indications from the literature that the application of such an approach may positively impact on healthcare professionals' willingness to communicate with service users and that the use of SFBT may help healthcare professionals develop a collaborative, goal-oriented approach to working with service users.[2] Sound therapeutic communication affords service user dignity and respect as healthcare professionals consider their perspective.[3,4]

An underpinning element of any service user-staff interaction is respect, dignity, honesty and the generation of hope- valuing the person as an individual too. That is where Heron's Six Categories of Intervention has a role.

Heron's six categories of intervention

Heron's Six Category Intervention Analysis[5] provides a framework for healthcare staff delivering help, care and/or treatment. This framework addresses the need for service users to be treated with greater dignity and respect by healthcare personnel, to be given more information about their care and/or treatment plans and be "heard".

Essentially, Heron's model consists of two main categories of interactions authoritative and facilitative: 1) authoritative - the person intervening is giving information and challenges the person they are helping and suggesting what they should do. The 3 types of authoritative interventions are prescriptive i.e. you explicitly direct the person you are helping by giving advice and direction, informative i.e. you provide information to instruct and guide the other person, confronting i.e. you challenge the other person's behaviours or attitude in a positive and constructive manner (not aggreesively). 2) facilitative-the person intervening is drawing out ideas, solutions to help build the self-confidence of the person they are helping to reach their own solutions and/or decisions. The 3 types of facilitative interventions are cathartic i.e. you help the other person to express and overcome thoughts or emotions that they have not previously confronted; catalytic i.e. you help the other person reflect, discover and learn for themselves, self-directing in making decisions, solving problems etc; supportive i.e. you build up the confidence of the other person by focusing on their competences, qualities and achievements.

Much of the published research on SFBT has not been in the central domain of inpatient care however mental health nursing staff is best placed to lead in this area by conducting studies to determine the appropriateness and effectiveness of this approach due to the demand that clinical practice should be firmly rooted in evidence of clinical and cost-effective rigors. Studies should ensure that nursing staff can evaluate this approach and to express their views on the acceptability and utility of the integration of SFBT approaches in their routine practice. This study is the first time that Heron's Six Categories of Intervention and SFBT have been combined as a training course for psychiatric nursing staff.

SFBT is a systems therapy i.e. explores behaviour patterns and human experience. The ideology is simple and aims to discover "what works" in each situation, simply and practically for each individual service user. The focus is positivity of all things – discussions centre on solutions, not problems, the future not the past and on what's going well rather than what's gone wrong. Solution-focused conversation is potentially something that all health and social care professionals can and should partake in and has already been used in a wide variety of different settings.[6] Health and social care personnel can use this ideological approach to form a meaningful therapeutic communication with service users who are and can get distressed.

SFBT stresses the need for service users to be more involved and active in decision-making surrounding their care and treatment which can lead to effective therapeutic engagement.[2] SFBT appears to share many of the values and principles of healthcare professionals by appreciating the cooperative nature of the therapeutic relationship and acknowledging that service users themselves have the abilities and resources to initiate positive change regardless of the clinical setting and/or health problem.[7]

Data suggest that SFBT techniques are congruent with the philosophical underpinnings of contemporary mental health nursing and can be safely incorporated into nursing practice.[1] This approach seems to be valued by an increasing number of nurses due to its brevity and effectiveness in enpowering service users to find solutions that will help them to deal with the challenges brought to them due to their ill-mental health.[8] Health professionals working in acute inpatient mental health settings should be armed with sound communication skills as part of their therapeutic toolkit. This is the crux of working with service users. SFBT principles therefore sit well within this area of nursing to boost therapeutic engagement between healthcare professionals and service user.

A range of mental health problems including depression and psychosis are considered receptive to SFBT across a variety of mental health settings.[6,9–11] Solution focused approaches have been described in mental health nursing clinical practice and research,[12–15] as well as healthcare professionals education, training and practice development.[16–19]

Webster et al.[20] and Vaughn et al.[21] describe the implementation of SFBT principles to an acute inpatient unit. Their research showed less ward conflict and more consistency between staff members; there was also a decreased length of stay by service users and no increase in re-admission or adverse events. Stevenson et al.[12] and Hosany et al.[2] both describe SFBT training programs for mental healthcare professionals in acute inpatient units in the UK. Positive results were also obtained. Service user feedback was reported by Stevenson et al.;[12] service users stated that they felt that their problems were addressed and that they were "heard" and understood. There was also a perception of hope and a sense that service users were more able to shift their thoughts toward a future orientation aiding recovery.

To the authors' knowledge, there are no known adverse effects of training staff in SFBT and the limited published literature available suggests that many acute psychiatric inpatients may find these approaches more beneficial than "treatment as usual".[2,22]

Key elements of SFBT include:

1) Miracle question

This question asks service users to imagine and describe how the future would or could be different when the problem no longer exists.

2) Exception-seeking questions

These questions identify times when the service users' problem(s) are less severe or even absent. Service users are encouraged to identify when and how these situations arise and discuss how they can be maximised so gain their ideal future or goals.

3) Coping questions

These questions seek to identify how the service user copes with setbacks and/or ongoing difficulties so that positive coping mechanisms can be identified, supported and reinforced.

4) Scaling questions

These questions help service users subjectively track the quantify and track their experiences on a simple 1-10 graduated scale and challenge "all or nothing" thinking with the goal of desirable outcomes.

Much of the published research on SFBT has not been in the central domain of in-patient care. Mental health professionals can lead in this area by conducting studies to determine the appropriateness and effectiveness of this approach given that clinical practice should be rooted in evidence and cost-effectiveness.[2] Studies should ensure that healthcare professionals can evaluate this approach and express their views on the acceptability and utility of the integration of SFBT approaches in routine practice. This study is the first time that Heron's Six Category Intervention Analysis and SFBT have been combined as a training course for mental health professionals.

2. STUDY

2.1 Aim

The aim of this small study was sought to determine the outcomes of a short training in therapeutic interaction using a combination of Heron's Six Categories of Intervention and SFBT for staff working in adult inpatient acute wards to examine: 1) the knowledge and/or skills that were acquired during training, 2) to examine any application of techniques/approach in the clinical work of nursing staff, 3) to identify any barriers encountered to using techniques/approaches learnt and 4) to identify any benefits and/or improvements needed to the training as identified by nursing staff. This course was developed and delivered in partnership with service users.

2.2 Method

All members of the in-patient team from adult acute inpatient psychiatric care wards/units in a Mental Health Trust in the South of England were invited to undertake the training. The number of beds in each ward/unit ranged from 18 to 23. Service users residing in the units were a combination of detained and voluntary residents. The respective managers of all wards were very supportive of the intervention and

wished staff to benefit.

The staff members completed a 4-day training on programme on Heron's Six Category Intervention Analysis (2 days) and SFBT (2 days) (see Table 1). All the staff were released from work for one day a month for 4 months for the training i.e. 4 days training period. Each training session lasted for 6 hours. As "homework" course participants were expected to record and report back on an interaction they had with a service user that outline the skills used that were rehearsed during the preceding training days. They were also required to consider what they did well and what could have been enhanced. This was in an attempt to integrate theory and practice and encourage reflective practice.

Table 1. The training programme

▪ Days 1 and 2: Heron's Six Category analysis of framework
▪ Days 3 and 4: SFBT
▪ Day 4: Philosophical elements of recovery and their integration into practice

Twelve members of staff that included registered mental health nurses, a ward manager, a deputy ward manager, healthcare assistants and an occupational therapist participated in this 5-month follow-up study. Four female and 8 male staff members were recruited to the study. Staff members had varying degrees of clinical experience (2-30+ years; staff grades 3-7); the majority being a staff nurse grade 5 (42%). Most participants (50%) reported having 4-7 years of mental health work experience. The participants were essentially from 4 different ethnic groups; most of the participants were British. Ten participants reported having some knowledge of SFBT and theses participants reported having previous vocational training in SFBT.

2.3 Data collection

Focus groups were chosen as the method of data collection offering the opportunity for peer support, exchange of ideas and sharing of common values.[23,24] Guidance questions based on a literature review and expert knowledge of mental health professionals (academic and clinical) were formulated based upon a developed focus group schedule. All the focus groups were carried out by one experienced researcher. Focus group size varied from 2 to 4 nurses. The group that had only 2 participants consisted of 2 registered mental health nurses and was undertaken like a "dyadic discussion" with a facilitator. Each focus group lasted approximately 25 minutes (due to time constraints of nursing staff and staff-service user ratios on the wards), and were audio-recorded. Participants contributed to one of 4 focus groups, on one occasion. The focus groups were held on the ward where participants were working. During the focus groups, all the healthcare professionals who undertook the training were invited to discuss how the training programme had (or may in the future) influenced their subsequent clinical practice. The following topics were addressed: *usefulness of the programme content to daily practice, relevance of the skills training to service user interactions on the ward, personal learning, and factors that enable interactions with service users when transferring the learning to the ward environment plus any barriers to this.* Participants were also asked to discuss the strengths of their learning experience and managers present asked for suggestions on how the training could be improved. It should be noted that it was not determined in this study if the presence of senior ward staff impacted on group dynamics though it was noted that the atmosphere was affable.

Approval to conduct the focus groups was obtained from the Mental Health NHS Trust's research and development committee as well as permission from the Director of Nursing. All participants were informed of the nature of the study via an invitation email and participant information sheet and their written informed consent was obtained prior to their participation. All participants were assured anonymity and confidentiality and informed they could withdraw at any time from the study without consequence.

3. RESULTS

The topics that were addressed in each of the focus groups are discussed below with verbatim illustrations from the focus group transcripts.

All trainees gave positive feedback about their learning experience. There was consensus across the 4 groups that the programme content was sound and reflective (around therapeutic communication skills), the teaching pertinent and that a lot had been achieved in a brief period. Trainees (70%) stated that they had learned new and valuable skills for interacting with service users and that they were incorporating them in the implementation of service user recovery care plans. Participants also reported feeling more confident interacting with service users in their charge as the programme broadened their understanding on how to relate to service users.

All participants felt that the use of SFBT techniques and Heron's approach promoted a culture of increased engagement with service users by staff focusing on the strengths of service users when advance care-planning i.e. advanced directives. Staff participants also reported that the skills learnt were of real value to service users during their one-to-one sessions with them. Effects of training seem to be a more positive regard for service users and better therapeutic interaction in general.

3.1 Usefulness of the programme content to daily practice and relevance of the skills training to service user interactions encountered on the ward

Overall, all aspects of the training content were believed to be highly relevant to practice especially the "miracle" and "scaling" questions

> "Aims of patients come out when you ask the miracle question, when you ask them about recovery goals" (FG1).

Staff responses suggested that a marked change had occurred their interactions with service users

> "The majority of our team did do the training and we've adapted it to our way of working" (FG1).

It was evident that staff felt that they were doing better work with service users

> "I think it's (training) relevant to people with contact with service users irrelevant of their clinical environment (ward based or community based) as you are going to have a chat with a patient and see what is wrong with them and have recovery goals with that patient" (FG1).

Staff stated that they were more confident in having one-to-one therapeutic conversations with service users and felt able to use their newly acquired skills, time, opportunity and service user interest permitting

> "We found it very difficult to do it and worried about the response of the patient but the training we know how to act now. . . the training showed it is the manner in which you ask the patient and the tone of your voice", "Doing this training there are certain things I used to do and I used to think, am I doing the right thing or not, and this training made me feel that I was on the right track and then I just continue to do the same thing", "Certain issues I found difficult to handle, now I can handle them on my own" (FG1).

The training seemed to assist the staff when doing care plans with service users; the "miracle" question,

> "helped patients to think about their future" (FG1).
>
> "I incorporate this in care plans now" (FG2).
>
> The training, "Helped to identify goals and things they would like to do and their interests and aims", "Aims of patients come out when you ask the miracle question when you ask them about recovery goals", "It's more client orientated, it's what the client wants. Previously the client comes to the ward and we do a care plan for them; now we get the clients involved in the care we are giving. We use these approaches to do an effective care plan" (FG3).

Mental health clinical practice is founded upon positive therapeutic interactions with nursing staff utilising sound communication skills with service users.[25] This programme aimed to teach positive, solution focused communication between mental healthcare professionals and services users. Attending this programme imparted to staff a range of skills such as strategies for improved listening, increased confidence and empowering service users to search for their own answers giving them more responsibility towards their recovery

> "I think this course is relevant for those who are in contact with service users because it does incline on them how to form therapeutic relationships with the patients and how to solve some of the their problems based on a two way system which means helping the patients out, I've use it so I know how effective it can be with clients who are willing to engage; you can get lots of information with the relevant techniques" (FG3).

There were views that team relations on the ward had advanced since the training

> "On a shift basis, conversations are noted formally now, more emphasis on this since training, previously before the training we didn't have emphasis" (FG2);
>
> "Training has been positive and helpful. At times, you engage a patient and you can discuss with others how you got that information" (FG3).

3.2 Enabling factors and barriers encountered when transferring the learning to the ward environment

Staffing shortages and lack of time put huge constraints on the uptake of education or training and subsequently implementing what is learned into practice

> "Going for training impacts on staff on the ward" (FG4).

Enabling factors and barriers were encountered when transferring the learning to the ward environment

> "More opportunity for community staff to engage with patients daily as you are dealing with more settled patients as they are in their own home with no pressure. For those that want to see you they will give you their attention. We deal with unsettled patients–we don't have the time as they are unwell and you can't really utilise these techniques. When they are getting well and you can start implementing these techniques they move on" (FG2).

Apprehension on the part of service user about being moved to another ward could be considered as a barrier. If a service user reports that they are coping better and there is a shortage of in-patient beds then it is likely this person will be moved to another ward

> "Is the patient willing to engage with you? (FG1); *"Some of the clients are disinterested"* (FG3);
>
> "It ('coping' question) can make the patient a bit confused because the patient will think I'm getting better so why are you moving me? So, back to square one. When you ask them this question, how are you coping? When they tell you that they are coping alright, you move them, the chances of them being moved is higher, so it is mixed messages", "it's not that you are not confident in using the coping question technique it's that you are apprehensive about what the person is going to say, their response" (FG2).

Lack of time and opportunity were deemed as other barriers to adopting learnt techniques and approaches on the ward

> "In the last few months I have to say that I haven't been using what I learnt alot as we don't often have the patients for too long so we don't get the opportunity" (FG2);
>
> "Not sure how much it is being used on our ward as the circumstances on our ward are such that the staff struggle with offering consistent 1-1s and having the time, as we have a high turnover–close observations impact on the staff's ability to devote time for therapeutic 1-1s" (FG4);
>
> "...so they usually happen in the corridor" (FG2).

Pressure of beds was also an added factor which hindered staff in adopting techniques and approaches

> "If a patient is not settled you cannot start doing the 'scaling' ('scaling' question) with them. When it gets to the point when you want to start doing the scaling techniques with them they must move on. The problem we have now is the pressure of beds" (FG2).

Many staff complained that more senior staff e.g. ward managers, should be privy to this situation or do something about it if they are aware of it

> "They know from the top but they don't do anything. At the end of the day you want to come on duty and chat with the patients but there is not time", "People at the top should be on the ward to see what is happening. They just sit in the office"; "The people at the top should come and attend some of the staff meetings so we can say things of concern to them" (FG2).
>
> "I would worry about these skills being lost because of not being used consistently; concerned about our ability to carry out what we've learnt from the training in our day-to-day jobs due to the acuity on the wards and the staffing levels" (FG4).

To avoid these learnt skills being lost staff suggested that perhaps,

> "Increase number of staff members on ward. Think of health and safety of the staff" (FG2),
>
> senior members of staff to discuss things with staff members on the frontline "... so that they can express their feelings" (FG2),
>
> a further suggestion was that ward staff should have the opportunity to discuss things with one another "Would like to liaise/chat with other staff but the patients come first and there is no time" (FG2).

3.3 Personal learning and strengths of the learning experience

Staff reported feeling more confident and able to engage with service users using the learnt techniques and approaches

> "The training served as a reflective practice" (FG1),
>
> "Course taught me to engage with patients in a better way, in ways that I was weak in, areas

that I hadn't concentrated on in the past e.g. taking medication, speaking to them about things I wouldn't have before like family, situation at home" (FG3),

"Regret not doing some of the homework , missed opportunity; I really enjoyed it especially now that I am putting it into practice" (FG3).

"Staff are now informing service users that they will be note-taking/documenting conversations, which was not done previously–this keeps the line of communication open and honest" (FG3).

Staff reported that the course validated what they were already doing

"Could relate a lot of what we were already doing with the techniques that we learnt. In our day-to-day nursing, we were already doing the techniques but we were not aware of what they were called. When we were doing the course, we could identify the things that we were already doing" (FG4).

The skills learnt aided staff to help service users reflect about their own life using the "miracle" and "scaling" questions. One staff member stated that SFBT

"... should definitely be part of the bigger picture, should be part of the (nursing) training" (FG3).

Staff in focus group 4 stated that they would pass techniques and approaches learnt onto new colleagues and that,

"Refreshers would be useful – anything more than annual wouldn't be possible though", "Everybody (ward staff) participates, half a day to a whole day" (FG4).

Contrary to this however one staff member stated,

"It should not be compulsory but be based on a person wanting to do it" (FG1).

Whilst the course was deemed helpful and useful

"... it really helped me" (FG4).

Many staff members including a deputy ward manager felt that whilst,

"Everyone should do this training because it helps you with the patients, this 4 day session should be more for people (staff) with confidence issues and who may not have had training as nurses... healthcare assistants will not have the background knowledge nurses have" (FG1).

So it's,

"Good for people with less experience; a person lacking confidence would benefit from it" (FG1).

3.4 Suggestions for improvement to the training and learning experience

Whilst the overall majority enjoyed the training and learnt from it, it was stated that,

"... putting it into practice is not as easy as the theory" (FG4).

"The implementation of the training is hard" (FG2).

One member of the staff found that the

"Language used made it a bit formal" (FG3).

Others thought that the course

"... was intense; it needs to be condensed; needs to be trimmed down-not so many days" (FG1),

as the "... long, intense days for the training, I think, resulted in people losing their concentration at the end of the day" (FG4).

More practical matters that were discussed in the focus groups by participants were that

"Training should be on site for convenience" (FG1)

and that it "Would be a bonus for it (course) to be accredited to recognise the work you've done" (FG4).

Given the right circumstances, the "SFBT and Heron training" appears to have provided an interactional communication toolkit to the nursing staff that can be adopted when interacting with service users to treat them as individuals, with dignity and respect therefore this should have a positive impact on their recovery.[3]

4. DISCUSSION

This study has provided encouraging evidence to suggest that a short training in SFBT and Heron's approaches for healthcare staff working in acute inpatient units can produce significant results longer term. The results demonstrated clear increases in staff knowledge, if not refresher knowledge, and in the utilisation of several key techniques namely the "miracle" and "scaling" questions which were detectable up to 5 months after the completion of the training. Training can lead to increases in confidence and a change in attitudes[26] and would be beneficial for all personnel working with persons with mental health issues. The United Kingdom Central Council[27] recognises that newly qualified nurses and frontline unregistered staff like healthcare assistants may lack confidence and skills in some areas and recommends greater support and supervision and that this should be provided by more experienced and senior nursing staff. Experienced nurses require training that is focused more on updating their knowledge[28] and unregistered staff who deliver the bulk of hands-on health and social care[29] should receive appropriate training to ensure the safety of service users.[30]

This study has demonstrated that training in-patient healthcare professionals in the principles of SFBT has significantly influenced their clinical practice confirming the compatibility of this training with mental health nursing.[7]

Training staff in specific focused therapeutic approaches when working with service users has the potential to improve their motivation, individual and/or team morale, their self-esteem and their overall clinical performance. A skilled nursing workforce is crucial to the delivery of safe and effective acute inpatient care and the barriers to receiving education and training and indeed implementing learnt skills must be overcome. Leadership by senior healthcare staff to overcome barriers and to enable a change in the status quo should lead the way.

Limitations

Our study has considered certain limitations. This was a small study undertaken over a relatively brief period therefore it is not possible to generalise beyond the specific settings involved. Ideally, it would have been good for the entire staff to participate in the follow-up study to understand more fully if and/or how skills learnt during the training were integrated into daily practice; regrettably this was not possible.

Asking service users about how they view their care may have give some insight into any changes with regard to therapeutic engagement on the wards. This may have led to a better understanding of the status quo and its comparison to the impact of the training. However, as stated in Guise et al.,[31] it would be difficult to undertake a pre- and post-programme comparison of the impact of the training on service user-staff interactions because of the transitory nature of ward personnel and "residents". Also because of the difficulty in separating out the impact of the training from the range of care and treatment of different service users on the wards.

Resource constraints prevented the researchers from determining whether the adoption of these techniques produced benefits on healthcare professional-service user interaction and service user outcomes. We did not measure whether the activity captured in this study is meaningful (or not) to the service user – this is for future study as the importance of engagement in meaningful activity for service users within acute inpatient settings is of paramount importance.

Comparing SFBT and Heron's framework with other approaches to improving the short-term care of people admitted to acute psychiatric inpatient units would be beneficial. Ideally, these studies would include economic assessments.[31] Randomised controlled trials are required to determine the clinical and cost-effectiveness of other approaches to the enhancement of inpatient care which have begun to take root in the UK and elsewhere.[32]

It should be known that this training programme is now embedded in the fabric of the Trust who agreed to take part in this study.

5. CONCLUSION

The results demonstrate that it is possible for mental health nursing staff to achieve enhanced interaction and therapeutic skills from a short-focused education programme that can enable healthcare professionals and service users to share a communicative and collaborative relationship that focuses on the positive.

SFBT techniques and Heron's approaches seem to hold promise for improving both nursing staff–service user interactions and service user outcomes in acute psychiatric inpatient units. The skills can be learned quickly and may provide a framework for mental health nursing interventions. If results are reproducible and do bring benefits in terms of improved service user outcomes, then a cash-strapped NHS could adopt this programme across all Mental Health Trusts in England.

Implications for practice

- Mental health staff have noticed the effects of the training post 5 months
- Certain SFBT techniques were deemed more helpful and useful than others by nursing staff
- Barriers to the implementation of the training pro-

gramme include time constraints, low staffing levels and a heavy workload

- Sound and focused therapeutic communication affords service user dignity and respect within time constraints
- Whether training such as this produces idiosyncratic and/or objective advancement in the care of service users needs further exploration
- Further research is needed to determine the effectiveness of the combined training for example staff performance and ward atmosphere

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CONFLICTS OF INTEREST DISCLOSURE

None declared.

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