



What psychological theory does not teach us about life on acute mental health wards: An exploration of human rights using a mixed methods research design.

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Close

Further research aims to understand the underlying factors involved and where meaningful change is required. Using a human rights-based approach helps to give everyone a common language from which services can begin to embed the principles of fairness, respect, equality, dignity and autonomy. However, as the results and past research shows (Kanevskaya et al., 2018), implementing these approaches needs to go beyond targeting changes in individual staff members; it is required at an organisational level. This should include changes to policy at a managerial level, culture at a service level, alongside quality of care on an individual

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Thesis overview

This thesis explores human rights on acute mental health wards from the view of health professionals and service users. The theoretical framework chosen is the theory of planned behaviour (Ajzen, 1988; 1991) for which there is an emerging evidence-base for its use with staff teams (Perkins et al., 2007). Mental health professionals' intention to work using a human rights-based approach will be presented, as will service users' perceptions on whether they feel cared for with this approach. The thesis comprises two papers; a systematic literature review and an empirical paper.

Alice Donald (2012) from the Human Rights and Social Justice Research Institute has provided an extensive guideline on evaluating human rights-based approaches in health care. Part of a five-year programme in conjunction with the British Institute of Human Rights (BIHR), the Department of Health, and a number of National Health Service (NHS) Trusts, the Human Rights in Healthcare Programme (www.humanrightsinhealthcare.nhs.uk, 2011-2012) aimed to assist NHS Trusts to put human rights into practice in different areas of their work. The guideline outlines nine case studies of previous evaluations of human rights-based interventions in a range of health care settings. The case studies are predominantly within learning disability, older adult or physical health settings, with one within a high security forensic mental health hospital. There is a lack of evaluation in human rights-based approaches in adult mental health, in particular acute inpatient mental health services. All of the example evaluations published on the programme's website were studied during the design phase of the thesis, with consideration given to how previous work could be adapted for this population.

Chapter one is a systematic literature review that aims to explore how the theory of planned behaviour acts as a framework to understand staff team intentions and behaviours towards certain decisions, specifically focussing on staff teams in mental health settings. This

chapter does not have a human rights focus, the primary aim is to introduce the psychological theory chosen and understand how it has been implemented in a novel way. Human rights-based approaches will be introduced in chapter 2. Thirteen papers are systematically identified, quality assessed and reviewed. Data regarding the three constructs of the theory of planned behaviour; attitude, subjective norm and perceived behavioural control, is narratively synthesised. An evaluation into how the theory of planned behaviour can be used to guide intervention is also offered. The review comments on the range of predicting variables and methodologies used in the 13 papers. Results are discussed in detail and limitations and clinical implications are outlined.

Chapter two is an empirical paper that uses the theory of planned behaviour in a novel way to explore mental health professionals' intentions to work using a human rights-based approach on acute mental health wards. The paper outlines the process of constructing a theory of planned behaviour measure, the recruitment and data collection process and the quantitative data analysis. It also reports findings from service users' perspectives of their care on acute mental health wards and whether they feel staff support them using a human rights-based approach. This section of the report is a mixed methods design, reporting both categorical quantitative data and qualitative feedback analysed using content analysis. The findings are discussed in relation to existing literature, with the aim of identifying future recommendations and clinical implications.

It is important to note that the term 'service user' has been used throughout the thesis to refer to individuals that have experienced an inpatient stay on an acute mental health ward. Using this term keeps the thesis consistently in line with formal documents such as National Institute for Health and Care Excellence guidelines, however there is an understanding that some individuals may choose to use different terms (see McLaughlin, 2009; Simmons, Hawley, Gale & Sivakumaran, 2010). Those who participated in consultation were asked to

give their preferred term, resulting in a resounding response for ‘patient’. Therefore, the consultation section of the empirical paper is named ‘consultation with previous patients’. It did not feel appropriate to use this language throughout the document, as they cannot be considered a collective voice for all individuals with shared experiences.

The thesis is supplemented with further information in the appendices for examination purposes. The systematic literature review has been written for publication in the *British Journal of Social Psychology*, which welcomes theoretical reviews of analyses of previous social psychological theories. The empirical paper has been written for publication in *Social Science and Medicine* which is a forum for the dissemination of social science research on health.

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Simmons, P., Hawley, C. J., Gale, T. M., & Sivakumaran, T. (2010). Service user, patient, client, user or survivor: describing recipients of mental health services. *The Psychiatrist*, 34(1), 20-23. <https://doi.org/10.1192/pb.bp.109.025247>

Chapter 1: Systematic literature review

Evaluating the use of the theory of planned behaviour with mental health professionals: A
systematic review.

Stephanie Davis Le Brun

Prepared in accordance with guidelines for submission to the British Journal of Social
Psychology (Appendix A)

Abstract

A theoretical framework should guide research that is designed to change behaviour. This review aimed to examine the effectiveness of the theory of planned behaviour at predicting mental health professionals' intentions towards target behaviours. Four databases were systematically searched to identify any papers that used the theory of planned behaviour with health professionals working in mental health services. Thirteen papers were identified that were quality assessed and reviewed. Data was extracted and narratively synthesised. The studies varied in design, however the majority employed a cross-sectional design. Four of the studies incorporated the theory of planned behaviour into an intervention study. All of the studies showed overall effectiveness for the theory of planned behaviour in predicting intentions, however there was some variability in the significance of the three constructs; attitude, subjective norm and perceived behavioural control. Findings are discussed and recommendations for more consistent construction of the theory of planned behaviour measures are outlined.

Keywords:

Theory of planned behaviour, mental health professionals, intentions, questionnaire construction, behaviour change

Introduction

Research into health care results in the production of new policies and ways of working and it can be challenging for health professionals to implement changes to practice in a timely manner. Eccles, Grimshaw, Walker, Johnston & Pitts (2005) argue that clinical practice is a form of human behaviour and therefore, theories that concern behaviour change should be used as a basis to design implementation research. Behaviour change models are most dominant in the field of health promotion. Examples include the effectiveness of the transtheoretical model in addictions services (DiClemente &, Prochaska 1998), or the health belief model in public health campaigns, such as vaccination uptake or contraceptive use (Abraham & Sheeran, 2005).

The Theory of Reasoned Action (TRA; Ajzen & Fishbein, 1980; Fishbein and Ajzen, 1975) is an example of a health promotion model that originated from the study of social psychology. The model was designed to predict behavioural intentions through two determinants; attitude and subjective norm (see Figure 1 for a visual representation).

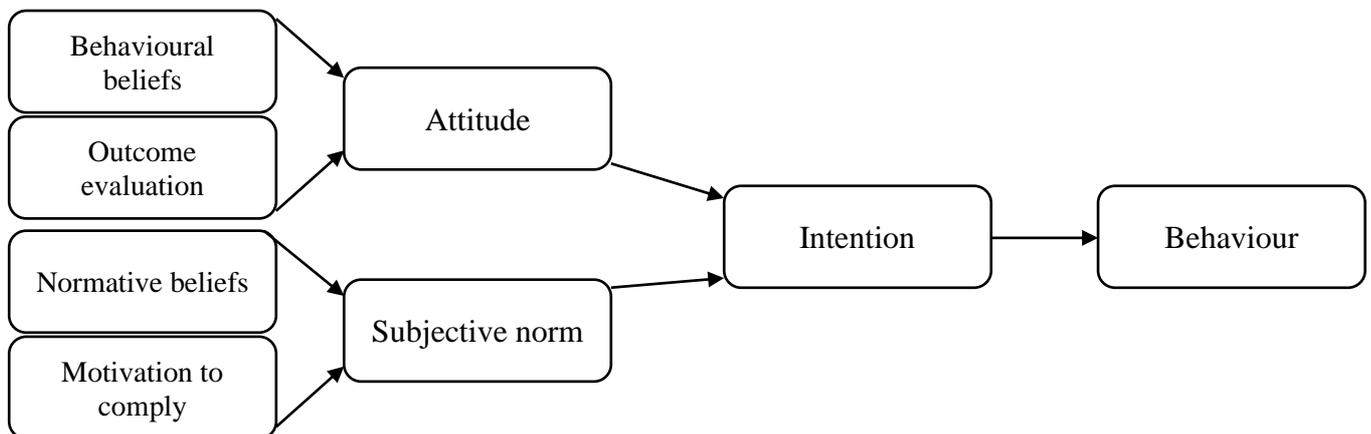


Figure 1. A visual representation of the Theory of Reasoned Action.

Attitude refers to the beliefs a person holds towards a certain outcome. Like intention, attitude is also preceded by two determinants; the behavioural belief (the strength of which influences attitude towards the outcome) and the evaluation of the possible outcome (for

example whether it will be favourable/unfavourable). Therefore, if a person has a strong belief towards a perceived favourable outcome, they may have higher levels of intention towards the behaviour. Subjective norm refers to perceived social pressure to carry out a behaviour from those deemed as important or influential. The two determinants that shape subjective norm consist of normative beliefs (whether others approve/disapprove of the action) and motivation to comply (whether a person complies with the perceived pressure). As an example, if important others approve of the behaviour and the person has high motivation to comply with these others, their intention to perform the behaviour will be increased. At its time of development, the TRA was unique in that it aimed to explain a multitude of behaviours using only a small number of concepts, in one theoretical framework.

Meta-analyses have found strong support for the overall predictive utility of the TRA, including both the relationship between intention and behaviour and the influencing factors of attitude and subjective norm on intention (Albarracín, Johnson, Fishbein & Muellerleile, 2001; Hagger, Chatzisarantis & Biddle, 2002; Sheeran & Taylor, 1997; Sheppard, Hartwick & Warshaw, 1988). Generally, attitude and subjective norm predict around 33-55% of the variance in intentions (Rivis & Sheeran, 2003). One limitation of the TRA however, is that the intended behaviour needs to be under a person's volitional control. Therefore, a person may have strong intention, but may be prevented from acting due to external factors; for example, someone may have strong intention to purchase a house, but is not able to get a mortgage approved. Sheppard et al. (1988) suggest the presence of moderating factors between the intention-behaviour relationship and the attitude-intention and subjective norm-intention relationship. Potential moderating factors included been given time to consider any intervening factors and estimate future performance. These limitations have resulted in the TRA being extended to incorporate a measure that also comprises beliefs around possession of resources and opportunities to perform a given behaviour (Madden, Ellen and Ajzen,

1992). The model developed was the theory of planned behaviour (TPB; Ajzen, 1988; 1991) which comprised an additional variable named perceived behavioural control (see Figure 2).

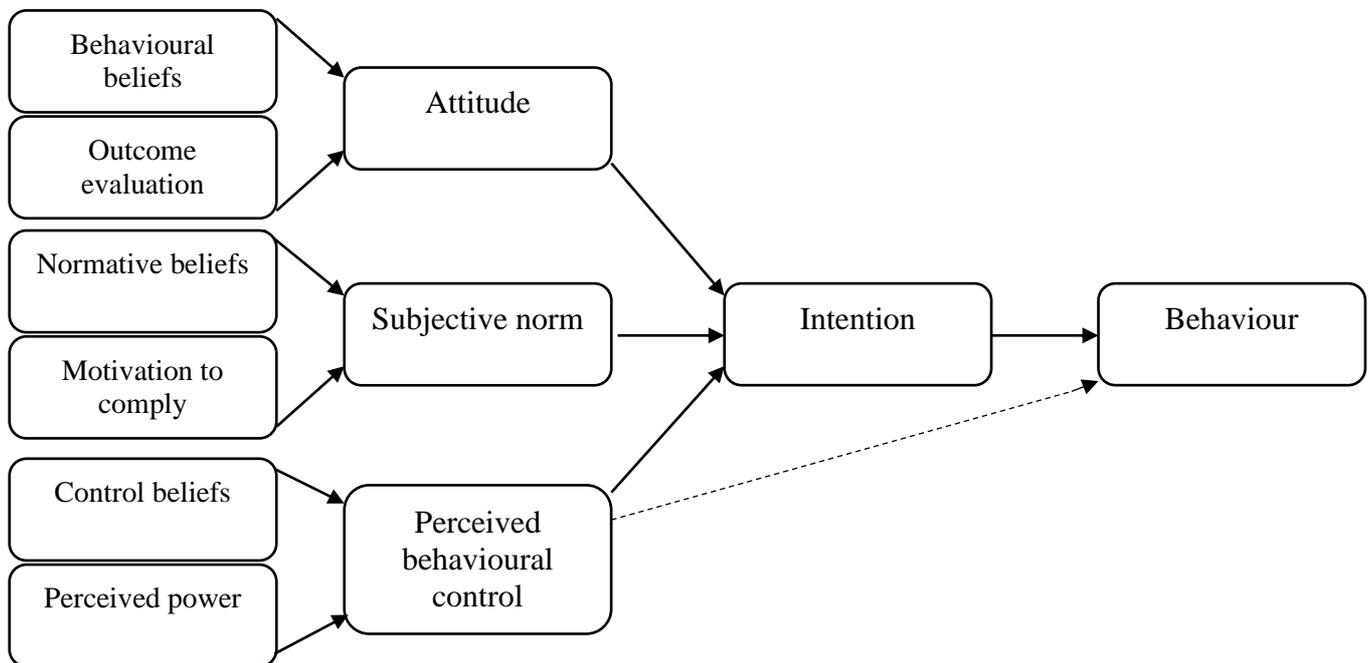


Figure 3. A visual representation of the Theory of Planned Behaviour.

Like attitude and subjective norm, perceived behavioural control is preceded by two determinants, control beliefs (whether resources and opportunities are available) and perceived power (whether it is perceived the behaviour is achievable). Therefore, using the example above, if a mortgage does get approved and the individual has saved enough money for a deposit, then levels of intention are enhanced. It has been evidenced that perceived behavioural control also acts as an independent determinant of behaviour, uniquely having both an indirect effect (through intentions) and a direct effect on behaviour (Armitage & Connor, 2001).

The TPB has been shown to have greater effectiveness at predicting behavioural intention than the TRA, with a wide range of health behaviours (Ajzen, 1991; Albarracin et al., 2001; Godin & Kok, 1996; Hausenblas, Carron, & Mack, 1997; McEachan, Conner, Taylor & Lawton, 2011). Armitage and Connor (2001) conducted a robust analysis on the

efficacy of the TPB based on 185 independent studies. Results found that perceived behavioural control adds on average 6% of variance to the prediction of intention over and above the TRA variables. Overall, the TPB accounted for 27% of the variance in behaviour and 39% in intention. Interestingly, the authors noted that subjective norm was often found to be the weakest predictor of intention, particularly when measured with only a single-item. Lastly, the model shows discrepancy in results between self-reported and objective (actual) behaviour, with self-report measures explaining 11% more variance. Therefore, the authors argue that objective behaviour should be reported where possible.

The TPB has shown most dominance in the field of health-related behaviours, for example (but not limited to) physical activity (Hagger et al., 2002; Hausenblas et al., 1997), condom use (Albarracin et al., 2001; Sheeran & Taylor, 1999), drinking alcohol and smoking cessation (Godin & Kok, 1996). This research has predominantly concentrated on predicting and changing patient's health behaviour. However, due to the growing need for health professionals to work more within the evidence base and given that the TPB has strong scientific support for understanding and modifying behaviour, researchers have begun to explore the utility of using the TPB in relation to health professional's behaviour. Faulkner and Biddle (2001) when investigating physical activity promotion in health care settings rationalise using the TPB in this way by stating "health care professionals are likely catalysts for changing the health behavior of clients and patients in a range of settings, and examining intentions to perform certain actions is worthwhile" (p. 99). A systematic review (Perkins et al., 2007) interested in further exploration of the gap between health professionals' knowledge of what they should do and what they actually do in everyday practice found that there is a growing amount of research using the TPB with this population. Nineteen articles were collated that used theory-driven approaches to understand and modify health professional's behaviour. The population concerned included physicians, nurses, pharmacists,

health care workers and mental health clinicians. The authors concluded that the review provided support for the applicability of the TRA and TPB with health professional's but seemed perplexed by the lack of studies in this area. It was also felt that studies could go further, by designing specific interventions to promote the adoption of new behaviours based around the strongest predictors of behavioural intentions. Of note within this systematic review, is that only two of the studies were within the mental health field and the authors call on further research in this area.

Aims

Following the recommendations by Perkins et al. (2007), the aim of this paper is to systematically review the evidence in the use of the TPB in mental health settings. The review has three objectives:

- To evaluate the overall effectiveness of the TPB to predict mental health professionals' intentions towards certain behaviours;
- To evaluate the overall effectiveness of the TPB to predict mental health professionals' behaviour;
- To examine how the theory of planned behaviour has been used in intervention studies

Method

This paper systematically reviewed available literature regarding applying the TPB to predict the intentions of mental health professionals in mental health settings.

Initial scoping searches were carried out to identify appropriate search terms given the wide-range of terminology used both clinically and in research to describe the population and theory. The research question was then framed using the PICO approach (see Table 1).

Table 1. Using the PICO approach to frame the research question

PICO	
Participants/population	Health professionals (any discipline; e.g. nurses, support workers, consultants, occupational therapists, psychologists) working in services specifically for people with mental health difficulties.
Intervention(s), exposure(s)	Any articles that use the theory of planned behaviour to predict the intentions and/or behaviour of mental health professionals.
Comparator(s)/control	Not applicable
Outcome(s)	To evaluate whether attitude, subjective norm and perceived behavioural control significantly predict mental health professionals' intentions towards a defined behaviour.

Computerised databases searched were CINAHL, Cochrane Library, MEDLINE and PsycINFO. Reference lists from articles deemed as suitable for review after reading the full-text were also studied. Terms used, including Medical Subject Headings (MeSH) where required, were “theory of planned behav*” (wild card approach to account for all permutations), “theory-based interventions”, “mental health professionals”, “mental health clinicians” and “staff teams”. Initial searches were conducted in November 2018 and were then repeated 6 months later in April 2019. Given the time factors and costs associated with searching for unpublished (grey) literature, and the variability in quality, consideration should be given to the amount of benefit it would add to the results of a systematic review (Egger, Jüni, Bartlett, Hoenstein & Sterne, 2003). Discussions with the reviewing team and an analysis of the evidence concluded that grey literature would not be included within the systematic review.

The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA; Moher, Liberati, Tetzlaff & Altman, 2009) checklist was followed for the reporting of the systematic review process. Duplicates were removed and then titles and abstracts reviewed

against the inclusion criteria. The full-text was requested for any articles that were found to be potentially relevant based on the title and abstract screening. Full-text articles were reviewed by the first author [SDLB] to identify whether they met the predetermined inclusion/exclusion criteria. A second reviewer [SB] independently replicated the initial searches using the terms above and applied the inclusion criteria to a sample of papers. There was full agreement between reviewers on the inclusion or exclusion of the sample papers.

Inclusion/exclusion criteria

Studies were included if they: a) were published in, or translated to, the English language; b) were conducted in mental health settings; c) were conducted with mental health professionals; d) explicitly cited the theory of planned behaviour as the model to understand intentions/behaviours; e) implemented a quantitative theory of planned behaviour questionnaire; f) reported quantitative findings based on the constructs of the TPB. There were no date limitations imposed.

Once duplicates were removed, the titles and abstracts of 96 articles were screened and of these, 43 full-text articles were obtained and assessed for eligibility. After applying the inclusion/exclusion criteria, 13 studies were deemed suitable for quantitative synthesis. This process is documented in the PRISMA flowchart (see Figure 3).

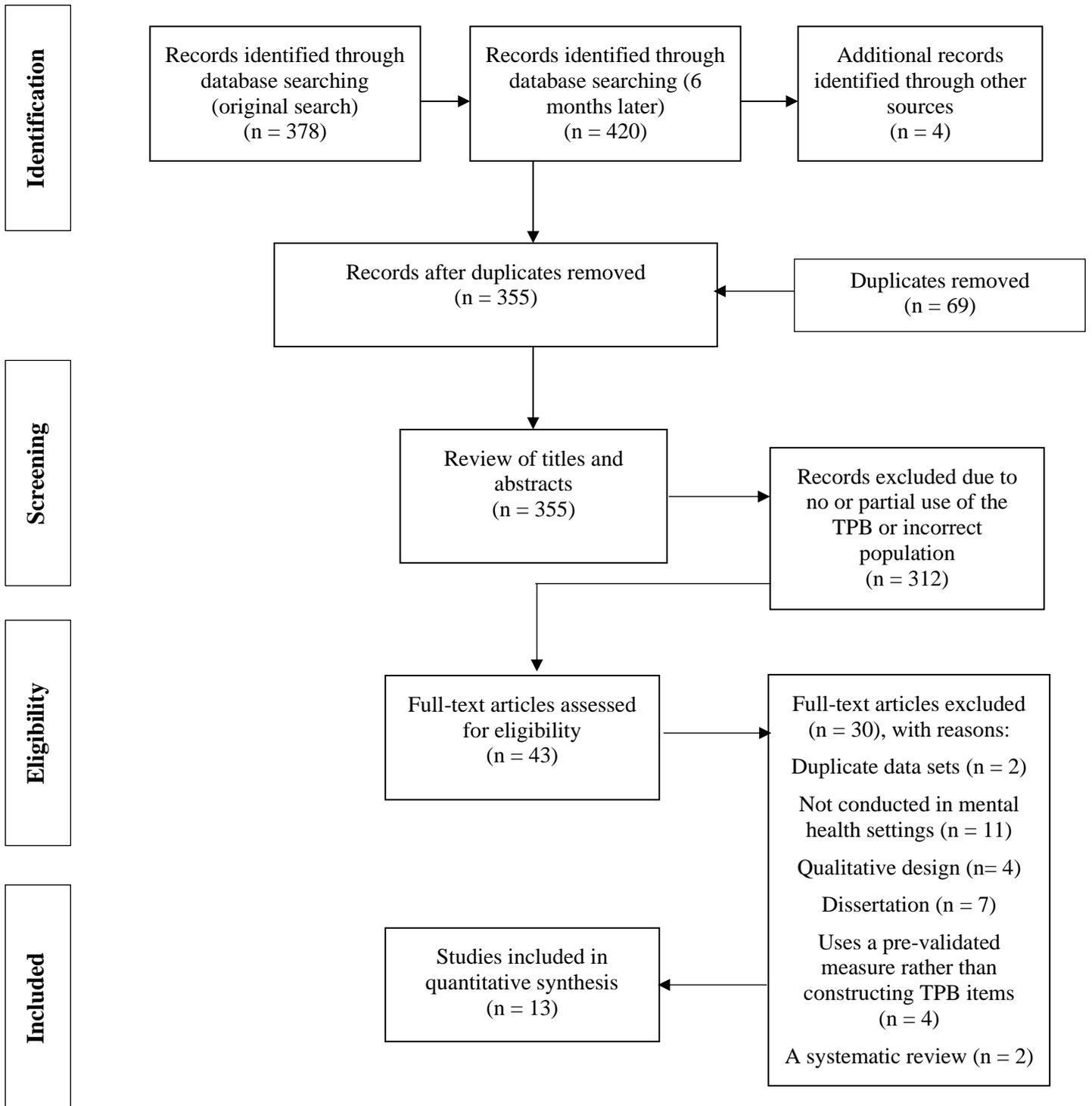


Figure 5. PRISMA flowchart of the systematic review process

Quality assessment

Articles were assessed using a quality assessment tool specifically designed for constructing TPB questionnaires by Oluka, Nie and Sun (2014).

Overall study quality

Oluka et al. (2014) first recommend conducting an overall study quality measure which they adapted from the National Institute for Clinical Health and Excellence (NICE) 'Methods for the development of NICE public health guidance' manual (2009). Quality is graded by overall score; ++ meaning the study has a low level of bias, + a moderate level of bias, and – a higher level of bias/variable quality (Appendix B). Overall quality assessment was undertaken by the first author, with the results presented in Table 2. The second reviewer independently assessed a sample of six studies with the agreement rate between reviewers for overall quality being 97.6%.

Table 2. Overall quality assessment findings for all 13 studies.

Study	Clear aim or research question?	Details of study methodology and design?	Description of data collection?	Research context; description of the study population?	Data analysis?	Results relevant to the aims of the study?	Ethical approval obtained?	Overall Assessment score
Blankers et al. (2016)	+	-	+	+	+	+	+	++
Casper (2007)	+	-	+	+	+	+	+	++
Faulkner & Biddle (2001)	+	+	+	+	+	+	+	++
Foy et al. (2007)	-	-	+	+	+	+	+	+
Garner et al. (2011)	+	+	+	+	+	+	-	++
Hanbury et al. (2010)	+	-	+	+	+	+	+	++
Ince et al. (2015)	+	+	+	+	-	+	+	++
Janus et al. (2017)	-	-	+	+	+	+	-	+
Jenkins & McKenzie (2010)	+	+	+	+	+	+	+	++
Kelly et al. (2012)	+	-	+	+	+	+	+	++
Lecomte et al. (2018)	+	+	+	+	+	+	+	++
Levy et al. (2016)	+	+	+	+	+	+	+	++
Martin et al. (2011)	+	+	+	+	+	+	+	++

Notes:

++ must meet at least 6 criterion indicated above.

+ must meet at least 4 criterion indicated above.

- did not have the 4 criterion necessary for + classification

Eleven of the studies were deemed as having a low level of bias, with an overall assessment score of ++. Two studies scored a moderate level of bias, achieving an overall score of +. None of the studies were deemed to be low/variable quality. The domains where the two studies fell short were around clear descriptions of the aims and study design and methodology. One of the studies did not report whether ethical approval had been obtained.

Quality of TPB questionnaire construction

The quality of TPB questionnaire construction was then measured using the tool developed by Oluka et al. (2014). The tool was developed from the manual outlining how to construct TPB questionnaires by Francis et al. (2004). The checklist is evaluated by awarding a score point for each domain; either a score of one when a domain has been satisfied, or zero if it does not meet the domain, or the information is unclear. The scoring of studies was adopted from Jack, McLean, Moffett and Gardiner (2010) and Husebø, Dyrstad, Søreide and Bru (2013). It is recommended that a score of one on at least 50% of the assessment criteria would deem the study high quality (Appendix C). Therefore, as the tool consisted of 16 questions, a score of eight or above was categorised as high quality. Any below a score of eight would be deemed as low/variable quality. The criteria for the quality assessment scores for the construction of the TPB measure can be found in Table 3. The results of the quality assessment for each study are then followed in Table 4. The second reviewer independently assessed a sample of six papers. The agreement rate on individual quality assessment domains between reviewers was 89.6%. After analysing and discussing this agreement rate, it was found that there was high agreement on the overall score of the study, with all six of the studies scored in the high quality category by both reviewers.

Table 3. Criteria for the quality assessment of construction of a theory of planned behaviour questionnaire.

Criteria	Score
A 1. Definition of population of interest?	+ / - / ?
2. Definition of clinical condition and/or behavior of Interest (TACT principle)?	+ / - / ?
B 3. Elicitation study conducted for salient beliefs? If yes,	+ / - / ?
4. Study design/mode of administration stated (focus groups/individual or mailed questions)?	+ / - / ?
5. Are participants from target population?	+ / - / ?
C 6. Is more than one reviewer/expert involved in choosing of questionnaire items?	+ / - / ?
7. Are all the constructs represented?	+ / - / ?
8. Inclusion of direct and indirect measures?	+ / - / ?
9. Inclusion of questions on demographics?	+ / - / ?
10. Total number of questionnaire items ≥ 40 ?	+ / - / ?
D 11. Was a pilot study conducted?	+ / - / ?
E 12. Was power calculation done for final study?	+ / - / ?
13. Total number of participants' ≥ 80 ?	+ / - / ?
14. Is sample representative of study population (higher response rate or characteristics compared between responders and non-responders)?	+ / - / ?
F 15. Ethical approval obtained?	+ / - / ?
G 16. Data analysis conducted for content validity/reliability?	+ / - / ?

*Glossary: TACT - The description of behaviour in terms of its *target*, the *action* itself, the *context* in which it is performed, and the *time* it is performed.

Elicitation study - A method to determine a population's salient behavioural, normative, and control beliefs.

Table 4. Quality assessment of TPB questionnaire construction.

Study	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	Score
Blankers et al., 2016.	1	1	1	1	1	0	1	0	1	0	0	1	1	0	1	1	11
Casper, 2007.	1	1	0	0	1	0	1	0	1	0	0	0	1	1	1	0	8
Faulkner & Biddle, 2001.	1	1	0	1	1	0	1	0	1	0	0	0	1	1	1	1	10
Foy et al., 2007.	1	1	1	1	1	0	1	1	0	1	0	1	1	0	1	1	12
Garner et al., 2011.	1	1	0	1	1	0	1	0	1	0	0	0	1	0	0	1	8
Hanbury et al., 2010.	1	1	1	1	1	0	1	1	1	0	1	0	1	0	1	0	11
Ince et al., 2015.	1	1	0	1	1	0	1	0	1	0	0	1	0	0	1	1	9
Janus et al., 2017.	1	1	1	1	1	0	1	1	1	1	1	0	1	0	0	1	12
Jenkins & McKenzie, 2010.	1	1	0	1	1	0	1	1	0	0	1	1	1	0	1	1	11
Kelly et al., 2012.	1	1	0	1	1	0	1	0	1	0	0	0	1	1	1	1	10
Lecomte et al., 2018.	1	0	0	1	1	1	1	0	1	1	0	0	1	1	1	1	11
Levy et al., 2016.	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	16
Martin et al., 2011.	1	1	0	1	1	0	1	0	1	0	0	1	0	1	1	1	10

Notes: Studies scoring ≥ 8 were considered 'high quality' (Grade A) while those ≤ 8 were rated 'low quality' (Grade B). Scoring adopted from Husebø et al. (2012) and Jack et al. (2010).

All of the 13 studies assessed were rated as being high quality on the construction of a TPB questionnaire. Those with the highest scores (Foy et al., 2007; Janus et al., 2017; Levy et al., 2016) were the studies that had conducted an elicitation study to gather salient beliefs, included direct and indirect measures of attitude, subjective norm and perceived behavioural control, and/or had completed a pilot study. Neither of the two lowest scoring studies

(Casper, 2007; Garner et al., 2011) had included a power calculation and had constructed questionnaires with a low number of items. It was hard to distinguish from the majority of the studies whether more than one reviewer was involved in the construction of items. Due to the systematic review inclusion criteria, all of the measures satisfied question 1; ‘definition of population of interest’ and question 7; ‘are all the constructs [of the TPB] represented’.

Analysis

A meta-analysis was not possible due to the differences between the study designs, primarily with the aims, methodology and type of data analysis. A narrative synthesis of quantitative data based on the variables of the TPB was therefore chosen in order to examine trends and variations across the studies. Data regarding the study sample and characteristics, behaviour to be studied, design and analysis, measures and outcome was extracted and tabulated using Microsoft Excel.

Results

The study characteristics and outcomes are summarised in Table 5.

Table 5. Data extraction table for the 13 studies included in the systematic review.

Study reference	Sample and characteristics	Aims/behaviour to be studied	Design and analysis	TPB constructs and reliability (Cronbach's α)	Additional measures	Outcome
Blankers et al., 2016. (Netherlands)	N=506 Participation rate: N/R Area of work: Mental health care institutes. Substance abuse treatment centres. Institutes for sheltered housing. Job role/s: Nursing (38.2%), social work (15.6%), psychology (8.0%), medicine (6.1%), other vocational backgrounds (2.4%), other (29.7%).	For mental health staff to provide smoking cessation support to patients.	Design: Cross-sectional Analysis: Structural equation modelling	ATT: 12 items ($\alpha = .90$) SN: 4 items ($\alpha = .71$) PBC: 4 items ($\alpha = .65$) INT: 4 items ($\alpha = .80$)	Past behaviour (PB): 3 items ($\alpha = .71$) Smoking behaviour (SMO): 3 items ($\alpha = .82$)	Model 1 (all variables): $\chi^2_{529} = 4273$, $p < .001$; root mean square error of approximation (RMSEA) = .109; comparative fit index (CFI) = .989. Regression coefficient estimates from SN to INT and SB to INT weak and non-significant (SN- > INT = .199, SE = .179, $p = .267$; SMO- > INT = -.037, SE = .154, $p = .812$). Model 2 (PBC, ATT, PB): $\chi^2_{327} = 3498$, $p < .001$; RMSEA = .127; CFI = .936. Model 3 (PBC, ATT, PB + 6 covariances): $\chi^2_{322} = 790$, $p < .001$; RMSEA = .049; CFI = .9991. ATT, PBC and PB strongly associated with INT. SN and SMO limited association with INT.
Casper, 2007. (USA)	Pre-intervention: N=94 TPB condition; n = 46 Standard condition; n = 48 Participation rate: 4 did not attend intervention. Post-intervention: TPB condition; n = 34 (74%) Standard condition; n = 33 (69%). Area of work: Mental health and substance abuse services. Job role/s: Rehabilitation counsellor (TPB; 54%:	For staff to implement an assessment tool (Need for Change Employment Scale) to people with serious mental illnesses.	Design: Randomised controlled trial Analysis: T-tests and Panel analysis	ATT: 4 items ($\alpha = \text{N/R}$) SN: 4 items ($\alpha = \text{N/R}$) PBC: 4 items ($\alpha = \text{N/R}$) INT: 9 items ($\alpha = \text{N/R}$)	Knowledge test: 12 multiple-choice questions on knowledge of class material.	Pre-class: ATT, SN and PBC accounted for 63% ($R = 0.79$) of the total variance in INT. Knowledge gains: Significant knowledge gains in both classes (paired $t = 43.30$, $df = 93$, $p < .001$) but not between groups. Pre-class vs post-class intentions (mean analysis): ($M = 58.5$, $SD = 2.7$ vs $M = 50.4$, $SD = 6.9$, $F = 73.1$, $df = 1$ and 91 , $p < .001$, Cohen's d [ANCOVA models] = 1.09). Post-3 months analysis: TPB class had higher implementation (74% vs 42%) and assessment rates (94% vs 74%) of tool.

Faulkner & Biddle, 2001. (UK)	<p>Standard; 67%), Case manager (TPB; 33%: Standard; 17%), Other (TPB; 13%: Standard; 16%).</p> <p>Initial survey: N=477</p> <p>Participation rate: Follow-up survey: N=394 (83% response rate).</p> <p>Area of work: Adult and rehabilitation directorate of mental health services - rehabilitation (n = 132), inpatient (n = 147) and community (n = 99).</p> <p>Job role/s: Nurses (n = 161), occupational therapists (n = 36), psychiatrists and clinical psychologists (n = 40), community psychiatric nurses (n = 57), support workers (n = 87), did not record (n = 13).</p>	To predict the stage of change for mental health professionals in promoting physical activity to their clients.	<p>Design: Prospective cohort study</p> <p>Analysis: Structural equation modelling.</p>	<p>ATT: 5 items ($\alpha = .84$)</p> <p>SN: 1 item ($\alpha =$ N/R)</p> <p>PBC: 4 items ($\alpha = .78$)</p> <p>INT: 2 items ($\alpha = .84$)</p>	<p>Stages of change (SOC): Measured through a 6-item algorithm. Measured at baseline and after 6 months.</p> <p>Past behaviour (PB): Measure N/R</p>	<p>MANOVA: Significant differences among TPB constructs on SOC (Wilks' $\lambda = .48$; $F_{10,774} = 33.701$, $p < .001$).</p> <p>Univariate F-tests: All constructs significantly different across SOC ($p < .001$).</p> <p>TPB: Model demonstrated good fit $\chi^2/57$ df = 2.023, $p > .05$; CFI = .98; goodness of fit index (GFI) = .96; adjusted goodness of fit index (AGFI) = .93; RMSEA = .05; standardised root mean square residual (SRMSR) = .04.</p> <p>ATT ($\lambda = .41$, $p < .01$) and PBC ($\lambda = .38$, $p < .01$) were approximately equal predictors of INT. SN to a lesser extent ($\lambda = .16$, $p < .01$). INT was the strongest predictor of SOC ($\lambda = .42$, $p < .01$).</p> <p>27% of variance in self-reported SOC was explained by the model. Intention to promote physical activity accounted for 61% of variance.</p>
Foy et al., 2007. (UK)	<p>N=399</p> <p>Participation rate: 1,269 individual professionals identified. 420 opted in (33.1%), 399 completed (31.4%).</p> <p>Area of work: Older people's services in mental health services.</p>	For professionals to disclose a diagnosis of dementia to patients. Disclosure = Exploring what the patient already knows,	<p>Design: Cross-sectional</p> <p>Analysis: Multiple regression analysis</p>	<p>ATT: 3 items per behaviour plus 7-10 items per behaviour ($\alpha = .77$)</p> <p>SN: 3 items per behaviour plus 1 general item ($\alpha = .83$)</p>	<p>Self-efficacy: 4-8 items per behaviour ($\alpha = .84$).</p> <p>Team role: 1 item for perceived role of colleagues ($\alpha =$ N/R) and 1 item for role responsibility for each job role ($\alpha =$ N/R).</p>	<p>Exploring what the patient already knows: TPB variables explained 29.4% of behavioural intention, SCT variables 24.2% and team variables 15.5%. Combined they explained 35.6% – however overlap between TPB and SCT.</p> <p>Use of explicit terminology: TPB variables explained 53.7% of behavioural intention, SCT 47.5% and two</p>

	<p>Job role/s (percentage of individuals in profession that completed survey): Doctors (27.6%), nurses (37.0%), allied health professionals (36.2%), social workers (23.3%), support workers (26.2%).</p>	<p>use of explicit terminology, exploring what the diagnosis means to the patient.</p>		<p>PBC: 3 items per behaviour ($\alpha =$ N/R) INT: 2 items ($\alpha = .91$)</p>		<p>team variables 42.2%. Combined they explained 63.5%. Exploring what the diagnosis means: TPB variables (SN and PBC) explained 48.6% of behavioural intention, SCT 31.1% and team variables 18.0%. Combined they explained 52.7%. SN consistently represented an important explanatory variable. TPB explained a greater proportion of variance than SCT constructs and team variables.</p>
<p>Garner et al., 2011. (USA)</p>	<p>N=95 Pay-for-performance (P4P) condition; n = 47 Control condition; n = 48 Participation rate: 108 eligible, response rate of 88% Area of work: Adolescent substance abuse services in outpatient settings. Job role/s: Substance abuse therapists (100%).</p>	<p>Whether P4P methods impact therapist's intentions to achieve two quality care targets (demonstrating monthly competence and delivering a targeted threshold level of treatment).</p>	<p>Design: Randomised controlled trial Analysis: Hierarchical linear modelling</p>	<p>ATT: 3 items per quality target (monthly competence $\alpha = .87$; targeted threshold $\alpha = .89$) SN: 2 items per quality target ($\alpha = .86$; $\alpha = .81$) PBC: 2 items per quality target ($\alpha = .73$; $\alpha = .75$) INT: 3 items per quality target ($\alpha =$ N/R)</p>	N/R	<p>Intention to achieve monthly competence: P4P condition: Significantly higher intentions than control condition ($B = 1.41$, $p < .001$). Accounted for 20% of the variance. ATT: Significant association with intention ($B = .42$, $p = .016$), 9% of variance. SN: Not significant ($B = .17$, $p = .109$) PBC: Not significant ($B = .01$, $p = .957$) Intention to achieve targeted threshold: P4P condition: Significantly higher intentions than control condition ($B = 1.31$, $p < .001$) and accounted for 18% of the variance. ATT: Significant association with intention ($B = .40$, $p = .004$), 9% of variance. SN: Significant association ($B = .23$, $p = .026$), 5% of variance. PBC: Not significant ($B = .01$, $p = .939$) Combined TPB constructs (pre-intervention): Accounted for 58% of variance in INT ($R^2 = .58$, $F(3, 6)$, $p < .0001$). ATT: N/R SN: The only significant predictor of INT ($t = 6.622$, $p < .001$) PBC: N/R Post intervention:</p>
<p>Hanbury et al., 2010. (UK)</p>	<p>N=50 Participation rate: Administered to 93, response rate of 54%. Area of work: Mental health directorate of a Primary Care Trust Job role/s: Community psychiatric nurses,</p>	<p>For mental health professionals to increase their uptake of a national suicide prevention guideline</p>	<p>Design: Time series analysis Analysis: Multiple regression analysis</p>	<p>ATT: N/R SN: N/R PBC: N/R INT: N/R</p>	N/R	

Ince et al., 2015. (UK)	<p>occupational therapists, psychiatrists and social workers (Frequencies N/R)</p> <p>N=68 Participation rate: 167 measures handed out, 82 participants recruited (49%) and 68 returned both baseline and outcome data (41%). Area of work: Community mental health teams from mental health trusts. Job role/s (By experimental and control group): Social worker (31%, 30%), Nurse (46%, 43%), Other (23%, 27%)</p>	For healthcare professionals to increase the implementations of clinical guidelines for psychological treatments in schizophrenia	<p>Design: Randomised controlled trial Analysis: Chi-square test. Mann-Whitney <i>U</i> test.</p>	<p>TPB: 24 items overall ($\alpha = .923$) ATT: 8 items ($\alpha = .85$) SN: 3 items ($\alpha = .73$) PBC: 10 items ($\alpha = .87$) INT: 3 items ($\alpha = .82$)</p>	<p>Satisfaction with guidelines: 2 items Comprehension of guidelines: 2 items</p>	<p>The intervention did not have a significant impact on adherence ($p > .05$, $R^2 = .27$). TPB questionnaire: 17 participants. Only PBC significantly higher after intervention ($t = 2.429$, $df = 16$, $p < .027$). Baseline (differences between groups): ATT: N/R SN: Only significant result ($U = 325$, $z = -3.140$, $p = .002$, $r = .38$) PBC: N/R INT: N/R Outcome (differences between groups): ATT: ($U = 525$, $z = -.649$, $p = .517$) SN: (Only significant result; $U = 410$, $z = -2.082$, $p = .037$, $r = .25$) PBC: ($U = 528.5$, $z = -.603$, $p = .547$) INT: ($U = 548.5$, $z = -.360$, $p = .719$) Satisfaction scores: No significant differences ($U = 499.5$, $z = -.793$, $p = .428$) Comprehension scores: No significant differences ($U = 459.5$, $z = -1.310$, $p = .190$)</p>
Janus et al., 2017. (Netherlands)	<p>N=81 Participation rate: Distributed to 296, response rate of 28% Area of work: Psychogeriatric wards of nursing homes. Job role/s: Nurses (38%), nursing assistants (62%)</p>	Nurses and nursing assistants requesting antipsychotics for people with dementia	<p>Design: Cross-sectional Analysis: Multiple linear regression analysis.</p>	<p>ATT: Direct - 2 items ($\alpha = .69$). Beliefs about treatment effects – 16 items ($\alpha = .87$). Beliefs about expected effects on staff – 6 items ($\alpha = .78$). SN: 12 items ($\alpha = .86$) PBC: 3 items ($\alpha = .83$) INT: 2 items ($\alpha = .73$)</p>	<p>Behaviour: 2 open-ended items</p>	<p>Multivariate analysis: ATT: Beliefs about treatment effects ($\beta = .85$, $p < .05$) Beliefs about expected effects on staff not significant – N/R SN: Not significant - N/R PBC: ($\beta = .38$, $p < .05$) INT: Beliefs about treatment effects and PBC accounted for 59% of variance: $F(7, 73) = 14.70$, $p < .05$, $R^2 = .59$ Behaviour: Current position significantly associated, less well-educated nurses more likely to call for antipsychotics, $F(8, 72) = 2.94$, $p < .05$, $R^2 = .25$</p>

Jenkins & McKenzie, 2010. (UK)	N=112 Participation rate: Distributed to 334, response rate of 34% Area of work: Voluntary and charitable organisations working with people with an intellectual disability Job role/s: Care staff (N/R)	For carers to encourage healthy eating to those they support	Design: Cross-sectional Analysis: Pearson correlation coefficients. Multiple linear regression analysis.	ATT: Number of items N/R ($\alpha = .93$). SN: N/R ($\alpha = .80$) PBC: N/R ($\alpha = .92$) INT: N/R	Self-identity (SI): Number of items N/R ($\alpha = .88$) Self-efficacy (SE): N/R ($\alpha = N/R$) Past behaviour (PB): N/R	Model 1 (TPB variables): All variables significant, $R^2 = .313$, $F(5,98) = 10.521$, $p < .001$. ATT: ($B = .335$, $\beta = .281$, $p = .004$) SN: Highest standardised coefficient ($B = .395$, $\beta = .340$, $p < .001$) PBC: Lowest standardised coefficient ($B = -5.208$, $\beta = -.164$, $p = .049$) Model 2 (Plus SI and SE): More predictive of intention, $R^2 = .349$, $F(3,100) = 16.607$, $p < .001$. PBC, SI and SE not significant. SI: ($B = .026$, $\beta = .027$, $p = .755$) SE: ($B = .131$, $\beta = .160$, $p = .139$) PB: Significantly correlated with future intention (Spearman's $P = .504$, $p < .001$) Combined TPB constructs: Accounted for 41% of variance in INT ($R = .65$ adjusted $R^2 = .41$, $F_{3,103} = 24.87$, $p < .00$). ATT: ($B = .16$, $\beta = .18$, $p < .05$) SN: ($B = .33$, $\beta = .39$, $p < .01$) PBC: ($B = .24$, $\beta = .26$, $p < .01$)
Kelly et al., 2012. (Australia)	N=108 Participation rate: 160 eligible, response rate of 68% Area of work: Residential drug and alcohol rehabilitation treatment (modified therapeutic community) Job role/s: Substance abuse workers (N/R)	For substance abuse workers to implement evidence-based practices (EBP)	Design: Cross-sectional Analysis: Multiple linear regression analysis.	ATT: 4 items ($\alpha = .87$) SN: 4 items ($\alpha = .79$) PBC: 4 items ($\alpha = .73$) INT: 3 items ($\alpha = .90$)	N/R	Combined TPB constructs: Accounted for 49% of variance in INT ($F_{3,125} = 38.49$, $p < .001$). ATT: ($B = .59$, $t_{125} = 7.56$, $p < .001$) SN: ($B = .17$, $t_{125} = 2.19$, $p < .05$) PBC: ($t_{125} = -.71$, $p = .48$) Actual behaviour: CBTP training (OR = .23, CI = .06-.58) and social norms (OR = .79, CI = .068-.93) significant
Lecomte et al., 2018. (Australia and Canada)	N=142 (Canada site 1 n=48; Canada site 2 n=52, Australia site n=42) Participation rate: Estimated at 6%; actual N/R Area of work: Public mental health authorities and professional mental health associations	For clinicians to deliver cognitive behavioural therapy for psychosis (CBTp)	Design: Mixed methods Analysis: Linear regression analysis and qualitative content analysis.	TPB: 74 items overall (including demographic questions) ATT: 8 items ($\alpha = .89$) SN: 7 items ($\alpha = .64$) PBC: 8 items ($\alpha = .50$)	Perceived obstacles: Open-ended qualitative question Proposed solutions: 8 items Actual behaviour: 1 item	

Levy et al., 2016. (UK)	<p>Job role/s: Psychology (20%, 53.2%, 42.9%), Psychiatry (25.5%, 3.2%, 0%), Nursing (5.5%, 5.3%, 33.3%), Social work (12.7%, 10.6%, 16.7%), Occupational therapy (3.6%, 10.6%, 7.1%), Other (32.7%, 17.0%, 0%)</p> <p>N=94</p> <p>Participation rate: Approx. 500 eligible, 112 accessed survey, 19% response rate</p> <p>Area of work: Improving Access to Psychological Therapies programme, step 2 services</p> <p>Job role/s: Psychological wellbeing practitioners in training</p>	PWPs to increase use of CBT self-help materials routinely in clinical practice	<p>Design: Cross-sectional</p> <p>Analysis: Multiple linear regression analysis. Qualitative content analysis</p>	<p>INT: 9 items ($\alpha = .81$)</p> <p>TPB: 110 items overall (including demographic questions)</p> <p>ATT: 22 items ($\alpha = \text{N/R}$)</p> <p>SN: 15 items ($\alpha = \text{N/R}$)</p> <p>PBC: 11 items ($\alpha = \text{N/R}$)</p> <p>INT: 3 items ($\alpha = .89$; only acceptable score)</p>	<p>Perceived barriers: 4 items</p> <p>Past behaviour (PB): 2 items</p> <p>Self-help training: 1 item</p>	<p>Model 1: Past behaviour accounted for 23% of variance in ATT ($F_{1,92} = 29.04, p < .001$), 25% in SN ($F_{1,92} = 31.20, p < .001$) and 31% in PBC ($F_{1,92} = 42.24, p < .001$). Past behaviour significant predictor of intention accounting for 42% of variance ($F_{1,92} = 67.92, p < .001$).</p> <p>TPB variables: ATT, SN and PBC all significant predictors of INT. Attitude accounted for 58% ($F_{1,92} = 130.72, p < .001$), SN for 35% ($F_{1,92} = 51.20, p < .001$), and PBC for 41% ($F_{1,92} = 65.82, p < .001$) of the variance.</p> <p>Model 1 (TPB variables): Model significant ($F_{3,74} = 20.93, p < .001$), with R^2 value of .459.</p> <p>ATT: ($B = .413, \beta = .259, t = 2.76, p = .007$)</p> <p>SN: ($B = .217, \beta = .166, t = 1.73, p = .088$)</p> <p>PBC: ($B = .475, \beta = .447, t = 4.69, p < .001$)</p> <p>Model 2 (PA and PBC): Model significant ($F_{2,75} = 8.71$), with R^2 value of .19.</p>
Martin et al., 2011. (UK)	<p>N=78 (n=35 paper questionnaire; n=43 online questionnaire)</p> <p>Participation rate: 210 questionnaires distributed, 35 returned, response rate of 17%</p> <p>Area of work: Care organisations for people with an intellectual disability</p> <p>Job role/s: Care staff (N/R)</p>	For carers to support physical activity for people with an intellectual disability	<p>Design: Cross-sectional</p> <p>Analysis: Multiple linear regression analysis.</p>	<p>ATT: N/R ($\alpha = .75$)</p> <p>SN: N/R ($\alpha = .54$)</p> <p>PBC: N/R ($\alpha = .84$)</p> <p>INT: N/R ($\alpha = .72$)</p>	<p>Physical activity (PA): The international physical activity questionnaire – short form (IPAQ-SF; Craig et al., 2003) ($\alpha = .61 - .83$)</p>	<p>Model 1 (TPB variables): Model significant ($F_{3,74} = 20.93, p < .001$), with R^2 value of .459.</p> <p>ATT: ($B = .413, \beta = .259, t = 2.76, p = .007$)</p> <p>SN: ($B = .217, \beta = .166, t = 1.73, p = .088$)</p> <p>PBC: ($B = .475, \beta = .447, t = 4.69, p < .001$)</p> <p>Model 2 (PA and PBC): Model significant ($F_{2,75} = 8.71$), with R^2 value of .19.</p>

Note. N/R = Not reported; ATT = Attitude; SN = Subjective norm; PBC = Perceived behavioural control; INT = Intention

Study characteristics

Articles were published between 2001 and 2018, with one study conducted in Australia, one in both Australia and Canada, two in the Netherlands, two in the United States of America and seven in the United Kingdom. Various job roles were represented, however qualified nurses were the most recurrent, appearing in seven of the studies. Nursing assistants and social workers both appeared in five of the studies and medical doctors/psychiatrists in four. Other professions included clinical psychologists/psychological therapists, occupational therapists and more specialised roles. The studies comprised differing settings and client groups; adult mental health, alcohol and substance abuse services, dementia, intellectual disabilities and older adult's mental health were all represented.

Study methodology

Twelve of the studies reported using quantitative methods with one study using a mixed methods approach. Within this, the research designs varied between a prospective cohort study (1 study), a time series analysis (1 study), randomised controlled trials (3 studies) and cross-sectional studies (8 studies). The quantitative element of the mixed methods study appears to be a cross-sectional design and therefore has been categorised as so. The randomised controlled trials used the TPB variables to evaluate any differences between two groups. The prospective cohort study and one of the randomised controlled trials collected follow-up data however these were on differing variables to the TPB; one was measuring implementation of a tool and the other looked at stage of change. The time series analysis used TPB variables to explore factors influencing adherence to a guideline, with the data then being used to develop an intervention. As per the inclusion criteria, all studies used a TPB questionnaire that had either been designed by the authors or adapted from published studies. Ten studies reported on additional measures alongside the TPB variables. Four of the studies

included a measure of actual behaviour, four included a measure of past behaviour, and two included measures of self-efficacy.

Instruments

All studies administered a quantitative TPB questionnaire, which as a minimum measured attitude, subjective norm, perceived behavioural control and intention, as per the inclusion criteria. There are guidelines available that researchers can follow when constructing TPB questionnaires (Ajzen, 2006; Francis et al., 2004). If constructing both indirect and direct measures, questionnaires should contain a minimum of 30-items, plus another 10 if completing the behavioural simulation method of measuring intentions. Brief questionnaires of 12-items, only containing direct measures, may be considered. Internal consistency should be established and the guidelines by Francis et al. (2004) recommend a value of $>.06$ to be deemed as acceptable for the items to be included in the final analysis.

The number of questionnaire items and Cronbach's α scores can be found in the data extraction table (Table 5). Two studies did not report on number of questionnaire items and four studies did not contain the minimum amount of questionnaire items required for each construct (Faulkner & Biddle, 2001; Foy et al., 2007; Garner et al., 2011; Janus et al., 2017). Only five studies reported the Cronbach's α scores for all the constructs; attitude, subjective norm, perceived behavioural control, and intention. Two studies did not report any Cronbach's α scores and six studies reported scores for only some of the constructs. For those that were reported, attitude items ranged from $\alpha = .69-.93$. One study did not report the reliability score for attitude as it was not deemed acceptable. Cronbach's α scores for subjective norm items ranged from $\alpha = .54-.86$. Two studies did not report the reliability score for subjective norm, with one reporting that it was not deemed acceptable. Cronbach's α scores for perceived behavioural control items ranged from $\alpha = .50-.92$. Two studies did not report the reliability score for perceived behavioural control, with one reporting that it

was not deemed acceptable. Cronbach's α scores for intention items ranged from $\alpha = .72-.91$. Two studies did not report the reliability score for the intention items, with one reporting that it was not deemed acceptable.

Objective 1: To evaluate the overall effectiveness of the theory of planned behaviour to predict mental health professionals' intentions towards certain behaviours

Studies examined how effective attitude, subjective norm, and perceived behavioural control were at predicting mental health professionals' intentions to carry out a specified behaviour. The total amount of variance accounted for by the three TPB variables in intentions ranged from 29.4% to 63% across the 13 studies.

Blankers et al. (2016) measured mental health workers intention to provide smoking cessation support to people with mental health difficulties. They found that attitudes and perceived behavioural control were strongly associated with intentions to provide future smoking cessation support, however subjective norm had a limited association with intentions. This was not the only study to find limited support for subjective norm as a predictor of intention. Janus et al. (2017) in their study exploring nurses and nursing assistants' requests for antipsychotic medication for people with dementia found subjective norm not to be a significant variable. Attitude and perceived behavioural control however were both significantly associated with intentions. Martin et al. (2011) also found the same pattern of results when looking at carer intentions to support physical activity for people with an intellectual disability.

Conversely, Foy et al. (2007) when investigating professionals' intentions to disclose a diagnosis of dementia to patients found subjective norm to be an important explanatory variable across analyses. Here behaviour was categorised into 'exploring what the patient already knows', 'use of explicit terminology when talking to patients' and 'exploring what the diagnosis means to patients'. Subjective norm was consistently significant and explained

the greatest amounts of variance in intention over attitude and perceived behavioural control (23.5%, 38.8%, 36.4% for each behaviour respectively). Interestingly, this was the only cross-sectional study not to find a significant affect for attitude in regards to the ‘exploring what the diagnosis means’ behavioural outcome; attitude was a significant factor in all other studies.

Perceived behavioural control was only found not to be a significant contributor in Lecomte et al’s. (2018) study exploring clinicians’ delivery of cognitive behavioural therapy for people diagnosed with psychosis (CBTp).

Four studies found all of the TPB variables to significantly contribute to intention; Faulkner and Biddle (2001) in a 6-month prospective study to promote physical activity to people with mental health difficulties; Jenkins and McKenzie (2010) when studying whether carers encourage healthy eating to people with intellectual disabilities; Kelly et al. (2012) investigating whether substance abuse workers implement evidence-based practices; Levy et al. (2016) understanding how to increase psychological wellbeing practitioners’ use of cognitive behavioural therapy self-help materials.

Two of the studies included an additional measure of self-efficacy (Bandura, 1977) alongside the TPB variables (Foy et al., 2007; Jenkins & McKenzie, 2010). In both studies, self-efficacy significantly correlated with intention, however did not explain a greater proportion of the variance than the TPB constructs. In the latter study, self-efficacy reduced the association between perceived behavioural control and intention and was not found to be a significant predictor variable.

Four studies also measured past behaviour, all using self-report measures, with all four studies finding a significant association between past behaviour and intention (Blankers et al., 2016; Faulkner & Biddle, 2001; Jenkins & McKenzie, 2010; Levy et al., 2016). Levy et al. (2016) reported that past behaviour accounted for 42% of the total amount of variance in

intention ($p < .001$) and Faulkner and Biddle (2001) reported that including past behaviour improved the predicted amount of variance in intentions by 10% ($p < .01$).

Objective 2: To evaluate the overall effectiveness of the theory of planned behaviour to predict mental health professionals' behaviour

Four of the studies measured mental health professionals' behaviour; three using self-report methods through incorporating additional items into questionnaires, and one using an objective measure.

In their self-report measure of behaviour, Janus et al. (2017) incorporated an open-ended question asking nurses how often they requested either a physician or nurse specialist to prescribe antipsychotics to people with dementia over the past 3 months; with 63% of respondents stating they had. The only variable found to predict this behaviour in the regression analysis was current position; nurses that were less well-educated were more likely to request antipsychotics. Lecomte et al (2018) also incorporated a self-report item into their measure, "Do you use cognitive behaviour therapy in your practice for consumers with symptoms of psychosis?". Results showed that training in CBTp and subjective norm predicted use of CBTp.

Rather than evaluating the implementation of the target behaviour, Blankers et al. (2016) measured the self-reported smoking behaviour of mental health professionals to examine whether there was an association between their actions and their intention to provide smoking cessation support to mental health service users. Although there was an association between smoking behaviour and attitude, the regression coefficient estimates between smoking behaviour and intention were not significant.

In a randomised controlled trial, Casper (2007) measured behaviour objectively to compare the TPB and standard class groups in their implementation of an assessment tool with people with mental health difficulties. Participants in the TPB class had significantly

higher implementation rates of the tool (74% versus 42%, $p < .01$) and higher numbers of caseload assessed with the tool (94% versus 74%, $p < .01$).

Objective 3: To examine how the theory of planned behaviour has been in intervention studies

Garner et al. (2011) investigated whether pay-for-performance (P4P) methods impacted on therapists' intentions to achieve quality care targets in adolescent substance abuse services. The experimental group were given the opportunity to earn financial gains if certain targets were satisfied; to achieve a monthly competence level and to deliver a targeted threshold of treatment. Therapists in the P4P group reported significantly higher intention to perform both targets than the implementation-as-usual group.

Ince et al. (2015) adapted clinical guidelines for psychological treatments in schizophrenia to be more behaviourally specific and using plain English language. The experimental group were given the adapted guidelines to work from, and the control group were given the standard guidelines. All participants completed a TPB measure at baseline and 1-month later. No significant differences were found in intentions to implement the guidelines between the groups, nor attitude and perceived behavioural control. Subjective norm was found to be significant, however this was also the case at baseline and so was stable over time, regardless of intervention.

Casper (2007) used the TPB to guide development of an intervention; a continuing education class to mental health practitioners in order to encourage use of an employment scale with the individuals they support. For the control group, the class were presented the information as usual, however the intervention group completed an elicitation study to produce the group's common attitudes, social norms and perceived behavioural control regarding a statement based on the TPB. The class was then guided by this content. All participants completed the TPB questionnaire before and after the class. Pre-class, the TPB

variables accounted for 63% of the total variance in intentions. The TPB guided format resulted in significantly greater mean post-class intentions than the standard format.

Lastly, Hanbury et al. (2010) conducted a time series analysis that included developing a TPB intervention aimed at increasing community mental health professionals' uptake of a national suicide prevention guideline. Similar to Casper (2007), the TPB was used to guide the development of the intervention. Pre-intervention, attitude, subjective norm and perceived behavioural control accounted for 58% of the variance in intention, however subjective norm was found to be the only significant predictor. Therefore, the intervention was tailored to focus around the normative beliefs using presentations, group discussion and vignettes. The TPB questionnaire was re-administered post-intervention and only scores on perceived behavioural control had significantly increased.

Discussion

This systematic review aimed to analyse emerging literature that uses the TPB as a theoretical base from which to understand mental health professionals' intentions and behaviours. With increasing demands on staff to work within the evidence-base, it is important to understand any potential barriers and the factors behind decision-making. The 13 empirical studies in this review were undertaken from 2001 onwards, with nine completed in the last 10 years. As a developing concept, it is important to review its efficacy in relation to any clinical implications.

All of the reviewed studies were able to report an overall significant result when using the constructs of the TPB to predict mental health professionals' intentions to carry out a targeted behaviour. The amount of variance in intention ranged from 29.4% to 63%, which corresponds with previous meta-analyses of TPB studies, including studies conducted in health settings (Armitage & Connor, 2001; Godin & Kok, 1996; Sheeran & Taylor, 1999). Subjective norm proved to be the weakest variable, not adding a significant amount of

variance in the prediction of intention in three studies. This can be a common occurrence in TPB studies, with little known reasoning. Armitage and Connor (2001) found evidence to suggest that studies that only measure subjective norm using only a single-item find a weaker association between subjective norm and intention. This did not seem to be an issue with the reviewed studies however. Ajzen (1991) argues that intentions are more directly influenced by personal factors, such as attitude and perceived control. However, others feel that the subjective norm component is too narrow, only exploring perceived social pressures from others, not what others think or do themselves in relation to the targeted behaviour; a measure of descriptive norm (Norman, Clark & Walker, 2006; Ravis & Sheeran, 2003).

Including additional theory alongside the TPB showed little impact on the prediction of intention. Self-efficacy did not account for any significant variance over the original TPB constructs. Self-efficacy (Bandura, 1977) refers to a person's beliefs around whether they feel capable to undertake a behaviour and is usually expressed in terms of confidence. Perceived behavioural control differs slightly in that it measures perceived ease or difficulty of undertaking a behaviour. Both, however, suggest a process of appraising ability and potential successes and therefore measurement of them has the potential for overlap. In previous meta-analyses, authors have concluded that the two constructs could be considered synonymous (Sheeran & Taylor, 1999) and therefore there seems to be little rationale for including self-efficacy alongside the TPB constructs.

Of the studies that measured actual behaviour, only the study that objectively measured behaviour, rather than relying on self-report, found a significant association between intention and behaviour. Previous evidence has found a discrepancy between subjective and objective behaviour reporting, particularly due to overlap between self-report behaviour and intention (Armitage & Connor, 2001). Therefore, as this review reinforces, behaviour should always be measured objectively where possible.

Ajzen (2006b) recommends including a measure of past behaviour within a TPB questionnaire. Four studies adhered to this and all found a significant relationship between past behaviour and future intention. It is important to note however, that past behaviour can act as a confounding variable if the correlation between it and intention is high, or if it adds its own unique variance to the prediction of behaviour. Ajzen (1991) has argued that past behaviour should be mediated through perceived behavioural control. It appears this was the case in the Blankers et al. (2016) study, however past behaviour was also directly associated with intention.

Four studies designed a behavioural intervention targeting the constructs of the TPB, with the aim to change intention and subsequently behaviour, with varying success (for guidelines on constructing behavioural interventions, see Ajzen, 2006a). Only two studies (Casper, 2007; Garner et al., 2011) found significant changes in intention post-intervention. It is important to note however, that in the Garner et al. (2011) study, payment was offered to those who subsequently changed their behaviour. This feels that it would not only directly impact intention to perform the behaviour, but could have an implicit bias on attitude, subjective norm and perceived behavioural control. It is felt that the authors should have measured whether being in the payment condition alone had a direct association with the targeted behaviour. In a meta-analysis exploring the effectiveness of TPB interventions (Steinmetz, Knappstein, Ajzen, Schmidt & Kabst, 2016), the authors found that effect sizes were increased if the intervention was conducted in a group. Although the Hanbury et al. (2011) study, which did not find significant before and after results, did administer the intervention in a group, Casper (2007) included a group discussion on salient beliefs which were then used to guide the intervention. This may have resulted in greater group conformity (and therefore increased social influences) and participants perceiving more ownership over the intervention.

Limitations

A requirement of conducting a TPB study is to design a measure that meets the specific aims and targeted behaviour required for the needs of the population to be studied. Therefore, unless a previous study is being replicated, a pre-defined, validated TPB measure generally, may not exist. This poses a challenge to the systematic review process, in that the quality and type of measures vary, with differences in measuring direct and indirect constructs, and including measures of past and actual behaviour. This is further compounded by the studies adopting varying research designs, making directly comparing results challenging.

Multiple studies either did not report internal scale consistency or had missing Cronbach's alpha ratings. Some had values that were deemed unacceptable but continued to use the measures in the final analysis; where they may not have had acceptable enough reliability to be included in a predictive model. Alongside this, two of the studies had a low sample size and would not meet power of 0.8 for a medium effect size, if the guidelines by Francis et al. (2004) were followed. Therefore, some of the results and conclusions reported should be considered with caution.

Articles that used qualitative methods for data collection were excluded from this review due to the wide-range of methodologies presented, potentially missing out on further rich information that could be a meaningful addition to the evidence base.

Clinical implications

The studies reviewed have all shown that using the TPB as a theoretical base to understand mental health professionals' intention to perform a targeted behaviour can be effective. This is similar to results from physical health settings as shown in the systematic review by Perkins et al., 2007. The majority of the cross-sectional studies comment on how the findings can be utilised to develop an intervention aimed at changing health professional behaviour. In completing this first phase, the intervention benefits from being informed on what specific

areas to target in an intervention to maximise its effectiveness. It would be important for researchers to pay attention to the existing literature in using the TPB to inform intervention, due to the diverse range of behaviour change methods identified. Casper (2007) gave a good example of how undertaking an elicitation exercise, where participants had to agree on salient beliefs within a group setting during the intervention, could lead to meaningful behaviour change.

One important factor of note is that although the range of variance accounted for in intention in this systematic review was often quite high (highest 63%), a large percentage of variance remains unaccounted for. When undertaking TPB studies with health professionals, other, broader factors could be of influence. The Improved Clinical Effectiveness through Behavioural Research Group (2006) state that the TPB is a 'mid-range theory' in that it is de-contextualised, and it can be applied to a range of specific problems. It is most appropriate when the focus is the behaviour of individual clinicians, not when there are external factors involved. Therefore, it may be beneficial to consider a systems approach that takes into account organisational factors, culture and management support when developing behavioural intervention (Berry & Haddock, 2008).

Conclusion

This is the first known systematic review to explore the use of the TPB with health professionals in mental health settings. The results have shown that the TPB can be effective in predicting intentions in a wide range of services and with varied behaviours. There continues to be limited research in using the TPB to guide intervention and where this has been conducted, results have been varied. Empowering mental health professionals to be more invested in the behaviour through group discussion has been shown to be beneficial. Due to the varying nature of populations and behaviours the TPB can be effective with, systematically reviewing data output can prove challenging. Researchers should endeavour to

strictly follow published guidelines on constructing TPB measures and utilise TPB specific quality assessment tools to enable more consistency in measurement and data analyses.

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Chapter 2: Empirical paper

What psychological theory does not teach us about life on acute mental health wards: An exploration of human rights using a mixed methods research design.

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(Appendix D)

Abstract

There has been a shift to implement human rights-based approaches in mental health care due to increasing concerns around quality of care, particularly on acute mental health wards. National Health Service (NHS) Trusts have a legal duty to promote and uphold a person's human rights, therefore it is important to understand what some of the barriers to using this approach might be. Using psychological theory as a framework may help to develop this understanding. The aim of this research was to test whether the theory of planned behaviour is effective in predicting mental health professionals' intentions to work using a human rights-based approach. Secondly, it explored service users' perceptions of care using a human rights-based framework. Participants were recruited from two separate NHS Trusts in the North West of England between October 2018 – April 2019. A cross-sectional, survey design was used to examine mental health professionals' intentions to use human rights-based approaches. Service users' perspectives were analysed using mixed methods, where qualitative data was used to contextualise quantitative data. Content analysis was used to categorise service user responses to a structured questionnaire. Multiple regression analyses were performed on the theory of planned behaviour constructs which showed that attitude and subjective norm significantly predicted intention. Perceived behavioural control did not add any significant variance to the model, neither did any demographic variables. Pearson Chi-Square showed some significant differences on service user perspectives on human rights between NHS Trusts, particularly around physical safety and safety of belongings, basic needs and feeling informed. This was supported by the results from the content analysis. Psychological theory may not in fact be useful in understanding human rights on acute mental health wards if there are external barriers that are beyond health professionals' control. It is recommended that NHS Trusts urgently review the ward environment to verify compliance with human rights law.

Keywords:

Human rights-based approaches, theory of planned behaviour, mental health professionals, service user perspectives, acute mental health care.

Introduction

The Human Rights Act 1998

The Human Rights Act 1998 incorporates 16 articles from the European Convention on Human Rights into law in the United Kingdom (UK). Human rights belong to everyone and reflect the minimum standard of treatment in relation to physical, psychological and social wellbeing. The Human Rights Act gives protection to anyone living in the UK, regardless of whether they are a British Citizen and enables individuals to defend their rights in UK court (Liberty, n.d.). All public organisations, including the National Health Service (NHS), schools, police and government, must comply with the Human Rights Act. They also have a positive obligation to actively promote rights, particularly in vulnerable groups (Citizens Advice, 2019). Some of the articles within the Act are ‘absolute’, meaning they cannot be interfered with under any circumstances, such as the right not to be tortured. However, there are rights that can be restricted in given situations. ‘Limited’ rights constitute articles that can be restricted in limited circumstances, such as the right to liberty for someone who is detained under section of the Mental Health Act (1983). ‘Qualified’ rights can also be restricted where there is a legitimate interest to do so, such as the right to freedom of expression if it was to interfere with someone’s right to privacy. Qualified rights can only be lawfully restricted if the reason is proportionate to the intended objective and should be the least restrictive option (EQHRIA, n.d.). The Human Rights Act is considered primary legislation meaning that any current or future legislation must be compatible with it (Department for Constitutional Affairs, 2006). This includes the Mental Health Act, which must only be used when all other options have been taken into account and no other, lesser restrictive options, can be considered (Care Quality Commission, 2018).

The Mental Health Act 1983 and mental health wards

In 2007, amendments were made to the Mental Health Act after longstanding calls for reform. Part of these calls were to ensure the Mental Health Act focussed more on the rights of individuals who experience mental health difficulties, rather than risk. However, consensus within the literature suggest that the amendments continue to be driven by public safety (The King's Fund, 2008). It is possible to restrict the rights of individuals who require hospital or medical treatment under the Mental Health Act due to legitimate interests such as protection of health, or public safety. One right that can be limited is the right to liberty, for example when a person is detained on a mental health ward and is unable to leave. In the final report of the Independent Review of the Mental Health Act (2018), of being detained in hospital the authors write "the service user, stands to lose authority over him or herself, loses self-determination and as a result, quite apart from other features of the system, can be stripped of their dignity and self-respect" (p. 5). There have been a number of reports highlighting concern with the quality of acute inpatient services for a number of years (Commission for Healthcare Audit and Inspection, 2008). The Care Quality Commission (CQC; 2018) completed comprehensive inspections of mental health services from 2014-2017 finding that on mental health wards there were still considerable issues around safety and persistent use of restrictive practices. In 2018, the Parliamentary and Health Service Ombudsman published a report summarising complaints and investigation reports which continue to find failings in upholding people's dignity and human rights on acute mental health wards.

Human rights-based approaches

In 2007, the Department of Health published a framework to assist NHS Trusts to implement a human rights-based approach (HRBA) to healthcare. The five key principles of a HRBA are outlined as:

- 1) putting human rights principles and standards at the heart of policy and planning;
- 2) empowering staff and patients with knowledge, skills and organisational leadership and commitment to achieve human rights-based approaches;
- 3) enabling meaningful involvement and participation of all key stakeholders;
- 4) ensuring clear accountability throughout the organisation;
- 5) non-discrimination and attention to vulnerable groups.

Although it feels essential to have a clear framework in place if the goal is to increase knowledge and create a shift towards working within a rights-based approach, there has been criticism that these frameworks have been too vague and defined too broadly. Having a definition too conceptual in nature makes it much more difficult to hold those who violate the approach to account, risking its integrity and usefulness (Batliwala, 2007). Being so broad also causes evaluative issues, as the concepts do not lend themselves to tangible measurement. There have also been concerns surrounding the universality of HRBAs, particularly the concept of individual rights, rather than collective rights. In this sense, HRBAs have been criticised for being too Westernised and making cross-cultural judgements about individuals and societies, not taking into account the complexities of human dignity (Mutua, 2013). Kinderman and Butler (2006) also reflect on how human rights can be poorly defined, misunderstood and therefore, not fully implemented into public services. In a paper aimed to explore how psychological theory can help develop human rights policy, they suggest that embedding HRBAs into a code of practice will help public sector workers take into account that human rights are required by law, but the principles complement already existing value systems such as an ethos around equality. Curtice and Exworthy (2010) introduced a human rights-based framework that aimed not to be too broad or technical, but that followed the core values of fairness, respect, equality, dignity and autonomy, or the FREDA principles. It is assumed that health care professionals are already familiar with these

values and therefore it is a framework that could be more easily implemented into healthcare settings. Kinderman and Butler (2006) offer a detailed overview of psychological theories that may help or hindrance implementation. Behavioural models of change could include punishing or sanctioning those who do not comply with the approach, or offering reward to those who do. Using a more directive approach however, increases the risk of ‘psychological reactance’; wanting to resist changes that feel imposed on you. Cognitive models could address this reactance by focussing on cognitive scripts, such as attitudes and beliefs in the first instance, before intervening to change behaviour. However, many psychologists believe that behaviour cannot be fully understood by just examining the individual alone and that social context and networks are important influencing factors. The authors refer to the theory of planned behaviour as a model that incorporates both these factors, as well as influences from self-efficacy, an individual’s belief in their control to carry out a behaviour, particularly health-related behaviours.

The theory of planned behaviour

The theory of planned behaviour (TPB) has a background in social psychology and has predominantly been used in relation to health behaviours. Developed from the theory of reasoned action (Ajzen & Fishbein, 1980; Fishbein and Ajzen, 1975), the model proposes that for an individual to behave in a certain way, they first must have intention to do so. It also supposes that there are three underlying factors that cause someone to have intention to act; attitude, subjective norm and perceived behavioural control. Attitude relates to the belief an individual holds towards the action (positive or negative), subjective norm relates to the perceived social pressure from important others, and perceived behavioural control relates to whether that individual believes they have control in carrying out the action (both internal and external control). The TPB has a large evidence base in relation to health behaviours, such as predicting intention to quit smoking cigarettes (Godin & Kok, 1996), increase

exercise (Hagger et al., 2002; Hausenblas et al., 1997), condom use (Albarracin et al., 2001; Sheeran & Taylor, 1999), to name a few. During the last few decades, there has been an emergence of research in using the TPB with health professionals (see Perkins et al., 2007). This has widely focussed on predicting health professional's intention to carry out a behaviour that may have a direct influence on patient care, such as hand washing (White et al., 2015) and incident reporting (Lee, Yang, & Chen, 2016). However, there continues to be a limited number of studies that aim to predict intentions of health professionals working in mental health settings (Perkins et al., 2007). To date, no research using the TPB to predict intentions to use HRBAs in mental health settings have been identified.

Aims

This research is interested in human rights on acute mental health wards. The aim of this paper is two-fold: Firstly, to test whether the theory of planned behaviour is effective in predicting mental health professionals' intentions to work using a human rights-based approach. Secondly, to explore service users' perceptions of their care using a human rights-based framework.

Being aware of the complications around defining HRBAs, this research will draw upon the FREDA principles to act as a more operationally defined measure of behaviour.

Method

Ethics

Approval for the design of the study was first agreed by the Doctorate in Clinical Psychology Research Review Committee at the University of Liverpool (Appendix E). Ethical approval was sought and given a favourable opinion by the National Research Ethics Committee (18/NW/0170) and Health Research Authority (Appendix F and G). The University of Liverpool acted as sponsor for the research (UoL001352; Appendix H).

Design

This study adopted a mixed methods research design, specifically a sequential explanatory design (Cresswell and Plano-Cark, 2007) where the qualitative component was used to contextualise the quantitative results. There were two groups of participants; mental health professionals and service users. The mental health professionals were recruited for the quantitative component of the study, which was a cross-sectional, questionnaire design. The theory of planned behaviour questionnaire aimed to test whether the attitudes, subjective norm and perceived behavioural control of the mental health professionals predicted intention to work using a human rights-based approach. Service users were recruited for the qualitative component of the study, which consisted of a content analysis (Hsieh & Shannon, 2005) of responses from open-ended feedback on a structured questionnaire. In a previous study by Kinderman et al. (2018), it was found that although staff working with individuals with dementia reported more positive attitudes towards human rights and intention to make changes to their ways of working, service users reported no differences in quality of care. Therefore, the mixed methods design of this study followed from this apparent intention-behaviour gap, attempting to understand what the possible barriers might be, from the perspective of service users. The Human Rights Survey (Appendix R) was used to attempt to gather this perspective. In order to protect anonymity, it was not possible to directly match the health professional data to the service user data and therefore, the service user data cannot be used as a measure of actual behaviour. The design has been visually captured in Figure 4.

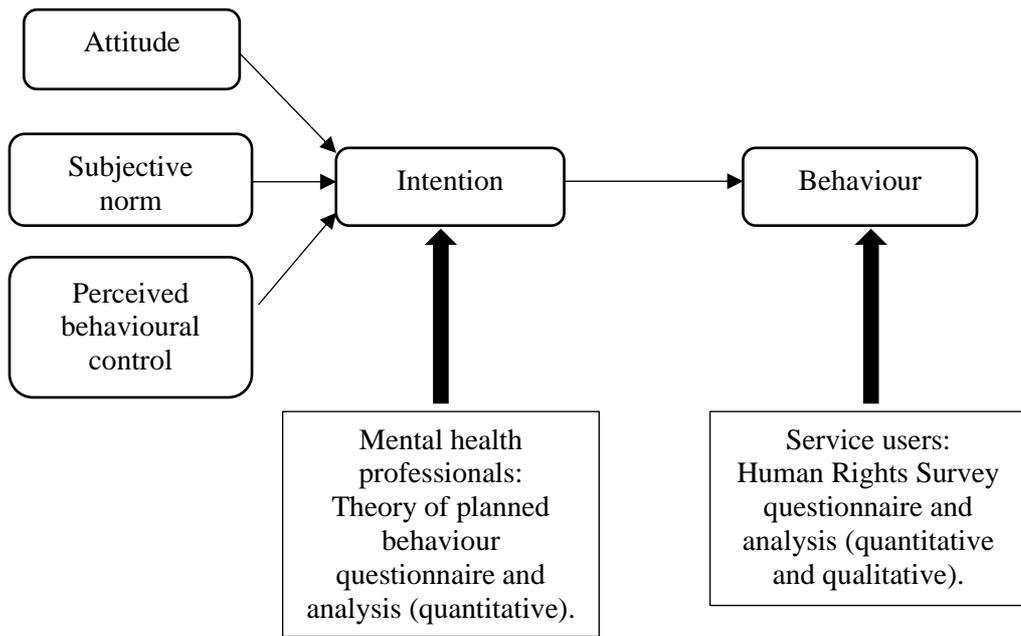


Figure 7. Visual representation of how the design of the study fits the framework of the theory of planned behaviour.

Consultation with previous patients

Consultation was undertaken during the design phase of the research. Involvement was advertised through the research departments of both NHS Trusts and four individuals were able to provide consultation. The involvement of individuals with experiences of inpatient stays on acute mental health wards felt in keeping with a human rights-based approach. Involvement helps to create a shift from conducting research on or about people, to developing and conducting research with people, or by them (INVOLVE, 2012). The consultations provided the researchers with specialist knowledge on spending time in such an environment and possible barriers to recruitment. Notes containing further information about the discussions can be found in Appendix I. Payment was provided to all individuals who contributed to the consultation phase.

Construction of the theory of planned behaviour questionnaire

The TPB questionnaire was constructed based on the published guidelines by Francis et al. (2004) and the recommendations of Ajzen (2006a). The model assumes that there are three variables that predict intention; attitude, subjective norm and perceived behavioural control. However, specific salient beliefs underlie these three variables; behavioural beliefs, normative beliefs and control beliefs. Therefore, the theory of planned behaviour allows for the development of both direct and indirect measures of the three variables (Gagné & Godin, 2000). Here, the indirect measures were constructed by first conducting an elicitation study to gather commonly held behavioural, normative and control beliefs from a small sample of the target population. A questionnaire with open ended questions was emailed to five mental health nurses, recruited through convenience sampling. Four replies were received (response rate of 80%) and themes were explored through a content analysis. The beliefs that were most recurrent were then converted into questionnaire items. Direct measures of attitude, subjective norm and perceived behavioural control were constructed as per examples

provided in the guidelines, with a change in content to fit the behavioural outcomes of the study. The same procedure was used to construct generalised intention items. All the items were measured on a 7-point Likert-scale. The questionnaire was checked by the supervisory team for any issues with grammar or comprehension.

Participants

The study recruited from two NHS Trusts specialising in mental health in the North West of England. Initial contact was made through the research departments to gain approval for the study and then to managers to seek consent for access to the acute mental health wards.

Participants were recruited from five wards in total.

Staff

Staff members were invited to participate if they; worked in acute adult mental health inpatient services, were employed directly by the NHS Trust, and worked directly with service users. Based on a medium effect size ($f^2 = 0.15$) and a power level of 0.8, the minimum number of health professionals required for a multiple regression analysis is 76.

Across five wards there were a total of 150 mental health professionals eligible to participate.

Overall, 76 members of staff participated resulting in a response rate of 50.7%.

Service Users

Service users were invited to take part if they; were an inpatient on an acute mental health ward, had a minimum length of stay of 48 hours at the time of participation, and were deemed to have capacity to consent to research participation. Eligible number of services users to participate could not be calculated due to the amount of admissions and discharges and changeable nature of capacity. One service user was not able to participate due to their stay not reaching 48 hours, one service user was identified as not having capacity to consent during the consenting procedure, one withdrew consent during participation and five decided not to participate after having time to process the information sheet and consent process.

Settings

The two acute wards in NHS Trust A where data were collected both had separate rooms for each service user, each with an ensuite bathroom containing a toilet, sink and shower. Each bedroom contained a bed, wardrobe, desk and each had a window. Both were mixed sex wards, however male and female rooms were located on different corridors, with a common space separating them. Each had a communal dining area and separate television room. Each also had at least two other separate communal areas and a smaller room containing a telephone, which could be used for private meetings. On admission to the ward, each service user receives an electronic 'fob' which acts as a key to their bedroom and the main ward door if given access. If granted leave, service users are required to sign out, but can leave the ward using their own fob. There is no outside access on either of the wards, for time outside service users have to leave the ward.

The three wards in NHS Trust B all had dormitory accommodation, with a curtain separating each bed. There were also some additional private rooms. Bedrooms contained a wardrobe or a cabinet without doors on the front. All service users had access to shared bathrooms, which would include a toilet, sink, shower or bath. One ward was mixed sex, again separated by different corridors and the other two wards were single sex (one male, one female). Each ward had a communal dining area and separate television room. Each ward had one other smaller room, often used for private meetings. All three wards had access via lock and key which only staff had access to. If a bedroom door was locked or they wanted to go off the ward, service users are required to ask staff. There was some access to outside space, however this was shared between the three wards and so was only accessible at certain times.

Measures

Staff

The TPB measure provided to participants consisted of 59 items in total measuring generalised intention, attitude, subjective norm and perceived behavioural control.

Generalised intention consisted of 3 items and achieved an acceptable Cronbach's alpha score ($\alpha = .75$). The attitude measure initially consisted of 16 items, 4 direct measures and 12 indirect measures. Whilst piloting the measures it was noticed that 2 of the indirect belief items did not have a corresponding outcome evaluation measure and were removed from the final analysis, resulting in attitude consisting of 14 items. These achieved an acceptable Cronbach's alpha score ($\alpha = .88$). Subjective norm consisted of 22 items, 4 direct measures and 18 indirect measures which achieved an acceptable Cronbach's alpha score ($\alpha = .80$). Perceived behavioural control initially consisted of 18 items (4 direct items, 14 indirect items), however issues with internal consistency resulted in 12 of the items being removed from the final analysis, resulting in perceived behavioural control consisting of 6 items, 2 direct measures and 4 indirect measures. These achieved an acceptable Cronbach's alpha score ($\alpha = .76$).

Demographic variables were also measured which included information on job role, amount of years qualified, how many years working in acute mental health services and training in human rights.

Service Users

The 'Human Rights Survey: Hospital Patients' was developed as part of the Human Rights in Healthcare Programme which ran from 2011-2012. The survey was trialled at City Hospitals Sunderland. It consists of a total of 18 questions drawing upon the FREDAs principles as the primary framework. Each question has an answer format on a 3-point descriptive rating.

There is an open-ended feedback section at the end where participants are asked for

additional comments. Each of the 18 questions includes a qualitative aspect to further expand on responses. The content and scoring system were slightly adapted to better meet the research aims. No data concerning usability, reliability or effectiveness have been published. With the data set presented here, the questionnaire achieved a Cronbach's alpha score ($\alpha = .61$).

Demographic variables were also measured which included information on length of stay, previous admissions, diagnosis, Mental Health Act (1983) status and training in human rights.

All participants, staff and service users, received an information leaflet on human rights outlining the articles of the Human Rights Act (1998) that are most relevant to someone who is an inpatient on a hospital ward (see British Institute for Human Rights at <https://www.bihhr.org.uk>).

Procedure

Data was collected over a period of 6 months, from October 2018 to April 2019. First author [SDLB] actively recruited on the wards on a weekly basis; NHS Trust A was visited on 12 occasions and NHS Trust B was visited on 11 occasions.

Service managers were initially contacted by email to give the details of the study, present the research materials and answer any concerns. Once agreement was sought for the research to go ahead, ward managers were then contacted to gain permission to enter the wards on specified dates.

Staff

In order to maximise participation, paper copies of the questionnaire pack were left on each ward for staff to complete in their own time. The pack included the participant information sheet (Appendix J), consent form (Appendix K), demographic questionnaire (Appendix L), human rights leaflet (Appendix M) and TPB measure (Appendix N). These could then be

placed into a separate envelope once completed. Alongside this, the first author had a physical presence on the wards (as explained above) to answer any questions and collect completed questionnaires. Contact details of the research team were made available if any participant had any further enquiries or concerns.

Service Users

To meet the inclusion criteria, service users had to be deemed as having capacity to consent to research at the time of recruitment. Staff on the ward identified those who would be appropriate for participation, who were then asked if they would like to speak to the researcher for more details. Service user recruitment was face-to-face on an individual basis and in a private room to respect confidentiality. Time was given to study the participant information sheet (Appendix O), ask any questions and sign the consent form (Appendix P). The service user was also given time to study the human rights leaflet. The researcher then completed the measures with the service users; a demographic questionnaire (Appendix Q) and the Human Rights Survey: Hospital Patient questionnaire (Appendix R). Service users were given the choice to keep a copy of the information sheet and human rights leaflet. Contact details of the local complaints and advocacy service and the research team were made available.

Data analysis

Data were inputted and analysed using IBM SPSS Statistics Version 24 software. For the TPB analysis, Pearson product moment correlation coefficients were conducted between the direct and indirect measures of attitude, subjective norm and perceived behavioural control to confirm the validity of the indirect measures. Correlations were also performed to explore any relationships between the three direct predictor variables and generalised intention.

Analyses found the data not to be normally distributed and therefore the multiple regression analysis was performed with bootstrapping. The multiple regression analysis was

conducted in three stages; firstly, the indirect measures were regressed onto the direct measures for each construct. Secondly, the direct measures of attitude, subjective norm and perceived behavioural control were then regressed onto generalised intention. Thirdly, demographic variables were inputted as additional, potentially confounding predictor variables.

The quantitative service user data was analysed using frequencies for each question of the Human Rights Survey, with a Pearson Chi-Square test conducted to test for any significant differences between NHS Trust. Qualitative data was analysed using content analysis due to its flexible nature in examining text data. As the data to be studied originated from a structured questionnaire, the content analysis was conducted in a directed way (Hsieh & Shannon, 2005), using each question as a framework to begin building categories and themes based on service user answers. The analysis was undertaken by the first author [SDLB] and reviewed by the research team.

Results

Participant characteristics

Staff

Out of 76 participants, 57 (75.0%) described themselves as female and 18 (23.7%) described themselves as male; one preferred not to answer (1.3%). The majority of participants were aged 25-34 (27, 35.5%), followed by 45-54 (16, 21.1%), 35-44 (15, 19.7%), 16-24 (13, 17.1%) and 55-64 (4, 5.3%); one preferred not to answer (1.3%). The predominant ethnic group reported was White British (61, 80.3%), followed by British Indian (2, 2.6%), White Irish (2, 2.6%) and White Other (2, 2.6%). Nursing assistants were the most common job role represented (29, 38.2%), followed by nurses (27, 35.9%). Thirteen participants (17%) held a role defined as allied health professional. Also represented were psychiatrists (5, 6.6%) and an assistant practitioner (1, 1.3%). Just over half of participants had worked in acute mental

health services for 4 years or less (41, 54%) with the biggest majority being in the 'less than one year' category (17, 22.4%). Forty participants (52.6%) reported having received internal training on human rights and 10 (13.2%) reported receiving external training.

Service Users

Out of 54 participants, 27 (50.0%) described themselves as female and 26 (48.1%) described themselves as male; one preferred not to answer (1.9%). The majority of participants were aged 25-34 (14, 25.9%), followed by 35-44 (12, 22.2%), 45-54 (11, 20.4%), 16-24 (9, 16.7%) and 55-64 (7, 13%) and 65+ (1, 1.9%). The predominant ethnic group reported was White British (45, 83.3%), followed by British African (2, 3.7%) and Mixed (2, 3.7%). Other reported representations included Asian Indian (1, 1.9%), Black African (1, 1.9%) and White Other (1, 1.9%). The majority of service users had been an inpatient for 1-2 weeks (15, 27.8%), followed by 1-3 months (12, 22.2%), less than one week (11, 20.4%), 2-4 weeks (8, 14.8%) and 3-6 months (7, 13.0%). One service user had been an inpatient for over 6 months (1, 1.9%). Of those who have had previous admissions (36, 66.7%), the majority had five or less (30, 55.6%). Five participants (9.5%) have had 10 or more previous admissions. Half of the participants were staying on the ward on an informal basis (27, 50.0%), 23 (42.7%) were sectioned under the Mental Health Act and four (7.4%) were not aware of their status. The diagnoses most reported were depression (12) and bipolar disorder (12). Percentages are not reported due to participants reporting multiple diagnoses (number of diagnoses ranged from 1-5). Ten participants reported a diagnosis of psychosis (including drug induced and post-partum), nine reported anxiety, nine reported schizophrenia (including paranoid schizophrenia and schizoaffective disorder), seven reported emotionally unstable personality disorder, five reported a developmental disorder (including autism spectrum condition and attention deficit hyperactivity disorder), four reported an eating disorder (including body dysmorphia) and four reported post-traumatic stress disorder. Only six (11.1%) participants

reported having a discussion with a staff member about their human rights and 11 (20.4%) participants had received training in human rights.

Theory of planned behaviour analysis

Descriptive statistics and correlation analysis

Descriptive statistics from the TPB questionnaire are presented in Table 6.

Table 6. Minimum values, maximum values, means and standard deviations from the theory of planned behaviour questionnaire

Predictor variable (with range of scores)	Minimum	Maximum	Mean	Std. deviation
Direct ATT (1 to 7)	4	7	6.47	.82
Indirect ATT (-105 to +105)	0	105	87.24	23.17
Direct SN (1 to 7)	2.75	7	5.21	.90
Indirect SN (-189 to +189)	10	189	118.97	41.17
Direct PBC (1 to 7)	3	7	4.45	.74
Indirect PBC (-42 to +42)	0	42	29.26	11.95
Intention (1 to 7)	4	7	6.54	.71

ATT = attitude; SN = subjective norm; PBC = perceived behavioural control

Pearson product moment correlation coefficients were calculated to test for the assumption of linear correlation as required by multiple regression analysis between the three predictor variables and intention (as shown in Table 7). Both attitude and subjective norm showed a significant positive correlation with intention (p 's < .01). Perceived behavioural control showed a negative correlation and was not significant with intention (p > .05).

Table 7. Pearson product moment correlation coefficients for the three TPB predictor variables and intention

	Subjective Norm	Perceived Behavioural Control	Intention
Attitude	.360**	-.236*	.695**
Subjective Norm		.044	.462**
Perceived Behavioural Control			-.211

* Correlation is significant at the .05 level

** Correlation is significant at the .01 level

In order to confirm whether the indirect items adequately measured the breadth of each of the three variables, bivariate correlations between the direct and indirect measures were also conducted to test for validity. The direct and indirect scores of attitude were significant and positively correlated ($r = .686, p < .01$), as were the subjective norm scores ($r = .451, p < .01$), however the direct and indirect perceived behavioural control scores were not significant and negatively correlated ($r = -.106, p > .05$).

Prediction of intention

Two multiple regression analyses were performed for the prediction of intention. Firstly, to test the TPB variables of attitude, subjective norm and perceived behavioural control. Secondly, to test the TPB measures with the additional demographic variables of age, gender, NHS Trust, training in human rights, qualified or non-qualified member of staff, and amount of time worked in acute mental health. Tests of normality showed the data not to be normally distributed, therefore in order to test the stability of the model, the regression analysis was performed with bootstrapping. The bootstrap was performed with a 95% percentile confidence interval and the number of samples was 1000.

The direct measures of attitude, subjective norm and perceived behavioural control significantly predicted generalised intention ($F_{3,72} = 28.271, p < .001$) and accounted for 52.2% (adjusted R^2) of the overall variance. Attitude was the strongest predictor of the three variables, having the highest standardized coefficient ($\beta = .508, p = .001$), followed by subjective norm ($\beta = .202, p = .042$). Perceived behavioural control was not found to be a significant predictor of intention ($\beta = -.082, p = .466$).

None of the demographic variables included in model two significantly predicted generalised intention. The amount of variance in this model was lower than model one (Adjusted $R^2 = .483$) and it reduced the influence of subjective norm on intention, becoming non-significant ($\beta = .210, p = .053$).

Human rights survey analysis

Responses on each item were assigned a score of 1, 2 or 3, with higher scores representing care more aligned with a human rights-based approach, as rated by the service user.

Frequencies were calculated on the categorical data and then a Pearson's Chi-Square was performed to report any significant differences between NHS Trusts; these can be found in Table 8.

The three most highly-rated questions were question 12c *'would you feel able to complain?'* with 45 (83.3%) respondents scoring it as 3 (able to complain), question 9b *'how easy is it for you to access your belongings?'* with 40 (74.1%) respondents scoring it as 3 (easily accessible), and question 4 *'have you been in severe pain and not been given treatment?'* with 39 (72.2%) respondents scoring it as 3 (no). The three lowest-rated questions were question 11b *'have you had difficulty understanding your care plan?'* with 21 (38.9%) respondents scoring it as 1 (yes), question 9a *'do you feel your belongings are safe here?'* with 20 (37.0%) respondents scoring it as 1 (not safe), and question 12a *'have you been concerned about aspects of your care?'* with 19 (35.2%) respondents scoring it as 1 (yes).

Table 8. Frequencies and Pearson Chi-Square analysis for the Human Rights Survey quantitative data.

	Score	How would you describe your general treatment and care?	How well do you think your basic needs are provided for?	To what extent do you think you are treated with respect?	Have you been in severe pain and not been given treatment?	Do you think your freedom of movement is respected?	How well do staff respect your privacy?	Have you ever felt discriminated against?	Do you feel your needs and beliefs have been respected?	Do you feel your belongings are safe?	How easy is it to access your belongings?	Do visiting hours give chance to see family and friends?	Have you been informed about your care plan?	Have you had difficulty understanding your care plan?	Have you been concerned about aspects of your care?	Have your concerns been addressed?	Would you feel able to complain?
Overall		5	3	5	13	12	5	10	16	20	5	8	16	21	19	10	5
NHS Trust A	1	1	0	1	3	4	1	4	6	3	3	1	3	5	4	1	1
NHS Trust B		4	3	4	10	8	4	6	10	17	2	7	13	16	15	9	4
Overall		10	19	16	2	16	19	6	4	17	9	14	9	2	10	3	2
NHS Trust A	2	0	5	7	1	7	10	3	0	8	5	7	6	1	3	3	1
NHS Trust B		10	14	9	1	9	9	3	4	9	4	7	3	1	7	0	1
Overall		38	32	33	39	25	30	38	34	17	40	29	29	31	25	13	45
NHS Trust A	3	22	19	16	20	12	13	17	18	13	16	14	15	18	17	2	20
NHS Trust B		16	13	17	19	13	17	21	16	4	24	15	14	13	8	11	25
Pearson Chi-Square		**12.03	*7.82	1.43	3.17	.71	1.74	.16	4.51	***14.13	1.26	3.64	*6.70	5.98	**10.67	**11.40	1.15

Pearson Chi-Square: * significant at p < .05 level; ** significant at p < .01 level; *** significant at p < .001 level

Pearson Chi-Square test reported significant differences in frequency of responses between the two NHS Trusts on six questions; question 1 *'How would you describe your general treatment and care?'*; question 2 *'How well do you think your basic needs are provided for?'*; question 9a *'Do you feel your belongings are safe here?'*; question 11a *'Have you been informed about your care plan?'*; question 12a *'Have you been concerned about aspects of your care?'*; question 12b *'Have your concerns been satisfactorily addressed'*.

Participants would only respond to question 12b if they had answered 'yes' (score of 1) or 'possibly' (score of 2) on question 12a. Six participants gave a response from NHS Trust A, whereas 20 participants gave a response from NHS Trust B. On all of the questions that showed a significant difference in responses, a greater number of participants had given a score of 3 in NHS Trust A, and a greater number of participants had given a score of 1 in NHS Trust B.

Qualitative analysis

For the purpose of qualitative analysis, the 18 questions on the Human Rights Survey were grouped into four categories; general care and treatment (question numbers 1, 2 and 12a), values (question numbers 3, 6 and 7), basic needs (question numbers 2, 5, 8, 9a, 9b and 10), and information and communication (question numbers 11a, 11b, 12b and 12c). The four categories with corresponding themes and example citations for each can be found in Table 9.

Table 9. Categories, themes and example citations of the qualitative data from the Human Rights Survey.

Categories	Themes	Example citations
General care and treatment	Supportive staff	Nothing negative to say they treat you with respect and dignity
	Staff trying their best	All the nurses are trained well, they're very busy. They try their best to do things for you, try to be helpful
	Feeling overlooked	No-one is taking care of me, I'm taking care of myself
Values	Concerns with care and safety	Been concerned about my life, crying all the time...I just want to get across that I don't feel safe here, would be safer at home
	Receiving values-based care	Overall very respectful and caring and non-judgemental. Nothing where anyone has been disrespectful
	Care not led by values	At some point we all get treated badly because they're trying to teach us what we should do
	Inconsistent/conditional care	At the minute I am compliant and they have been nice
Basic needs	External issues/barriers to values-based care	Hard because it's not a very private place, you share rooms. People are banging to use the toilet, you have no privacy
	Needs well catered for	Got my own facilities if I need to use the bathroom. Getting a drink is completely open and you can go and make yourself a brew, freely available. Surprised how freely available it is
	Environmental barriers	Basic needs for fresh air, the only access is the smoking cage out there, it's disgusting...the building is not fit for purpose
Information and communication	Not feeling in control	Feel like a pain every time I go out, want to know where you are going and how long, you just want to enjoy your time out, I should be able to do what I want
	Feeling informed	Ward reviews every week, asked how you are doing and about leave, that's good
	Not feeling informed	Don't know what I'm working towards. I know it's long-term inpatient but don't know where, nobody knows so nobody can tell me. I've been told I can't go home, so what am I working towards?
	Ability to complain	I would because I trust them
	Not feeling able to complain	Not while I'm here, just had an independent advocate. Will complain when I've left

As this mixed methods research adopts a sequential explanatory design (Cresswell & Plano Clark, 2007), the qualitative component of the results was used to further contextualise the quantitative data. Therefore, the responses were analysed using content analysis due to the questions on the Human Rights Survey being pre-defined. A richer and more in-depth exploration of the qualitative data is planned for a future report.

General care and treatment

Four themes were identified under general care and treatment; *supportive staff*, *staff trying their best*, *feeling overlooked* and *concerns with care and safety*. There were 28 responses in this category that were coded as staff being supportive, with examples such as staff being

friendly, having the time to listen, and providing appropriate care. Service users also showed sympathy towards the staff, recognising the challenges of the job role. These comments centred around services being short-staffed leaving the nurses with unmanageable amounts of work, and how they can experience verbal and physical aggression. In conjunction with this, 34 service users reported feelings of being overlooked, having to wait for time with the nursing staff, or not receiving appropriate levels of attention. Some reported feeling overlooked due to appearing less symptomatic than others or having a quieter presence on the ward. Fourteen service users reported having concerns with their care or not feeling safe on the ward. Reports included service users being in fear of their physical safety due to low staffing levels or environmental issues or the facilities being unfit to meet their basic needs.

Values

For this category, values-based care was split into *receiving values-based care* and *care not led by values*. Further themes identified were *inconsistent or conditional care* and *external issues and barriers to values-based care*. There were 47 responses that had an expression of receiving care that was values-based, such as staff being respectful, maintaining privacy, or treating everyone fairly. In contrast, 13 service users gave an example of receiving care that was not led by values, such as feeling that staff had been rude, not being cared for in a dignified manner and breaching privacy. Many in this category did not attribute this to all of the staff, just certain interactions they had experienced. Some comments did refer to the use of agency staff and how the quality of care did not meet the standards of the regular staff.

There were 35 responses that suggested values-based care could be inconsistent or conditional. Participants expressed that some staff would be more values led than others, and some felt they only received respect if they showed it first. This was similar to some feeling that the staff were more supportive when they were viewed as being more compliant. Some examples of barriers to values-based care included wards being short-staffed or the

environment not being conducive to privacy. There were multiple comments about staff always being able to see into their rooms and further comments about staff entering when people have been showering, using the toilet or getting dressed.

Basic needs

In regard to basic needs, themes consisted of *needs well catered for*, *environmental barriers* and *not feeling in control*. It was noted however, that there may be overlap between the last two themes, as some environmental issues impacted on participants' feelings of being in control. Generally, service users felt that their basic needs in terms of being able to access food and drinks and go to the toilet when needed felt well catered for. This was similar to having visitors to the ward where many participants expressed how flexible ward staff had been. If visitors lived far away, had childcare commitments, or worked full-time, service users often found that staff would allow them to arrive outside of the visiting times. However, there were 60 responses (over multiple questions) that identified environmental barriers to basic needs being catered for, especially those who were required to share facilities. Service users reported that the toilets and showers were often blocked or left in an unhygienic state, stating that they would either not have a shower, or only shower straight after they had been cleaned. In general, but particularly in NHS Trust B, participants did not feel their belongings were safe. There were 24 responses that specifically stated that service users had experienced possessions go missing, with many perceiving that they were stolen by other service users. Again, this was primarily due to sharing living space and not having adequate secure storage facilities. Context was given to the high number of people rating that they felt their belongings were accessible, as it was felt that they were accessible to everyone and not safe. There was also a sense of not feeling in control of needs, again due to having to share facilities, or having to rely on nursing staff for access to belongings, access to fresh air, or activities. Many felt that due to staff-shortages they often had to wait for nurses to be

available or had to ask multiple times. In NHS Trust B service users cannot access any locked doors, so movement around the ward could also often be out of their control, such as having to asking staff to unlock their bedroom door.

Information and communication

This category was split between those who were *feeling informed* and those *not feeling informed* and those having the *ability to complain* and those *not feeling able to complain*.

There were 30 responses from participants that were coded as feeling informed, which related specifically to their care plan or feeling listened to and informed by staff when raising concerns. This was opposed to 40 responses coded as not feeling informed. A number of participants expressed that they did not understand what their care plan was, or why they were being given certain treatment. Some commented on having conversations with staff after certain events, such as a medication change or not being able to leave the ward, and then feeling more informed. However, there were only eight responses from service users who did not feel able to complain if there was an issue. Some had made complaints in the past which they did not feel was dealt with appropriately and some did not feel there was any point, as they would not be taken seriously. There were 24 responses around feeling able to speak to staff or complain if needed, with some expressing that they had already done so; on some occasions this was with the support of an advocate.

Discussion

The primary aim of this study was to explore mental health professionals' intention to work using a human rights-based approach. Overall, the TPB constructs were able to significantly predict intention, accounting for 52.2% of the variance, with this effect size being comparable to other TPB studies (Armitage & Connor, 2001). Attitude was the strongest predictor of intention with the highest mean, followed by subjective norm. There has been much written in the literature about subjective norm being the weakest construct of the three

variables, however, contrary to common findings, this study found perceived behavioural control to be the weakest component; not adding a significant amount of variance to the model. This could have been impacted by issues with internal consistency, which mirrors findings of a similar study aiming to better understand clinicians' perspectives on the implementation of cognitive behavioural therapy for psychosis (Lecomte, Samson, Naeem, Schachte & Farhall, 2018). Kraft, Rise, Sutton and Røysamb (2005) also report that considerable variation in internal consistency on the perceived behavioural control measure is not uncommon, having been observed on a number of previous occasions. According to Ajzen (2002), the perceived behavioural control component involves people believing that the behaviour is within their control and that either performing or not performing the behaviour is their choice.

The Improved Clinical Effectiveness through Behavioural Research Group (2006) suggest that the TPB may not be a sufficient theory-base to apply when there are external influencing factors outside of the individual clinicians' control, even though there seems to be increasing evidence of the theory being used in health settings with staff teams (Perkins et al., 2007). Although it is beyond the remit of this study to make judgements on what the influencing external factors may be, it can outline previous literature in this area. There is substantial coverage around burnout amongst mental health professionals, particularly nurses. Some of the external factors identified for the causes of burnout have included lack of adequate staffing, higher workloads (Jenkins and Elliot, 2004), as commented on here by the service user participants, and a discrepancy between the skills learned in training and those required in the job role, due to the ever changing demands of evidence-based practice (Higgins et al., 1999). Socio-political factors have also seemed to influence mental health nurses perceived lack of control and increased stress levels. Edwards, Burnard, Coyle, Fothergill and Hannigan (2000) identified issues such as not having sufficient community

resources to refer clients onto, long waiting lists and uncertain job roles due to rapid NHS reforms. There is evidence to suggest that cuts to staffing and further reform has continued to increase since austerity measures were implemented in the UK, not only having a great impact on mental health professionals, but also to those who use the services (Hannigan, 2013). In an exploration of leadership in mental health nursing, Cleary, Horsfall, Deacon and Jackson (2011) were able to identify organisational and cultural factors that may alienate mental health professionals and increase perceived feelings of a lack of control. These included not being treated as individuals (person centred-values), being punished for mistakes, not being given enough praise, implementing new policies with explanation. Thinking back to psychological reactance as described by Kinderman and Butler (2006), if public service staff do not feel empowered to implement, for example a human rights approach, or feel a socially collective responsibility then staff may feel resistance to it. Therefore, organisational culture can be an important component of staff feeling that they have the power to work within certain guidelines or approaches.

Another influencing factor to consider is the potential for the Mental Health Act to not be fully consistent with the Human Rights Act (Leung, 2002). As outlined, rights that are qualified or limited can be restricted for an individual under section. This may include not being able to leave the ward, having to be kept under constant observation, or receiving medication against their will (Mind, 2013). This has the potential to impact on health professional's perceived sense of control when using human rights-based approaches. The Independent Review of the Mental Health Act 1983 outlines four new principles that should be incorporated into the Mental Health Act to enable more of a focus on rights; choice and autonomy, least restriction, therapeutic benefit, and the person as an individual (Department of Health and Social Care, 2018).

The second aim of this study was to explore whether service users perceive mental health professionals as providing care to them using a human rights-based approach as measured by the Human Rights Survey. When adding NHS Trust as a predictor variable into the regression analysis for staff intention, it was not a significant factor. The mean scores for each construct per NHS Trust show very little variance, meaning that staff in each setting had a similar attitude towards human rights, felt similar amounts of social pressure, but equally did not feel in control of using human rights-based approaches. Using a sequential explanatory design helped to give context to these findings, particularly those around a perceived lack of control. There were significant differences between NHS Trusts within the Human Rights Survey, particularly on questions concerning safety and environmental issues. Service users were clearly stating that external issues such as staff shortages and the design and structure of the wards were causing them to feel their human rights were not being fully upheld. Although the study accounted for a large amount of variance in intentions, it is clear that there are other influencing variables. The study did not intentionally measure extenuating external factors so is not able to make any firm hypotheses at this stage, however it is possible to comment on the settings of each hospital, as described in the methods section.

A large number of service users from NHS Trust B voiced not feeling their belongings were safe, primarily due to sharing a room with others and not having their own private space. This was also a concern for people in terms of safety due to sharing with individuals who could be particularly distressed or agitated. Bathroom facilities were also shared, with participants expressing feeling too uncomfortable to use them. The CQC document 'The state of care in mental health services' (2018) states "In the 21st century, patients, many of whom have not agreed to admission, should not be expected to share sleeping accommodation with strangers – some of whom might be agitated. This arrangement does not support people's privacy or dignity" (p. 43). Therefore, it does not feel surprising

that there were significant differences on these aspects between the NHS Trusts. This is not the first time that ward environments have been seen to be having a detrimental impact on the care of service users in inpatient settings, with this being a large focus in the literature around using restrictive and coercive practices. Service users in particular view locked doors and environmental restrictions on inpatient wards as having negative consequences to their therapeutic relationship with staff (Duxbury et al., 2019). In a paper by Ulrich, Bogren, Gardiner and Lundin (2018) a conceptual model was produced for redesigning mental health hospitals in order to reduce aggressive incidents. The authors compared three hospitals in Sweden; a newly built hospital, the old hospital that was replaced by the new hospital and a control hospital. The new hospital had more private space in terms of private bedrooms and bathrooms, an accessible garden, more natural light and the ward layout was more central-based rather than corridor-based. In the new hospital it was found that the average number of restraints reduced and reliance on compulsory rejections significantly reduced. It is interesting to note the similarities between the design features identified as unhelpful in Ulrich et al's. (2018) study and those that the service users identified as not upholding their human rights in this study.

There was also a sense of 'staff trying their best' with the resources they had. Generally, service users rated staff values positively and regularly spoke about them being supportive, however felt that they were being let down by staff shortages. Service users reported feeling overlooked and not feeling in control of their care or environment. There were specific comments on the quality of care from agency staff, often falling short. Staffing levels on acute mental health wards is a problem on a national scale (CQC, 2018), with too many services relying on agency staff who may not possess sufficient experience or training.

Service users wish to spend more time with nursing staff to build a therapeutic relationship and feel more informed, however often experience organisational barriers (Bee et

al., 2007; Hopkins, Loeb and Fick, 2009). The results here coincide with this research, with service users expressing not feeling fully informed about their care, as staff often do not have the time to listen. When time was spent with staff, service users generally felt listened to and supported. When exploring health professionals' perspectives on acute mental health services, time pressures and the environment have been cited as barriers to compassionate care planning (Crawford, Gilbert, Gilbert, Gale & Harvey, 2013).

Limitations

There have been limitations with the measures used in this study. For the TPB questionnaire, Francis et al. (2004) recommend conducting an elicitation study for the development of the indirect measures with approximately 25 health professionals. This study completed this phase of the questionnaire construction with four mental health nurses. Although this is lower than recommended, it is not dissimilar to other TPB studies with staff in mental health settings (Foy et al. 2007; Hanbury, Wallace & Clark, 2010; Janus et al., 2017; Levy, Holtum, Dooley & Ononaiye, 2016).

Two of the questions on the subjective norm component of the TPB measure referred to 'clinical psychologists'. NHS Trust A did not have any psychology provision on the wards and so many participants felt unable to provide answers. It would be beneficial to know what professions are represented beforehand and tailor the questionnaire accordingly. Two of the behavioural belief questions on the indirect attitude component did not have corresponding outcome evaluations and so were not included in the data analysis. The perceived behavioural control items showed issues with internal consistency, suggesting that this variable may not have been constructed as robustly as attitude and subjective norm. Increasing the value to an acceptable amount required deletion of the majority of items. Although the number of items was not less than what is recommended for a brief measure (Francis et al., 2004), it was

considerably less than the two other constructs. This would need attention if the study were to be replicated.

It would also be useful to return to certain criticisms around HRBAs, such as definitions being too broad and conceptual. For a TPB measure, the behaviour is usually stringently defined, and consideration should be given to whether asking participants if they felt in control of using a HRBA may have been too broad, as per the critique by Batliwala (2007). Future recommendations when designing a TPB study around human rights, therefore, would be to break-down the individual components and narrow the focus of the items. For example, if using the FREDAs principles as the framework, individuals could be asked whether they feel in control of treating services users with fairness, respect, equality etc.

When constructing a TPB study, it is recommended to objectively measure actual behaviour when possible (Armitage & Connor, 2001). Unfortunately, this study was not able to fulfil this. Although the service user data aimed to offer some perception on health professionals' behaviour, it was not able to be directly statistically analysed.

The Human Rights Survey was initially used as part of an evaluation project on human rights in healthcare to identify areas of good practice and areas of concern. It was originally designed for an older adult population and there is no guidance available on scoring. For the purpose of this study, the authors designed a scoring system in order to interpret the data. Guidance notes do state that the survey can be changed and improved depending on need. There is also no published data on the questionnaire's validity or reliability. With this population, the questionnaire achieved a Cronbach's alpha score of 0.61 suggesting that further development may be required before good scale reliability can be achieved.

As per the procedure, paper copies of the questionnaires were left on the wards for the health professionals to complete in their own time. Therefore, consideration should be given to bias, as those who were less motivated about human rights-based approaches could have chosen not to complete the questionnaire. Therefore, it cannot be stated that the attitudes reported here can be generalised to all acute mental health staff.

Clinical implications

Multiple reviews into the quality of acute mental health care continue to present examples of clinical practice that does not uphold the rights of individuals when they are potentially at their most vulnerable; with this study highlighting further examples. It is imperative that further research aims to understand the underlying factors involved and where meaningful change is required. Using a human rights-based approach helps to give everyone a common language from which services can begin to embed the principles of fairness, respect, equality, dignity and autonomy. However, as the results and past research shows (Kinderman et al., 2018), implementing these approaches needs to go beyond targeting changes in individual staff members; it is required at an organisational level. This should include changes to policy at a managerial level, culture at a service level, alongside quality of care on an individual level. Evaluating the impact of the environment on quality of care and wellbeing is of utmost importance. The Independent Review of the Mental Health Act 1983 commissioned by the Department of Health (2018) recommended that “a review should be undertaken of the physical requirements for ward design for mental health units... The design of this review should be co-produced with people with lived experience” (p. 33).

All NHS mental health Trusts have a duty to protect the human rights of the individuals who use their services; however, it is clear that there continue to be examples where people’s rights are not being upheld. Human rights-based approaches are not limited to the attitudes and behaviour of the staff, they should be implemented in all aspects of care. It

is clear, both from the evidence and the results presented, that urgent structural changes to the environment are required to those acute mental health wards that have the potential to be unlawfully restricting people's human rights.

Conclusion

Mental health professionals' attitudes and perceived social pressures significantly predicted their intention to work using human rights-based approaches on acute mental health wards. Contrary to previous findings, perceived behavioural control did not add any significant variance, suggesting that working completely within a human rights-based approach feels out of health professionals' direct control. Service users perceive staff to provide values-led care, however, highlight a number of environmental issues that impact on their human rights. More focus needs to be given to implement human rights-based approaches at an organisational level. Due to the positive attitudes already held by health professionals, increased training to instil individual differences may not be relevant to produce meaningful change. In this instance, psychological theory may not provide the answers needed; it is significant structural changes and innovative ward design that are necessary to deliver quality, human rights-based care.

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Appendix A

British Journal of Social Psychology – style guidelines

MANUSCRIPT CATEGORIES AND REQUIREMENTS

- Articles should be no more than 7000 words (excluding the abstract, reference list, tables and figures). Online appendices are not included in the word limit; footnotes however are included.

In exceptional cases the Editor retains discretion to publish papers beyond this length where the clear and concise expression of the scientific content requires greater length (e.g., explanation of a new theory or a substantially new method). Authors must contact the Editor prior to submission in such a case.

- We recognise that when presenting high-quality, multi-study papers it is sometimes necessary to exceed this word limit. Authors of such work should seek prior permission from the Editors, who retain discretion to publish longer papers in cases where the clear and concise expression of the scientific content requires greater length. Papers that are over the word limit without prior permission will be returned to the authors.
- Please refer to the separate guidelines for [Registered Reports](#).
- All systematic reviews must be pre-registered.

PREPARING THE SUBMISSION

Contributions must be typed in double spacing. All sheets must be numbered.

Abstract

Please provide an abstract of between 100 and 200 words, giving a concise statement of the intention, results or conclusions of the article. The abstract should not include any sub-headings.

Keywords

Please provide appropriate keywords.

Acknowledgments

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Main Text File

As papers are double-blind peer reviewed, the main text file should not include any information that might identify the authors.

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Supporting information should be supplied as separate files. Tables and figures can be included at the end of the main document or attached as separate files but they must be mentioned in the text.

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References

References should be prepared according to the *Publication Manual of the American Psychological Association* (6th edition). This means in text citations should follow the author-date method whereby the author's last name and the year of publication for the source should appear in the text, for example, (Jones, 1998). The complete reference list should appear alphabetically by name at the end of the paper. Please note that for journal articles, issue numbers are not included unless each issue in the volume begins with page 1, and a DOI should be provided for all references where available.

For more information about APA referencing style, please refer to the [APA FAQ](#).

Tables

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

Figures

Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted.

[Click here](#) for the basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

Colour figures. Figures submitted in colour may be reproduced in colour online free of charge. Please note, however, that it is preferable that line figures (e.g. graphs and charts) are supplied in black and white so that they are legible if printed by a reader in black and white. If an author would prefer to have figures printed in colour in hard copies of the journal, a fee will be charged by the Publisher.

General Style Points

For guidelines on editorial style, please consult the [APA Publication Manual](#) published by the American Psychological Association. The following points provide general advice on formatting and style.

- **Language:** Authors must avoid the use of sexist or any other discriminatory language.
- **Abbreviations:** In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.
- **Units of measurement:** Measurements should be given in SI or SI-derived units. Visit the [Bureau International des Poids et Mesures \(BIPM\) website](#) for more information about SI units.
- **Effect size:** In normal circumstances, effect size should be incorporated.
- **Numbers:** numbers under 10 are spelt out, except for: measurements with a unit (8mmol/l); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).

Appendix B
Assessment for the overall quality of TPB-based questionnaires

Overall study quality

Oluka, O. C., Nie, S., & Sun, Y. (2014). Quality assessment of TPB-based questionnaires: a systematic review. *PloS one*, 9(4), e94419. <https://doi.org/10.1371/journal.pone.0094419>

Criteria	Score
1. Clear aim or research question?	+/-
2. Details of study methodology and design?	+/-
3. Description of data collection?	+/-
4. Research context; description of the study population?	+/-
5. Data analysis?	+/-
6. Results relevant to the aims of the study?	+/-
7. Ethical approval obtained?	+/-
Overall Assessment	++/+/-

Notes:

++ must meet at least 6 criterion indicated above.

+ must meet at least 4 criterion indicated above.

- did not have the 4 criterion necessary for + classification.

++ denotes low level of bias; + denotes moderate level of bias; and – denotes higher degree of bias.

Appendix C
Quality assessment for the construction of a TPB questionnaire

Oluka, O. C., Nie, S., & Sun, Y. (2014). Quality assessment of TPB-based questionnaires: a systematic review. *PloS one*, 9(4), e94419. <https://doi.org/10.1371/journal.pone.0094419>

Criteria	Score	
A	1. Definition of population of interest?	+ / - / ?
	2. Definition of clinical condition and/or behavior of Interest (TACT principle)? Target, Action, Context, Time	+ / - / ?
B	3. Elicitation study conducted for salient beliefs? If yes,	+ / - / ?
	4. Study design/mode of administration stated (focus groups/individual or mailed questions)?	+ / - / ?
	5. Are participants from target population?	+ / - / ?
C	6. Is more than one reviewer/expert involved in choosing of questionnaire items?	+ / - / ?
	7. Are all the constructs represented?	+ / - / ?
	8. Inclusion of direct and indirect measures?	+ / - / ?
	9. Inclusion of questions on demographics?	+ / - / ?
	10. Total number of questionnaire items ≥ 40 ?	+ / - / ?
D	11. Was a pilot study conducted?	+ / - / ?
E	12. Was power calculation done for final study?	+ / - / ?
	13. Total number of participants' ≥ 80 ?	+ / - / ?
	14. Is sample representative of study population (higher response rate or characteristics compared between responders and non-responders)?	+ / - / ?
F	15. Ethical approval obtained?	+ / - / ?
G	16. Data analysis conducted for content validity/reliability?	+ / - / ?

Appendix D

Social science and medicine – style guidelines

The journal publishes the following types of contribution:

1) Peer-reviewed original research articles and critical or analytical reviews in any area of social science research relevant to health. These papers may be up to 9,000 words including abstract, tables, and references as well as the main text. Papers below this limit are preferred.

PREPARATION

References

There are no strict requirements on reference formatting at submission. References can be in any style or format as long as the style is consistent. Where applicable, author(s) name(s), journal title/book title, chapter title/article title, year of publication, volume number/book chapter and the article number or pagination must be present. Use of DOI is highly encouraged. The reference style used by the journal will be applied to the accepted article by Elsevier at the proof stage. Note that missing data will be highlighted at proof stage for the author to correct.

Formatting Requirements

The journal operates a double blind peer review policy. For guidelines on how to prepare your paper to meet these criteria please see the [attached guidelines](#). The journal requires that your manuscript is submitted with double spacing applied. There are no other strict formatting requirements but all manuscripts must contain the essential elements needed to convey your manuscript, for example Abstract, Keywords, Introduction, Materials and Methods, Results, Conclusions, Artwork and Tables with Captions.

If your article includes any Videos and/or other Supplementary material, this should be included in your initial submission for peer review purposes.

Divide the article into clearly defined sections.

Text

In the main body of the submitted manuscript this order should be followed: abstract, main text, references, appendix, figure captions, tables and figures. Author details, keywords and acknowledgements are entered separately during the online submission process, as is the abstract, though this is to be included in the manuscript as well. During submission authors are asked to provide a word count; this is to include ALL text, including that in tables, figures, references etc.

Title

Please consider the title very carefully, as these are often used in information-retrieval systems. Please use a concise and informative title (avoiding abbreviations where possible). Make sure that the health or healthcare focus is clear.

Abstract

An abstract of up to 300 words must be included in the submitted manuscript. An abstract is often presented separately from the article, so it must be able to stand

alone. It should state briefly and clearly the purpose and setting of the research, the principal findings and major conclusions, and the paper's contribution to knowledge. For empirical papers the country/countries/locations of the study should be clearly stated, as should the methods and nature of the sample, the dates, and a summary of the findings/conclusion. Please note that excessive statistical details should be avoided, abbreviations/acronyms used only if essential or firmly established, and that the abstract should not be structured into subsections. Any references cited in the abstract must be given in full at the end of the abstract.

Research highlights

Research highlights are a short collection of 3 to 5 bullet points that convey an article's **unique contribution to knowledge** and are placed online with the final article. We allow 85 characters per bullet point including spaces. They should be supplied as a separate file in the online submission system (further instructions will be provided there). You should pay very close attention to the formulation of the Research Highlights for your article. Make sure that they are **clear, concise and capture the reader's attention**. If your research highlights do not meet these criteria we may need to return your article to you leading to a delay in the review process.

Keywords

Up to 8 keywords are entered separately into the online editorial system during submission, and should accurately reflect the content of the article. Again abbreviations/acronyms should be used only if essential or firmly established. For empirical papers the country/countries/locations of the research should be included. The keywords will be used for indexing purposes.

Methods

Authors of empirical papers are expected to provide full details of the research methods used, including study location(s), sampling procedures, the date(s) when data were collected, research instruments, and techniques of data analysis. Specific guidance on the reporting of qualitative studies are provided [here](#).

Systematic reviews and meta-analyses must be reported according to [PRISMA](#) guidelines.

Footnotes

There should be no footnotes or endnotes in the manuscript.

Artwork

Electronic artwork

General points

- Make sure you use uniform lettering and sizing of your original artwork.
- Preferred fonts: Arial (or Helvetica), Times New Roman (or Times), Symbol, Courier.
- Number the illustrations according to their sequence in the text.
- Use a logical naming convention for your artwork files.

- Indicate per figure if it is a single, 1.5 or 2-column fitting image.
- For Word submissions only, you may still provide figures and their captions, and tables within a single file at the revision stage.
- Please note that individual figure files larger than 10 MB must be provided in separate source files.

A detailed [guide on electronic artwork](#) is available.

Figure captions

Ensure that each illustration has a caption. A caption should comprise a brief title (**not** on the figure itself) and a description of the illustration. Keep text in the illustrations themselves to a minimum but explain all symbols and abbreviations used.

Tables

Please submit tables as editable text and not as images. Tables can be placed either next to the relevant text in the article, or on separate page(s) at the end. Number tables consecutively in accordance with their appearance in the text and place any table notes below the table body. Be sparing in the use of tables and ensure that the data presented in them do not duplicate results described elsewhere in the article. Please avoid using vertical rules and shading in table cells.

References

Citation in text

Please ensure that every reference cited in the text is also present in the reference list (and vice versa). Any references cited in the abstract must be given in full at the end of the abstract. Unpublished results and personal communications are not recommended in the reference list, but may be mentioned in the text. If these references are included in the reference list they should follow the standard reference style of the journal (see below) and should include a substitution of the publication date with either "Unpublished results" or "Personal communication" Citation of a reference as "in press" implies that the item has been accepted for publication.

Web references

As a minimum, the full URL should be given and the date when the reference was last accessed. Any further information, if known (DOI, author names, dates, reference to a source publication, etc.), should also be given. Web references can be listed separately (e.g., after the reference list) under a different heading if desired, or can be included in the reference list.

Data references

This journal encourages you to cite underlying or relevant datasets in your manuscript by citing them in your text and including a data reference in your Reference List. Data references should include the following elements: author name(s), dataset title, data repository, version (where available), year, and global persistent identifier. Add [dataset] immediately before the reference so we can properly identify it as a data reference. The [dataset] identifier will not appear in your published article.

References in special issue articles, commentaries and responses to commentaries

Please ensure that the words 'this issue' are added to any references in the reference list (and any citations in the text) to other articles which are referred to in the same issue.

Appendix E

Doctorate in Clinical Psychology Research Review Committee – final approval



D.Clin.Psychology Programme
Division of Clinical Psychology
Whelan Building, Quadrangle
Brownlow Hill
LIVERPOOL
L69 3GB

Tel: 0151 794 5530/5534/5877
Fax: 0151 794 5537
www.liv.ac.uk/dclinpsychol

17 October 2017

Stephanie Davis Le Brun
Clinical Psychology Trainee
Doctorate of Clinical Psychology Doctorate Programme
University of Liverpool
L69 3GB

RE: Using the theory of planned behaviour to understand staff intention to work within a human rights-based approach in adult acute inpatient mental health services.

Trainee: Stephanie Davis Le Brun

Supervisors: Richard Whittington & Sarah Butchard

Dear Stephanie,

Thank you for your response to the reviewers' comments of your research proposal submitted to the D.Clin.Psychol. Research Review Committee (letter dated 12/10/17).

I can now confirm that your amended proposal (*version number 3, dated October 2017*) meets the requirements of the committee and has been approved by the Committee Chair.

Please take this Chairs Action decision as **final** approval from the committee.

You may now progress to the next stages of your research.

I wish you well with your research project.

A handwritten signature in black ink, appearing to be 'Catrin Eames'.

Dr Catrin Eames
Vice-Chair D.Clin.Psychol. Research Review Committee.

A member of the
Russell Group

Dr Laura Golding
Programme Director
l.golding@liv.ac.uk

Dr Jim Williams
Clinical Director
j.r.williams@liv.ac.uk

Dr Ross White
Research Director
r.g.white@liv.ac.uk

Dr Gundi Kiemle
Academic Director
gkiemle@liv.ac.uk

Mrs Sue Knight
Programme Co-ordinator
sknight@liv.ac.uk

Appendix F
NHS Research Ethics Committee – favourable opinion



North West - Liverpool Central Research Ethics Committee

3rd Floor
Barlow House
4 Minshull Street
Manchester
M1 3DZ

Telephone: 0207 104 8196

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

05 June 2018

Professor Richard Whittington
Professor of Mental Health
University of Liverpool
Muspratt Building
University of Liverpool
Liverpool
L69 3BX

Dear Professor Whittington

Study title: Using the theory of planned behaviour to understand staff intention to work using a human rights-based approach in adult acute inpatient mental health services
REC reference: 18/NW/0170
Protocol number: UoL001352
IRAS project ID: 237278

Thank you for responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact hra.studyregistration@nhs.net outlining the reasons for your request.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

You should notify the REC once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. Revised documents should be submitted to the REC electronically from IRAS. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which you can make available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System, at www.hra.nhs.uk or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non-registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [UoL sponsor approval]	6	14 December 2017
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [CONFIRMATION OF INSURANCE]	1	01 July 2017
IRAS Application Form [IRAS_Form_13022018]		13 February 2018
Letter from sponsor [UoL sponsor approval]	6	14 December 2017
Letters of invitation to participant [Research advertisement]	1.1	01 April 2018
Non-validated questionnaire [Human rights survey hospital patients]	1	
Non-validated questionnaire [TPB questionnaire]	1.4	04 February 2018
Non-validated questionnaire [Demographic questionnaire – service users]	1.1	01 February 2018
Non-validated questionnaire [Demographic questionnaire – staff]	1.1	01 February 2018
Other [BIHR human rights poster]		
Participant consent form [Consent Form-Staff]	1.4	01 June 2018

Participant consent form [Consent Form - SU]	1.3	01 June 2018
Participant information sheet (PIS) [Participant Information Sheet STAFF]	1.2	01 April 2018
Participant information sheet (PIS) [Participant Information Sheet SERVICE USER]	1.2	17 April 2018
Referee's report or other scientific critique report [Reviewer recommendations]	1	05 July 2017
Referee's report or other scientific critique report [University approval of proposal]	1	17 October 2017
Research protocol or project proposal [Research proposal]	4	
Summary CV for Chief Investigator (CI) [Richard Whittington Research CV]		03 July 2017
Summary CV for student [Student research CV]	1.0	05 February 2018
Summary CV for supervisor (student research) [Supervisor research CV]	2	31 October 2016

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:

<http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/>

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at <http://www.hra.nhs.uk/hra-training/>

18/NW/0170

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely



**Signed on behalf of;
Mrs Julie Brake
Chair**

Email: nrescommittee.northwest-liverpoolcentral@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Appendix G Health Research Authority – approval letter



Ymchwil Iechyd
a Gofal **Cymru**
Health and Care
Research **Wales**



Prof Richard Whittington
Professor of Mental Health
University of Liverpool
Muspratt Building
University of Liverpool
Liverpool
L69 3BX

Email: hra.approval@nhs.net
Research-permissions@wales.nhs.uk

06 June 2018

Dear Prof Whittington

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title: Using the theory of planned behaviour to understand staff intention to work using a human rights-based approach in adult acute inpatient mental health services

IRAS project ID: 237278

Protocol number: UoL001352

REC reference: 18/NW/0170

Sponsor: University of Liverpool

I am pleased to confirm that [HRA and Health and Care Research Wales \(HCRW\) Approval](#) has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

How should I continue to work with participating NHS organisations in England and Wales?

You should now provide a copy of this letter to all participating NHS organisations in England and Wales*, as well as any documentation that has been updated as a result of the assessment.

**In flight studies' which have already started an SSI (Site Specific Information) application for NHS organisations in Wales will continue to use this route. Until 10 June 2018, applications on either documentation will be accepted in Wales, but after this date all local information packs should be shared with NHS organisations in Wales using the Statement of Activities/Schedule of Events for non-commercial studies and template agreement/ Industry costing template for commercial studies.*

Following the arranging of capacity and capability, participating NHS organisations should **formally confirm** their capacity and capability to undertake the study. How this will be confirmed is detailed in the "*summary of assessment*" section towards the end of this letter.

IRAS project ID	237278
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You should provide, if you have not already done so, detailed instructions to each organisation as to how you will notify them that research activities may commence at site following their confirmation of capacity and capability (e.g. provision by you of a 'green light' email, formal notification following a site initiation visit, activities may commence immediately following confirmation by participating organisation, etc.).

It is important that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details of the research management function for each organisation can be accessed [here](#).

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within the devolved administrations of Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) has been sent to the coordinating centre of each participating nation. You should work with the relevant national coordinating functions to ensure any nation specific checks are complete, and with each site so that they are able to give management permission for the study to begin.

Please see [IRAS Help](#) for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?

HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to [obtain local agreement](#) in accordance with their procedures.

What are my notification responsibilities during the study?

The document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The [HRA website](#) also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

I am a participating NHS organisation in England or Wales. What should I do once I receive this letter?

You should work with the applicant and sponsor to complete any outstanding arrangements so you are able to confirm capacity and capability in line with the information provided in this letter.

The sponsor contact for this application is as follows:

Name: Mr Alex Astor

Tel: 0151 794 8739

Email: sponsor@liv.ac.uk

IRAS project ID	237278
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Who should I contact for further information?

Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **237278**. Please quote this on all correspondence.

Yours sincerely

Michael Pate
Assessor

Email: hra.approval@nhs.net

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

<i>Document</i>	<i>Version</i>	<i>Date</i>
Costing template (commercial projects) [Proposal with costings]	4	
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [UoL sponsor approval]	6	14 December 2017
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [CONFIRMATION OF INSURANCE]	1	01 July 2017
HRA Schedule of Events	1	23 February 2018
HRA Statement of Activities	1	23 February 2018
IRAS Application Form [IRAS_Form_13022018]		13 February 2018
Letter from sponsor [UoL sponsor approval]	6	14 December 2017
Letters of invitation to participant [Research advertisement]	1.1	01 April 2018
Non-validated questionnaire [Demographic questionnaire – service users]	1.1	01 February 2018
Non-validated questionnaire [Demographic questionnaire – staff]	1.1	01 February 2018
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Referee's report or other scientific critique report [Reviewer recommendations]	1	05 July 2017
Referee's report or other scientific critique report [University approval of proposal]	1	17 October 2017
Research protocol or project proposal [Research proposal]	4	
Summary CV for Chief Investigator (CI) [Richard Whittington Research CV]		03 July 2017
Summary CV for student [Student research CV]	1.0	05 February 2018
Summary CV for supervisor (student research) [Supervisor research CV]	2	31 October 2016

Summary of assessment

The following information provides assurance to you, the sponsor and the NHS in England and Wales that the study, as assessed for HRA and HCRW Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England and Wales to assist in assessing, arranging and confirming capacity and capability.

Assessment criteria

Section	Assessment Criteria	Compliant with Standards	Comments
1.1	IRAS application completed correctly	Yes	No comments
2.1	Participant information/consent documents and consent process	Yes	No comments
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	A Statement of Activities and Schedule of Events will form the agreement between the sponsor and participating site.
4.2	Insurance/indemnity arrangements assessed	Yes	No comments
4.3	Financial arrangements assessed	Yes	No external funding and no funding to sites.
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	No comments
5.3	Compliance with any applicable laws or regulations	Yes	No comments
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Yes	No comments

IRAS project ID	237278
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Section	Assessment Criteria	Compliant with Standards	Comments
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

Participating NHS Organisations in England and Wales

<i>This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.</i>
<p>Two participating NHS organisations, both conducting the same activities, thus one site type.</p> <p>The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England and Wales in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. Where applicable, the local LCRN contact should also be copied into this correspondence.</p> <p>If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England and Wales which are not provided in IRAS, the HRA or HCRW websites, the chief investigator, sponsor or principal investigator should notify the HRA immediately at hra.approval@nhs.net or HCRW at Research-permissions@wales.nhs.uk. We will work with these organisations to achieve a consistent approach to information provision.</p>

Principal Investigator Suitability

<i>This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and Wales, and the minimum expectations for education, training and experience that PIs should meet (where applicable).</i>
<p>A local collaborator should be in place at participating sites. These have been identified as per the IRAS form.</p> <p>GCP training is <u>not</u> a generic training expectation, in line with the HRA/HCRW/MHRA statement on training expectations.</p>

IRAS project ID	237278
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HR Good Practice Resource Pack Expectations

This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken

The taking of consent and completion of questionnaires with service users would require a Letter of Access for researchers not holding a contract with a participating site. Evidence of standard DBS and OH clearance would be expected.

The taking of consent and completion of questionnaires with staff would require a Letter of Access should activities take place in a location where care is provided. No evidence of pre-engagement check would be required.

Other Information to Aid Study Set-up

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales to aid study set-up.

The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix H

University of Liverpool – sponsor permission to proceed notification



Professor Whittington
Muspratt Building
University of Liverpool
Liverpool
L69 3BX

Mr Alex Astor
**Head of Research Support – Health
and Life Sciences**

University of Liverpool
Research Support Office
2nd Floor Block D Waterhouse
Building
3 Brownlow Street
Liverpool
L69 3GL

05 July 2018

Tel: 0151 794 8739
Email: sponsor@liv.ac.uk

Sponsor Ref: UoL001352

Re: Sponsor Permission to Proceed notification

“Using the theory of planned behaviour to understand staff intention to work within a human rights-based approach in adult acute inpatient mental health services.”

Dear Professor Whittington

All necessary documentation and regulatory approvals have now been received by the University of Liverpool Research Support Office in its capacity as Sponsor, and we are satisfied that all Clinical Research Governance requirements have been met. You may now proceed with any study specific procedures to open the study.

The following REC Approved documents have been received by the Research Support Office. Only these documents can be used in the recruitment of participants. If any amendments are required please contact the Research Support Office.

Document title	Version	Date
Research protocol	Version 4	No date
Demographic questionnaire – service users	Version 1.1	01 February 2018
Demographic questionnaire – staff	Version 1.1	01 February 2018
Human rights survey hospital patients	Version 1	No date
TPB questionnaire	Version 1.4	04 February 2018
BIHR human rights poster	No version	No date
Participant Consent Form - Staff	Version 1.4	01 June 2018
Participant Consent Form - Service User	Version 1.3	01 June 2018
Participant information sheet - Staff	Version 1.2	01 April 2018
Participant Information Sheet - Service User	Version 1.2	17 April 2018

Please note, under the terms of your Sponsorship you must;

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1. Gain NHS Confirmation of Capacity and Capability from each participating site before recruitment begins at that site;
2. Ensure all required contracts are fully executed before recruitment begins at any site;
3. Inform the Research Support Office as soon as possible of any adverse events especially SUSARs and SAE's, Serious Breaches to protocol or relevant legislation or any concerns regarding research conduct;
4. Approval must be gained from the Research Support Office for any amendments to, or changes of status in the study prior to submission to REC and any other regulatory authorities (as per SOP018);
5. It is a requirement that Annual Progress Reports are sent to the NHS Research Ethics Committee (REC) annually following the date of Favourable Ethical Approval. You must provide copies of any reports submitted to REC and other regulatory authorities to the Research Support Office (as per SOP006);
6. Maintain the study master file (as per SOP005);
7. Make available for review any study documentation when requested by the sponsors and regulatory authorities for the purposes of audit or inspection;
8. Upon the completion of the study it is a requirement to submit an End of Study Declaration (within 90 days of the end of the study) and End of Study Report to REC (within 12 months of the end of the study). You must provide copies of this to the Research Support Office (as per SOP021);
9. Ensure you and your study team are up to date with the current RSO SOPs throughout the duration of the study.

If you have any queries regarding the sponsorship of the study please do not hesitate to contact the Clinical Research Governance Team on 0151 794 8373 (email sponsor@liv.ac.uk).

Yours sincerely



Mr Alex Astor
Head of Research Support – Health and Life Sciences
Research Support Office

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Appendix I

Consultation with previous patients¹ – notes and reflections

I met with four individuals between November 2017 to January 2018 to discuss the research design, measures and any other issues that may arise. All four had experienced an inpatient stay on an acute ward due to mental health difficulties. Both NHS Trusts were represented.

Two of the individuals were now in paid employment in mental health services.

Discussions predominantly centred around practical advice for the design of the research and the recruitment process, and reflections on their own experiences of inpatient services.

A summary of some of the practical advice received is as follows:

- To be aware that individuals who are under section of the Mental Health Act may feel that they have no rights and are powerless.
- That the information individuals provide could be influenced by their mood or events on that day.
- That there can be noticeably different cultures on different wards.
- That not everyone may have capacity to consent, even if the nursing staff deem them to do so and therefore this should also be assessed by me during recruitment.
- That people are not always aware of whether they have been given a diagnosis, or what it is.
- At least an hour of time should be made available to complete the Human Rights Survey.
- To work around important times on the ward, such as meal times, visiting times and ward rounds.
- When completing the Human Rights Survey, to be aware of the difference between people not understanding the question and becoming distracted/preoccupied. To ‘check in’ half way through the questionnaire.

¹ Refer to the thesis overview for a discussion on use of language.

- To be aware that some questions may trigger distress or a dissociative state.

Individual reflections were also offered about their experiences of being an inpatient on an acute mental health ward. Some of the key themes are summarised:

- Safety – all of the individuals discussed safety in their reflections, such as the staff not being able to keep everyone safe, for example from other patients becoming agitated or aggressive.
- Keeping a healthy lifestyle – it was felt that it was too difficult to maintain a healthy lifestyle on the wards, such as keeping up with a daily routine, practicing coping skills, or eating a healthy diet.
- Feeling powerless – not being made aware of your rights when on the ward or feeling that you do not have any. This included having to rely on legal advice or advocacy to feel empowered.
- Institutionalisation – the wards feeling very regimented, having to live by their structure or routine and missing out on home comforts that are beneficial to wellbeing.
- Support and care – having positive experiences of one-to-one care and including family and friends.

Having now completed data collection, it is interesting to see the comparisons between these reflections and the qualitative data gathered from the Human Rights Survey. The qualitative data collected was from one snapshot of time from two mental health hospitals, but it appears that some experiences have the potential to be generalised over time and setting. I was grateful for all of the practical advice given during the consultation, particularly issues around capacity and people feeling powerless. It was true that there were some individuals who quite clearly did not have capacity to consent to research, even though the nursing staff

had assessed them as having capacity. I spoke to some individuals who openly expressed feeling powerless and not feeling they had rights, which often stirred up powerful emotions within me, and to some degree, I feel that the consultation prepared me for this.

With permission, all of the individuals that I spoke to during this consultation have been emailed with regular updates of the study.

Appendix J Participant information sheet - staff



Human rights in adult acute mental health services

Participant Information Sheet – Staff

You are being invited to participate in a research study. Before you decide whether to participate, it is important for you to understand why the research is being done and what it will involve.

Please take time to read the following information carefully and feel free to ask us if you would like more information or if there is anything that you do not understand.

Please also feel free to discuss this with other people, such as friends, relatives and your colleagues if you wish. We would like to stress that you do not have to accept this invitation and should only agree to take part if you want to.

What is the purpose of the study?

The purpose of this study is to explore your views on human rights-based approaches to care on acute mental health wards. Service users on acute mental health wards will also be asked questions on this topic.

Why have I been chosen to take part?

You have been chosen to take part as you are currently providing care on an acute mental health ward, and we are interested in your views on this.

Do I have to take part?

No. Participation is completely voluntary. If you do not choose to take part, this will have no effect on your legal or employment rights. If you do agree to take part, you are free to withdraw at anytime without explanation and without incurring a disadvantage.

What will happen if I take part?

If you agree to take part, one of the research team will meet with you on the ward and you will be asked to sign a consent form. There will be three parts to your involvement:

- You will be asked to complete a demographic questionnaire. **We will ensure that you will not be identified from this information.**

- You will be presented with an information leaflet explaining more about human rights-based approaches.
- You will be asked to complete a questionnaire titled 'Theory of Planned Behaviour: Human Rights'. This questionnaire will take no longer than 30 minutes to complete. Support will be given from the researcher to complete this survey.

Overall it should take no longer than one hour to complete all three parts.

After this, you will have the chance to ask any questions about your participation.

Are there any risks in taking part?

We do not believe that there should be any risk to you if you agree to participate in this research. If you do experience any distress or discomfort, please make the researcher aware immediately so that your participation can be stopped.

The researcher has a responsibility to report any significant breaches in human rights in order to ensure safety. If any such information is disclosed, the researcher will make any next steps clear, including who it might be reported to.

Are there any benefits in taking part?

It is not believed that participation in this research will have any immediate benefits to you. The research may help to further understand how care is provided on acute mental health wards and may be able to recommend areas for future research.

What if I am unhappy or if there is a problem?

If you are unhappy, or if there is a problem, please feel free to let us know by contacting the principal investigator who will try and help:

Dr Sarah Butchard
 Ground floor, Whelan Building
 University of Liverpool
butchard@liverpool.ac.uk
 0151 794 5530

If you remain unhappy or have a complaint which you feel you cannot come to us with, then you should contact the Research Governance Officer at ethics@liv.ac.uk When contacting the Research Governance Officer, please provide details of the name or description of the study (so that it can be identified), the researcher(s) involved, and the details of the complaint you wish to make.

Will my responses be kept confidential?

Yes, your responses on the questionnaires will be kept confidential, and you will not be identified from them. All material for the study will be kept securely at the University of Liverpool, adhering to the Data Protection Act 1998 and University policies and procedures. Only the research team will have access to this data. The data will be under the responsibility of the research team for 5 years, and will then be destroyed after this time.

What will happen to the results of the study?

This research is being conducted for submission towards a Doctorate study programme which is anticipated to be completed by September 2019. A major research report will be written as a University requirement and the work will be submitted for publication in a peer-reviewed journal, which may be made accessible to the public. Feedback on the results will be offered to the Research Team within the Trust once the research is complete, which you will be able to request from them.

What will happen if I want to stop taking part?

You can withdraw your participation in the research at any time, without explanation. However, the results will be made anonymous, meaning that you will not be able to withdraw your responses after you have completed all of the questionnaires. If you withdraw your consent during your time with the researcher, anything that you have completed up to that point will be destroyed and not included in the results.

Who has reviewed this research?

This research has been reviewed by the University of Liverpool Doctorate in Clinical Psychology programme staff. Sponsorship approval has been granted from the University of Liverpool. The National Health Service Research Ethics Committees (NHS RECs) through the Health Research Authority (HRA) has also reviewed and approved this research.

Who can I contact if I have further questions?

Should you have any further questions, please contact the principal investigator:

Dr Sarah Butchard
Ground floor, Whelan Building
University of Liverpool
butchard@liverpool.ac.uk
0151 794 5530

Thank you

Appendix K
Participant consent form - staff

Committee on Research Ethics

PARTICIPANT CONSENT FORM - STAFF

Title of Research Project: Human rights in adult acute mental health services

Researcher(s): Stephanie Davis Le Brun, Dr Sarah Butchard, Professor Richard Whittington

- | | |
|---|--|
| 1. I confirm that I have read and have understood the information sheet dated July 2018 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. | Please
initial box
<input style="width: 60px; height: 20px;" type="text"/> |
| 2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my rights being affected. In addition, should I not wish to answer any particular question or questions, I am free to decline. | <input style="width: 60px; height: 20px;" type="text"/> |
| 3. I understand that confidentiality and anonymity will be maintained and it will not be possible to identify me in any publications. | <input style="width: 60px; height: 20px;" type="text"/> |
| 4. I understand and agree that once I submit my data it will become anonymised and I will therefore no longer be able to withdraw my data. | <input style="width: 60px; height: 20px;" type="text"/> |
| 5. I agree to take part in the above study. | <input style="width: 60px; height: 20px;" type="text"/> |

_____ Participant Name	_____ Date	_____ Signature
_____ Name of Person taking consent	_____ Date	_____ Signature
_____ Researcher	_____ Date	_____ Signature

Principal Investigator:

Dr Sarah Butchard
Whelan Building, University of Liverpool
butchard@liverpool.ac.uk

Student Researcher:

Stephanie Davis Le Brun
Whelan Building, University of Liverpool
sdlb@liverpool.ac.uk

Appendix L
Demographic questionnaire - staff

Human rights on adult acute mental health wards
Demographic questionnaire – staff

Where you see a box please mark your answer with an **X** inside of it.
Where you see a line, please write your answer in your own words.

1) What is your age? 16-24 25-34 35-44 45-54 55-64 65+

2) What best describes your gender? Female Male Prefer not to say

Prefer to self-describe _____

3) What is your ethnic group? _____

Prefer not to say

4) What is your job title? _____

5) Are you a qualified member of staff? Yes | | No |

a) If yes, how many years has it been since you qualified?

Less than one year	1-2 years	3-4 years	5-10 years	11-15 years	16-20 years	20+ years
--------------------------	-----------	-----------	---------------	----------------	----------------	--------------

6) How long have you worked in adult acute mental health services?

Less than one year	1-2 years	3-4 years	5-10 years	11-15 years	16-20 years	20+ years
--------------------------	-----------	-----------	---------------	----------------	----------------	--------------

7) Have you attended training in human rights through your NHS Trust? Yes | | No |

a) If yes, approximately how long ago was this?

8) Have you attended external training in human rights? Yes | | No |

a) If yes, approximately how long ago was this training?

b) If yes, who delivered the training?

Appendix M

British Institute of Human Rights – ‘Your human rights’ leaflet

Your human rights

Written down and protected in law by the Human Rights Act

The Human Rights Act is a law which protects your rights in the UK. It contains a list of 16 rights. The rights are called ‘Articles’. All of your human rights are really important. But, here are the 5 most important human rights to do with your health and care:



Right to life

This includes protecting your life when its at risk from yourself or other people

(Article 2)



Right to liberty

This is about not having unfair limits on being able to move about

(Article 5)



Right not to be tortured or treated in an inhuman or degrading way

This is about you being safe and not being hurt or neglected by other people

(Article 3)



Right to respect for private and family life, home and correspondence

This includes you being in charge of your own life and being asked about decisions to do with your care

(Article 8)



Right not to be discriminated against

This means when you are using the Human Rights Act you should be treated the same as everyone else

(Article 14)

Here are the other 11 rights you have in the Human Rights Act:

Right to freedom of thought, conscience and religion

(Article 9)

Right to peaceful enjoyment of possessions

(Article 1, Protocol 1)

Right to a fair trial

(Article 6)

Right to marry and have a family

(Article 12)

Right to education

(Article 2, protocol 1)

Right to be free from slavery or forced labour

(Article 4)

Right to vote in elections

(Article 3, Protocol 1)

Right to freedom of expression

(Article 10)

Right to freedom of assembly and association

(Article 11)

Right not to be punished for a criminal offence which wasn't against the law when you did it

(Article 7)

No-one to get the death penalty

(Article 1, Protocol 13)

You can find out more about these rights in a booklet called 'Mental Health, Mental Capacity: My human rights'

This booklet also explains how your rights are protected, how people providing your health or care should be making sure your rights are respected and protected and where to get more help.

To get your free copy of the booklet visit our website at www.bihr.org.uk/health or send an email to info@bihr.org.uk or phone us on 0207 882 5850.



Appendix N
Theory of planned behaviour questionnaire

For each question, please circle the number that best describes *your personal opinion*.

Human rights on adult acute mental health wards

Theory of Planned Behaviour – Questionnaire

This questionnaire is made up of 59 questions in total, and is 10 pages long
(including this front cover)

Please answer *all* of the questions.

For each question, please circle the number that best describes *your personal opinion*.

For the purposes of this questionnaire, the following definitions apply:

The term “human rights-based approach” refers to the information in the leaflet that should have been presented to you. If you are not familiar with this term, please read the leaflet before answering any questions.

The term “service user” refers to individuals who are an inpatient on an acute mental health ward, who you support in your role as a health professional.

The term “mental health difficulties” refers to a state of wellbeing which may be psychologically and/or emotionally distressing. A person with mental health difficulties may struggle to manage their thoughts, feelings and behaviours when faced with a stressful situation.

If you need any assistance, please ask the researcher who will be able to help you.

1) If I use a human rights-based approach it will promote a service user's dignity

Unlikely	1	2	3	4	5	6	7	Likely
----------	---	---	---	---	---	---	---	--------

2) I am expected to support service users with mental health difficulties using a human rights-based approach

Strongly disagree	1	2	3	4	5	6	7	Strongly agree
-------------------	---	---	---	---	---	---	---	----------------

3) Families and/or carers approval of my practice is important to me

Not at all	1	2	3	4	5	6	7	Very much
------------	---	---	---	---	---	---	---	-----------

4) My knowledge of a human rights-based approach makes me

Less likely	-3	-2	-1	0	+1	+2	+3	More likely
-------------	----	----	----	---	----	----	----	-------------

to support service users using this approach

5) Supporting a service user with mental health difficulties using a human rights-based approach is

Harmful	1	2	3	4	5	6	7	Beneficial
---------	---	---	---	---	---	---	---	------------

6) I often have to prioritise mandatory tasks over spending time with service users

Strongly disagree	1	2	3	4	5	6	7	Strongly agree
-------------------	---	---	---	---	---	---	---	----------------

7) I am confident that I could support service users using a human rights-based approach if I wanted to

Strongly disagree	1	2	3	4	5	6	7	Strongly agree
-------------------	---	---	---	---	---	---	---	----------------

8) I expect to support service users with mental health difficulties using a human rights-based approach

Strongly disagree	1	2	3	4	5	6	7	Strongly agree
-------------------	---	---	---	---	---	---	---	----------------

9) Psychologists

Do not	-3	-2	-1	0	+1	+2	+3	Do
--------	----	----	----	---	----	----	----	----

support service users using a human rights-based approach

10) Public approval of my practice is important to me

Not at all	1	2	3	4	5	6	7	Very much
------------	---	---	---	---	---	---	---	-----------

11) Reducing stigma for a service user is

Extremely undesirable	-3	-2	-1	0	+1	+2	+3	Extremely desirable
--------------------------	----	----	----	---	----	----	----	------------------------

12) There are some service users who do not deserve to be supported using a human rights-based approach

Unlikely	1	2	3	4	5	6	7	Likely
----------	---	---	---	---	---	---	---	--------

13) My managers allowing me to work using a human rights-based approach would make me

Less likely	-3	-2	-1	0	+1	+2	+3	More likely
-------------	----	----	----	---	----	----	----	-------------

to support service users with this approach

14) I feel equipped with the knowledge in how to use a human rights-based approach

Strongly disagree	1	2	3	4	5	6	7	Strongly agree
----------------------	---	---	---	---	---	---	---	-------------------

15) People who are important to me want me to support service users with mental health difficulties using a human rights-based approach

Strongly disagree	1	2	3	4	5	6	7	Strongly agree
----------------------	---	---	---	---	---	---	---	-------------------

16) Supporting a service user with mental health difficulties using a human rights-based approach is

Worthless	1	2	3	4	5	6	7	Useful
-----------	---	---	---	---	---	---	---	--------

17) Working using a human rights-based approach for someone who may lack capacity to make an informed decision is

Extremely undesirable	-3	-2	-1	0	+1	+2	+3	Extremely desirable
-----------------------	----	----	----	---	----	----	----	---------------------

18) The public would

Disapprove	-3	-2	-1	0	+1	+2	+3	Approve
------------	----	----	----	---	----	----	----	---------

of me supporting service users using a human rights-based approach

19) Psychiatrists

Do not	-3	-2	-1	0	+1	+2	+3	Do
--------	----	----	----	---	----	----	----	----

support service users using a human rights-based approach

20) Doing what nursing staff do is important to me

Not at all	1	2	3	4	5	6	7	Very much
------------	---	---	---	---	---	---	---	-----------

21) Thinking about my safety on the ward makes it

Much more difficult	-3	-2	-1	0	+1	+2	+3	Much easier
---------------------	----	----	----	---	----	----	----	-------------

to support service users using a human rights-based approach

22) There is a strong sense of leadership on the ward

Strongly disagree	1	2	3	4	5	6	7	Strongly agree
-------------------	---	---	---	---	---	---	---	----------------

23) Using a human rights-based approach helps me to work in the best interests of the service user

Unlikely	1	2	3	4	5	6	7	Likely
----------	---	---	---	---	---	---	---	--------

24) Service users think that I

Should not	-3	-2	-1	0	+1	+2	+3	Should
------------	----	----	----	---	----	----	----	--------

support them using a human rights-based approach

25) Doing what psychologists do is important to me

Not at all	1	2	3	4	5	6	7	Very much
------------	---	---	---	---	---	---	---	-----------

26) The decision to support service users using a human rights-based approach is beyond my control

Strongly disagree	1	2	3	4	5	6	7	Strongly agree
-------------------	---	---	---	---	---	---	---	----------------

27) Occupational therapists

Do not	-3	-2	-1	0	+1	+2	+3	Do
support service users using a human rights-based approach								

28) I intend to support service users with mental health difficulties using a human rights-based approach

Strongly disagree	1	2	3	4	5	6	7	Strongly agree
-------------------	---	---	---	---	---	---	---	----------------

29) Supporting a service user using a human rights-based approach helps me to work with the law

Unlikely	1	2	3	4	5	6	7	Likely
----------	---	---	---	---	---	---	---	--------

30) What psychiatrists think I should do matters to me

Not at all	1	2	3	4	5	6	7	Very much
------------	---	---	---	---	---	---	---	-----------

31) Feeling like I have to prioritise mandatory tasks makes me

Less likely	-3	-2	-1	0	+1	+2	+3	More likely
to support service users using a human rights-based approach								

32) Most people who are important to me think that

I should	1	2	3	4	5	6	7	I should not
support service users with mental health difficulties using a human rights-based approach								

33) Working within the law is

Extremely undesirable	-3	-2	-1	0	+1	+2	+3	Extremely desirable
-----------------------	----	----	----	---	----	----	----	---------------------

34) It is possible to support a service user who may lack capacity to make informed decisions using a human rights-based approach

Unlikely	1	2	3	4	5	6	7	Likely
----------	---	---	---	---	---	---	---	--------

35) Doing what the majority of my colleagues do is important to me

Not at all	1	2	3	4	5	6	7	Very much
------------	---	---	---	---	---	---	---	-----------

36) Having staff shortages on the ward makes it

Much more difficult	-3	-2	-1	0	+1	+2	+3	Much easier
---------------------	----	----	----	---	----	----	----	-------------

to support service users using a human rights-based approach

37) Restrictive practices are often used on the ward

Strongly disagree	1	2	3	4	5	6	7	Strongly agree
-------------------	---	---	---	---	---	---	---	----------------

38) What service users think I should do matters to me

Not at all	1	2	3	4	5	6	7	Very much
------------	---	---	---	---	---	---	---	-----------

39) Service users who have committed crimes in the past should be supported using a human rights-based approach

Unlikely	1	2	3	4	5	6	7	Likely
----------	---	---	---	---	---	---	---	--------

40) I want to support service users with mental health difficulties using a human rights-based approach

Strongly disagree	1	2	3	4	5	6	7	Strongly agree
-------------------	---	---	---	---	---	---	---	----------------

41) Supporting a service user with mental health difficulties using a human rights-based approach is

Pleasant (for me)	1	2	3	4	5	6	7	Unpleasant (for me)
-------------------	---	---	---	---	---	---	---	---------------------

42) Supporting a service user using a human rights-based approach will help to reduce stigma around their mental health difficulties

Unlikely	1	2	3	4	5	6	7	Likely
----------	---	---	---	---	---	---	---	--------

43) Working on a ward using restrictive practice makes it

Much more difficult	-3	-2	-1	0	+1	+2	+3	Much easier
---------------------	----	----	----	---	----	----	----	-------------

to support service users using a human rights-based approach

44) Whether I support service users using a human rights-based approach or not is entirely up to me

Strongly disagree	1	2	3	4	5	6	7	Strongly agree
-------------------	---	---	---	---	---	---	---	----------------

45) I feel under social pressure to support service users with mental health difficulties using a human rights-based approach

Strongly disagree	1	2	3	4	5	6	7	Strongly agree
-------------------	---	---	---	---	---	---	---	----------------

46) Doing what occupational therapists do is important to me

Not at all	1	2	3	4	5	6	7	Very much
------------	---	---	---	---	---	---	---	-----------

47) Service users' families and/or carers think that I

Should not	-3	-2	-1	0	+1	+2	+3	Should
------------	----	----	----	---	----	----	----	--------

support service users using a human rights-based approach

48) For me to support service users using a human rights-based approach is

Easy	1	2	3	4	5	6	7	Difficult
------	---	---	---	---	---	---	---	-----------

49) Nursing staff

Do not	-3	-2	-1	0	+1	+2	+3	Do
--------	----	----	----	---	----	----	----	----

support service users using a human rights-based approach

50) I often have to think about my safety when working on the ward

Strongly disagree	1	2	3	4	5	6	7	Strongly agree
-------------------	---	---	---	---	---	---	---	----------------

51) Supporting a service user with mental health difficulties using a human rights-based approach is

Good	1	2	3	4	5	6	7	Bad
------	---	---	---	---	---	---	---	-----

52) Working in the best interests of a service user is

Extremely undesirable	-3	-2	-1	0	+1	+2	+3	Extremely desirable
-----------------------	----	----	----	---	----	----	----	---------------------

53) Senior managers would

Disapprove	-3	-2	-1	0	+1	+2	+3	Approve
------------	----	----	----	---	----	----	----	---------

of me supporting service users using a human rights-based approach

54) The ward often experiences staff shortages

Strongly disagree	1	2	3	4	5	6	7	Strongly agree
-------------------	---	---	---	---	---	---	---	----------------

55) Having a lack of leadership on the ward makes it

Much more difficult	-3	-2	-1	0	+1	+2	+3	Much easier
---------------------	----	----	----	---	----	----	----	-------------

to support service users using a human rights-based approach

56) Promoting a service user's dignity is

Extremely undesirable	-3	-2	-1	0	+1	+2	+3	Extremely desirable
-----------------------	----	----	----	---	----	----	----	---------------------

57) Most of my colleagues

Do not	-3	-2	-1	0	+1	+2	+3	Do
--------	----	----	----	---	----	----	----	----

support service users using a human rights-based approach

58) My managers would allow me to work using a human rights-based approach

Strongly disagree	1	2	3	4	5	6	7	Strongly agree
-------------------	---	---	---	---	---	---	---	----------------

59) What senior managers think I should do matters to me

Not at all	1	2	3	4	5	6	7	Very much
------------	---	---	---	---	---	---	---	-----------

Appendix O

Participant information sheet – service user



Human rights in adult acute mental health services

Participant Information Sheet – Service User

You are being invited to participate in a research study. Before you decide whether to participate, it is important for you to understand why the research is being done and what it will involve.

Please take time to read the following information carefully and feel free to ask us if you would like more information or if there is anything that you do not understand.

Please also feel free to discuss this with other people, such as friends, relatives and your staff team if you wish. We would like to stress that you do not have to accept this invitation and should only agree to take part if you want to.

What is the purpose of the study?

The purpose of this study is to explore your views on human rights-based care on acute mental health wards. Staff members will also be asked questions on this topic.

Why have I been chosen to take part?

You have been chosen to take part as you are currently undergoing an inpatient stay on an acute mental health ward, and we are interested in your views on your care.

Do I have to take part?

No. Participation is completely voluntary. If you do not choose to take part, this will have no effect on your care or treatment. If you do agree to take part, you are free to withdraw at anytime without explanation and without incurring a disadvantage.

What will happen if I take part?

If you agree to take part, one of the research team will meet with you on the ward and you will be asked to sign a consent form. There will be three parts to your involvement:

- You will be asked to complete a demographic questionnaire. **We will ensure that you will not be identified from this information.**

- You will be presented with an information leaflet explaining more about human rights-based approaches.
- You will be asked to complete a questionnaire titled “Human Rights Survey: Hospital Patients”. This questionnaire has 12 questions overall and should take no longer than 40 minutes to complete. Support will be given from the researcher to complete this survey.

Overall it should take no longer than 60 minutes to complete all three parts.

After this, you will have the chance to ask any questions about your participation.

Are there any risks in taking part?

We do not believe that there should be any risk to you if you agree to participate in this research. If you do experience any distress or discomfort when discussing your care, please make the researcher aware immediately so that your participation can be stopped. The researcher can feedback information to your staff team, if requested.

The researcher has a responsibility to report any significant breaches in human rights in order to keep you and others safe. If you disclose any such information, the researcher will speak to you about this and make any next steps clear, including who it might be reported to.

Are there any benefits in taking part?

It is not believed that participation in this research will have any immediate benefits to you. The research may help to further understand how care is provided on acute mental health wards and may be able to recommend areas for future research.

What if I am unhappy or if there is a problem?

If you are unhappy, or if there is a problem, please feel free to let us know by contacting the principal investigator who will try and help:

Dr Sarah Butchard
 Ground floor, Whelan Building
 University of Liverpool
butchard@liverpool.ac.uk
 0151 794 5530

If you remain unhappy or have a complaint which you feel you cannot come to us with, then you should contact the Research Governance Officer at ethics@liv.ac.uk. When contacting the Research Governance Officer, please provide details of the name or description of the study (so that it can be identified), the researcher(s) involved, and the details of the complaint you wish to make.

You can also contact your local Patient, Advice and Liaison Service (PALS) who can help you try to resolve any issues or concerns you may have.

The website for PALS is:

[deleted to maintain NHS Trust confidentiality]

You can contact them either by:

Telephone: [deleted to maintain NHS Trust confidentiality]

Email: [deleted to maintain NHS Trust confidentiality]

Will my responses be kept confidential?

Yes, your responses on the questionnaires will be kept confidential, and you will not be identified from them. All material for the study will be kept securely at the University of Liverpool, adhering to the Data Protection Act 1998 and University policies and procedures. Only the research team will have access to this data. The data will be under the responsibility of the research team for 5 years, and will then be destroyed after this time.

What will happen to the results of the study?

This research is being conducted for submission towards a Doctorate study programme which is anticipated to be completed by September 2019. A major research report will be written as a University requirement and the work will be submitted for publication in a peer-reviewed journal, which may be made accessible to the public. Feedback on the results will be offered to the Research and Development Team within the Trust once the research is complete, which you will be able to request from them.

What will happen if I want to stop taking part?

You can withdraw your participation in the research at any time, without explanation. However, the results will be made anonymous, meaning that you will not be able to withdraw your responses after you have completed all of the questionnaires. If you withdraw your consent during your time with the researcher, anything you have completed up to that point will be destroyed and not included in the results.

Who has reviewed this research?

This research has been reviewed by the University of Liverpool Doctorate in Clinical Psychology programme staff. Sponsorship approval has been granted from the University of Liverpool. The National Health Service Research Ethics Committees (NHS RECs) through the Health Research Authority (HRA) has also reviewed and approved this research.

Who can I contact if I have further questions?

Should you have any further questions, please contact the principal investigator:
Dr Sarah Butchard
Ground floor, Whelan Building
University of Liverpool
butchard@liverpool.ac.uk
0151 794 5530

Thank you

Appendix P
Participant consent form – service user

Committee on Research Ethics

PARTICIPANT CONSENT FORM - SERVICE USER

Title of Research Project: Human rights in adult acute mental health services

Researcher(s): Stephanie Davis Le Brun, Dr Sarah Butchard, Professor Richard Whittington

**Please
initial box**

1. I confirm that I have read and have understood the information sheet dated July 2018 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my rights being affected. In addition, should I not wish to answer any particular question or questions, I am free to decline.

3. I understand that confidentiality and anonymity will be maintained and it will not be possible to identify me in any publications.

4. I understand and agree that once I submit my data it will become anonymised and I will therefore no longer be able to withdraw my data.

5. I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals from University of Liverpool, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.

6. I agree to take part in the above study.

Participant Name	Date	Signature
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Name of Person taking consent	Date	Signature
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Researcher

Date

Signature

Principal Investigator:

Dr Sarah Butchard
Whelan Building, University of Liverpool
butchard@liverpool.ac.uk

Student Researcher:

Stephanie Davis Le Brun
Whelan Building, University of Liverpool
sdlb@liverpool.ac.uk

Appendix Q
Demographic questionnaire – service users

Human rights on adult acute mental health wards
Demographic questionnaire – service users

Where you see a box please mark your answer with an **X** inside of it.
 Where you see a line, please write your answer in your own words.

9) What is your age? 16-24 25-34 35-44 45-54 55-64 65+

10) What best describes your gender? Female Male Prefer not to say

Prefer to self-describe _____

11) What is your ethnic group? _____

Prefer not to say

12) For this current admission, how long have you been an inpatient for?

Less than one week 1-2 weeks 2-4 weeks 1 month-3 months 3 months-6 months More than 6 months

13) Have you ever had a previous admission to an adult acute mental health ward? Yes | | No |

a) If yes, approximately how many admissions have you had previously? _____

14) Do you have a diagnosis for your mental health? Yes | | No |

a) If yes, please could you list
your diagnosis/diagnoses

15) Have you ever had a discussion about your human
rights with anyone involved in your care?

Yes | | No |

a) If yes, who was this?

16) Have you ever attended any training in human rights?

Yes | | No |

a) If yes, approximately how long ago was this
training?

b) If yes, who delivered
the training?

Appendix R Human Rights Survey: Hospital Patients



Human Rights Survey: Hospital Patients

Introduction

As public bodies, NHS Trusts have a positive obligation (Human Rights Act 2000, Section 6) to respect, protect and promote human rights. This survey aims to provide a practical way of ensuring that wards and departments are conforming with human rights law and human rights principles.

The Survey was developed as part of the 2011-2012 Human Rights in Healthcare Programme (www.humanrightsinhealthcare.nhs.uk) through a collaboration between the British Institute of Human Rights, City Hospitals Sunderland NHS Foundation Trust and Mersey Care NHS Trust. A version of this survey was trialled by City Hospitals Sunderland. (Contact: Austin.OMalley@chsft.nhs.uk)

The survey should be carried out by an organisation (eg Health Watch, a voluntary organisation) which is independent of the

NHS. Those conducting the survey must have a basic understanding of human rights and how they apply in a healthcare setting. For information about human rights training contact the British Institute of Human Rights (bihr.org.uk). The Rights contained in the Human Rights Act which are particularly relevant to this survey are:

- **Article 2: Right to life**
- **Article 3: Right to be free from torture, inhuman and degrading treatment**
- **Article 5: Right to liberty**
- **Article 6: Right to a fair trial**
- **Article 8: Right to private and family life, home and correspondence**
- **Article 9: Right to freedom of thought, conscience and religion**
- **Article 14: Right not to be discriminated against**

- **Protocol 1, Article 1 peaceful enjoyment of possessions**

Other rights may also be engaged.

**This survey is also suitable to be carried out in residential settings
such as nursing homes.**

Human Rights Survey: Hospital Patients

Background information:

Date of survey

Name of person conducting survey

Name of Ward or Department

Name of NHS Trust

Type of service:

Tick as appropriate	In-patient	Out-patient	Remove this box

Please return the finished survey to:

Introductory notes for individual conducting the survey:

- **Introduce yourself** and explain that you are conducting a survey on behalf of X organisation. Explain that X organisation is interested to get feedback from patients on the care and treatment they have received, and in particular, to check that it conforms with human rights law and human rights principles. X organisation wants to hear about concerns patients have and about examples of good practice.
- **Ask if the individual would mind answering a few questions.** Try to gain their trust and put them at ease – perhaps ask a few questions first of all about how they are feeling, whether they are happy to talk now or would prefer an alternative time, more privacy etc. Encourage them to speak freely, explain that survey results will be anonymous, and that there is no need for patients to be concerned that their responses will have any impact on their treatment except in a positive way.
- **Encourage them to give as much detail as they need** on particular questions, or to talk about related issues if they want to. Use the notes and prompts, if necessary, to help them understand what you are asking. You may need to note some of the related issues on a separate page.
- **Use the RAG rating** to indicate whether you think some of the issues will need following up:
 - ❖ Green (G) to indicate that you do not believe there is a human rights concern. No action is necessary.
 - ❖ Amber (A) to indicate that you think an issue is likely to be a human rights concern and needs further investigation.
 - ❖ Red (R) to indicate serious concern about an issue which is very likely to be a human rights violation: immediate follow-up needed.
- **Any red issues must be flagged immediately to:**
 - Named person (telephone _____)
 - The ward manager where the survey is taking place
- When carrying out the surveys, **try to be aware of what is going on around you.** You may want to record other examples of good or poor practice not directly related to an interview. Make a note of these on the last page of the survey.

Human Rights Hospital Patients Survey: questions and notes

Notes on Question 1:

The first question is to give a general overview. Make brief notes on any concerns or positive comments but explain that there will be an opportunity to address issues in more detail later on. **Remember to make sure at the end that you have picked these issues up.**

1. How would you describe your general treatment and care here?

Ask the patient to select one of the options below

Good	Acceptable	Poor	Don't know

Follow-up: *Do you have any particular concerns or positive comments?*

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Question 1 RAG rating:	R	A	G

Notes on Question 2:

This question is more specific than Question 1 in looking at *basic* needs. It relates to Article 8 and Article 3 - and possibly to Article 2. It is important to find out whether patients require assistance with these tasks and if so whether they are receiving it. For in patients, you may wish to ask about food as well as drink.

2. How well do you think that your basic needs are provided for here? (For example, are you able to get a drink or go to the toilet when you need to?)

Very well looked after	Well looked after	Not well looked after

Details: any comments to back up the answer given

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Question 2 RAG rating:	R	A	G

Notes on Question 3:

This question relates to Articles 8 and 3 and potentially Article 2. Examples of poor practice might relate to calls for help being ignored, bullying or patronising attitudes, being talked over instead of to. If the patient feels a lack of respect from staff, try to establish why they think this and whether it is to do with general staff attitudes or something particular to their case.

3. To what extent do you think that you are treated with respect by the people providing your care here?

Fully	Mostly	Not always

Details: ask for further evidence to support the answer

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Question 3 RAG rating:	R	A	G

Notes on Question 4:

This relates to Article 8, and possibly Article 3. Such cases will be extremely rare but it is very important that any potential issues are flagged up immediately. If the patient feels there may have been such instances, explore the extent of suffering, what measures were taken to alleviate it, how prolonged it was. Find out whether the patient informed members of staff.

4. While here, have you ever been in severe pain, distress or discomfort and not been given attention or treatment for this?

No	Possibly	Yes

Details: ask for further information if the patient thinks this is a possibility

Question 4 RAG rating:	R	A	G

Notes on Question 5:

The questions included here are about the extent to which patients are able to have control over their own choices and their own movements. The key rights are the **right to liberty** (Article 5) which relates severe restrictions on freedom of movement, and Article 8, which relates more broadly to *autonomy*. Autonomy is about the degree of control patients feel they have over their lives including key decisions which affect them.

For the second part of the question, bear in mind the differences between *restraining or restricting* a patient's movements – which may relate to autonomy – and *depriving* them of their liberty. These are mainly differences of degree. Deprivation of liberty is a much more severe restriction on someone's movement and it **must be** authorised. It may include extensive use of anti-psychotic medication or severe restrictions on a patient's movement or lifestyle.

5a) To what extent do you think your freedom of movement is respected here?

Fully	Mostly	Not always

Details: ask for evidence to support the answer – if there are severe restrictions, you will need to check with staff whether there is authorisation.

Question 5a) RAG rating:	R	A	G

5 b) To what extent is your freedom of movement respected here?

Fully	Mostly	Not always

Details: ask for evidence to support the answer

Question 5a) RAG rating:	R	A	G

Notes on Question 6:

This relates to Article 8 of the HRA, which gives individuals the right to 'private life'. If privacy has not been respected and the individual has suffered to an extreme degree as a result, there may be an Article 3 concern. Privacy may be in relation to how their care has been carried out (e.g. being washed or dressed by a carer of the opposite sex, their health issues being discussed in a loud voice by staff) or in relation to confidential discussions or issues – for example, relating to medical or personal details.

You may wish to ask whether the patient has any concerns about the confidentiality of their medical records.

6. How well do you think that staff here respect your privacy?

Very well	Well	Not well

Details: *explore reasons for the answer*

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Question 6 RAG rating:	R	A	G

Notes on Question 7:

This relates to Article 14 and the Equality Act. Prompt by giving examples: for example because of the patient's race, gender, age, sexual orientation, religious beliefs, disability - or for any other reason.

7. While you have been here, have you ever felt that you have been treated less well than others or discriminated against?

No	Possibly	Yes

Details: *ask for details of any potentially discriminatory treatment*

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Question 7 RAG rating:	R	A	G

Notes on Question 8:

This question relates to Article 14, possibly Article 9, and to duties under the Equality Act. Article 9 relates not only to religious beliefs but other beliefs, for example atheists, agnostics and vegetarians. If relevant, check whether any special dietary requirements are taken into account.

You may need to prompt the patient to think about whether particular needs such as mobility, language or religion have been taken into account.

8. Do you feel that your particular needs and beliefs have been respected in the way that your care is delivered here?

No	Possibly	Yes

Details: ask for evidence to support the answer

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Question 8 RAG rating:	R	A	G

Notes on Question 9:

This relates to Article 1 of Protocol 1, the right to the peaceful enjoyment of possessions. Financial abuse is a significant human rights concern of older people: you may need to check whether patients have access to their money as and when they need it. The question may also be related to Article 8.

9. a) Do you feel your belongings are safe here?

Very safe	Safe	Not safe

Details: ask for evidence for the response given

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.....

Question 9 a) RAG rating:	R	A	G

9 b) How easy is it for you to access your belongings when you need to?

Easy	Fairly easy	Not easy

Details: any evidence for the response given

Question 9 b) RAG rating:	R	A	G

Notes on Question 10:

This question relates to Article 8, which protects an individual's private life and ability to form and maintain social relationships, particularly family relationships. Find out what inpatients think of visiting times. You may also want to find out if they have ever felt excluded or isolated.

10. Do visiting hours give you sufficient opportunity to see family and friends?

Easy at all times	Generally easy	Occasionally difficult

Details: ask for evidence

Question 10 RAG rating:	R	A	G

Notes on Question 11:

The different parts of question 11 relate to Article 8, which gives individuals the opportunity to take part in decisions which affect them. They may also raise Article 6 issues, which relate to fair decision making processes. Treatment given without consent, or without the use of an advocate, may in the most severe cases raise Article 5 concerns (for example if sedation is used regularly) or even Article 2 or 3 issues.

- If the patient says they were not informed or consulted – try to find out more details
- If they had concerns or were not able to understand what they were told about their care plan or treatment, find out whether staff were aware of this and whether anything was done to assist.

11 a) Have you been informed and consulted about your treatment/care plan here?

Yes	A little	No

Details: Ask for further evidence

Question 11 a) RAG rating:	R	A	G

11 b) Have you ever had any difficulty understanding what is being proposed for your care plan?

Yes	A little	No

if the patient has had difficulty, find out whether they were given any assistance

- *If they did not tell staff about any difficulties, try to find out why*

Details:

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Question 11 b) RAG rating:	R	A	G

Notes on Question 12:

These questions may relate to a number of rights—depending on the nature of the concern or complaint. Patients should know about how to raise concerns or make complaints and should feel able to do so if necessary.

You should have information to hand about how to raise concerns or make complaints. You may want to mention other mechanisms as well—eg. PALS, the Health Ombudsman etc. If people are worried about complaining because of the possible consequences **please reassure them the survey is confidential.**

12a) Have you ever been concerned about aspects of your care here?

Yes	A little	No

Details: *If the patient answers 'yes' or 'a little, ask for details of the concerns*

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Question 12 a) RAG rating:	R	A	G



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IF THE PATIENT ANSWERS NO TO 12 a), GO TO QUESTION 12 c)

▼ IF THE PATIENT ANSWERS YES TO QUESTION 12 a):

12 b) Were your concerns addressed satisfactorily?

Yes	Mostly	No

Details: *If the concerns were not addressed satisfactorily, try to find out why - eg:*

- *If staff were not informed, what was the reason?*
- *If staff were informed, did they take the concerns seriously?*

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Question 12b) RAG rating:	R	A	G

▶ GO TO THE FINAL QUESTION IN THE SURVEY, QUESTION 13.

▼ IF THE PATIENT ANSWERS NO TO QUESTION 12 a):

12 c) If you ever felt unhappy with your care here – would you feel able to inform staff or complain?

Yes	Possibly	No

Details: *If no, ask why not (because they don't know how to? Because they would worry about the consequences?)*

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Question 12 b) RAG rating:	R	A	G

13. Do you have any other feedback about your care here?

Is there anything positive you would like to record?

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Is there anything negative you would like to record?

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