

Experiences of ward atmosphere in inpatients with intellectual disability and mental illness: clinical implications for mental health nursing

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Background: Patients with intellectual disability in psychiatric services are rarely asked about their experiences when admitted to inpatient units.

Aim: To enhance the understanding of ward atmosphere for inpatients with co-occurring intellectual disabilities (ID) and mental illness by exploring patients' experiences from a specialised mental health inpatient unit.

Methods: A selected sample of 10 adults with comorbid mental illness and ID were recruited for a qualitative interview study based on Gunderson's conceptualisation of therapeutic components in mental health wards. The patients were interviewed by two experienced clinicians and interviews were analysed using directed content analysis.

Results: Patients' experience of their relationships with ward staff seemed central to their experiences of several aspects of mental health nursing. Feeling safe, contained, and validated, were further important aspects. However, the patients seemed to have little influence on treatment choices and did not report participating in shared decision-making.

Conclusions: The patients' answers in this study are in line with previous research on ward atmosphere for patients in the general population. However, more research is necessary to inform future mental health nursing for patients with ID, both in inpatient and ambulatory services.

Keywords: ward atmosphere; intellectual disability; mental health nursing; patient reported measures

Introduction

People with intellectual disabilities (ID) are at increased risk of developing severe mental illness (Munir 2016, Cooper *et al.* 2007) and treatment will occasionally require admission to inpatient wards (Bakken and Martinsen 2013). Assessment and evaluation of treatment of mental illness in individuals with ID may be challenging (Fletcher *et al.*, 2016, Rysstad *et al.* 2020): individuals with ID may have limited verbal language skills or related difficulties affecting verbal communication (WHO 2018). Hence, symptoms may not be reported or directly observable to others. Although certain behavioural expressions of core symptoms of mental illness have been identified, e.g. disorganized

behaviours in schizophrenia (Bakken *et al.* 2007), such behavioural equivalents may differ considerably between individuals. Thus, symptom recognition remains complex and challenging in mental illness in individuals with ID, and this complexity needs to be managed in mental health nursing in this population, including attention to the symptom presentations and experiences of each specific individual (Taua and Farrow 2009, Donner and Gustin 2020).

Qualitative research is an under-utilised approach in research in (Beail and Williams 2014), and co-occurring ID and mental illness. However, emerging findings taking subjective experiences of people with ID into account demonstrate that this may reveal more perspectives than interviewing third parties (Douma *et al.* 2006, Moss *et al.* 1996). It is therefore important for

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research to explore ways of facilitating access to the subjective experiences of people with ID, and use this first-hand information as a main source of information about these individuals' experiences of mental illness. Qualitative studies exploring the views of individuals with ID may contribute to new understandings, new perspectives, and altered practices (Scott and Haverkamp, 2018, Rose and Kroese 2018). Though recent studies have shed light on the experiences of psychodynamic therapy by individuals with ID (Statham and Beail 2018), their experiences of emotion regulation (Littlewood et al. 2018), and belonging to a cultural minority (Larkin et al. 2018), the experiences of individuals with ID and mental illness being admitted to inpatient hospital wards remain under-researched.

The understanding of ward atmosphere as a potential therapeutic arena has been a central tenet of inpatient treatment in mental health services for almost a century (Gunderson 1978, Moos 1972, Jones 1953, Main 1946, Sullivan 1931). The concept of ward atmosphere, also described as social or emotional climate, was coined by Moos and Houts (1968). However, few studies have explored experiences of ward atmosphere among people with ID (Bakken et al. 2012). As a therapeutic ward atmosphere has been found to have positive impact on patient outcomes in inpatient mental health services for patients without ID (Smith et al. 1996, Eklund and Hansson 1997, Friis 1986), investigations of ward atmosphere for patients with ID are important to ensure that inpatient services for this population are sufficiently adapted to their needs.

For inpatients without ID, two largely overlapping areas of research have dominated the literature on ward atmosphere: Gunderson's conceptualisation of therapeutic components in mental health wards (Maree 2001, Gunderson 1978), and research focusing on ward atmosphere in mental health inpatient units (Bell et al. 2018, Chester et al. 2015, Schjødt et al. 2003, Eklund and Hansson 1997, Moos and Houts 1968). From the latter, an instrument for measurement of ward atmosphere, the Ward Atmosphere Scale (WAS) was first published in 1974, and remains the most widely used instrument for measuring the psychosocial climate of inpatient units (Rössberg and Friis 2003). However, the WAS has proven difficult to score for patients with co-occurring ID and mental illness in hospital settings, even when administering it as an interview rather than as a self-report measure (Bakken et al. 2012).

Largely overlapping with the concepts of the WAS, Gunderson's therapeutic components (Gunderson 1978) are viewed as an important contribution in the creation of therapeutic milieus (Maree 2001), and numerous studies have investigated their clinical applicability (Maree 2001, Farkas-Cameron 1998, Smith et al. 1996, Kurz-Cringle et al. 1994): *Containment* involves the provision of food, shelter, screened windows, and

seclusion if necessary, to protect the patient from harm and facilitate self-regulation in vulnerable phases. *Support* aims at supporting and strengthening the patient's ego-functions, making the patient feel better. Support emphasizes experiences of wellbeing and feeling safe. *Structure* involves adapting the environment to the patient, providing predictability. Structure includes defined rules, daily schedules, fixed appointments etc. *Involvement* is the process of helping the patient to improve social skills, aiding the patient in connecting with other people and breaking out of isolation. Staff-members contribute to involvement by facilitating and participating in activities with the patient. *Validation* affirms the patient's thoughts, feelings, and personality, including staff members accepting the patients' experiences of failure, and respecting patients' needs to be alone. Validation also involves viewing the patient's symptoms as meaningful, rather than signs of illness (Gunderson, 1978).

Mental health services have undergone considerable changes in the last decades, from viewing the patient as an 'object' needing treatment and care, to the current focus on shared decision-making, where the patient and the clinician work together to make treatment choices and decisions (Elwyn et al. 2010). However, for people with co-occurring ID and mental illness, there are numerous challenges in the practice of shared decision-making (Bigby et al. 2019). These challenges may result in failure to take these individuals' opinions and perspectives into account in the development and adaptation of mental health services. People with ID are often represented by significant others, which may involve a risk of misunderstanding the patient's inner states, or a lack of focus on what is important to the patients themselves (Scott and Haverkamp 2018, Rose et al. 2013). Thus, in addition to Gunderson's five components, *autonomy* was included as a sixth component for this study, as the opportunity to make decisions for oneself and the ability to influence one's surroundings has been found to be important to mental health (Killaspy et al. 2016, Lefcourt 2014).

Aims

The current study aims to enhance the understanding of ward atmosphere for inpatients with co-occurring ID and mental illness, by exploring patients' experiences from a specialised mental health inpatient unit:

How do patients with intellectual disabilities and co-occurring mental illness experience the ward atmosphere in a specialised inpatient unit for this population?

Methods

Design and setting

Because open-ended questions may be challenging for the population under study (Sommerstad, 2020), a qualitative study was designed based on Gunderson's

Table 1. Characteristics of the 10 participants.

Patient	Gender /age	Intellectual disability level/ Autism spectrum disorder (ASD)	Mental disorders at discharge	Months of stay before interview	Length of interview
1	M /27	Moderate	Schizophrenia	3	25 min
2	M/16	ASD	Anxiety, depression	4	20 min
3	M/21	Mild, ASD	Depression	4	55 min
4	M/43	Moderate, ASD	Psychosis	4	15 min
5	M/21	Mild	Anxiety	6	90 min
6	F/25	Moderate	Obsessive Compulsive Disorder, Attention, Deficit, Hyperactivity Disorder (Inattentive type)	5	40 min
7	F/46	Mild	Blandet PF	5	45 min
8	F/17	ASD	Depression	4	40 min
9	F/26	Mild	Blandet PF	3	50 min
10	M/26	Mild, ASD	Schizophrenia	6	20 min

five therapeutic components, plus autonomy. This included the construction of a semi-structured interview guide based on these six components, and subsequent use of directed content analysis (Hsieh and Shannon 2005). The study was planned, organised and carried out in a regional specialized mental health department for patients with intellectual disabilities (SPID). The SPID only allows referrals from other hospital-level services in mental health care or habilitation, serving a geographical area comprising more than half of Norway's population (see Bakken et al. 2008 for further information regarding the organization of services in Norway). At the time of the study, the department consisted of two separate inpatient units, each with capacity for five patients. All the authors are employed by this department in various capacities, and three have previous experience from the inpatient wards. However, none of the authors had worked in the wards for several years prior to the current project. The current study is part of a project concurrently exploring experiences of ward atmosphere in patients, staff, and patients' family members. Because the views of people with ID is rarely explored in the research literature, it was decided to report these in a separate paper, and staff and family members' experiences will be reported in subsequent papers.

Participants and recruitment

The study was approved by the Division of Mental Health and Addiction and the Data Protection Official at the Oslo University Hospital. Written consent was provided by all participants themselves. The consent form included information regarding the method, the storage and use of information from the participants, as well as the option of withdrawing their consent. Ward atmosphere and its relationship with treatment outcome were also described.

Patients were recruited for the study based on consecutive admissions within the same calendar year.

Inclusion criteria were being 16 years or older, having a diagnosis of intellectual disability and/or an autism spectrum disorder, having suspected or confirmed mental illness, being able to answer questions verbally, being able to consent verbally or in writing, and not being in an acute phase of mental illness at the time of the study. Of the twelve recruited participants, two were later excluded: one was not able to answer the questions verbally and one was in an acute phase at the time of the interview. The therapists read and explained the content of the consent form to the participants to ensure that they were fully aware of the procedure, their rights, and the option of withdrawing their consent at any time without any implications for their treatment.

On admission to the department, all participants were assigned a team of mental health professionals including a team leader (mental health nurse/ID nurse), an individual therapist (usually a clinical psychologist), a psychiatrist, and several nurses and nurses' assistants. Thorough, multidimensional assessments were carried out for all participants using a combination of standardized assessment tools, 24-h observation, interviewing family members and professional caregivers from their homes, gathering developmental histories, as well as reviewing all existing medical charts. The ten included participants (ages 16–46) received inpatient treatment for three to six months ($M = 4.4$ months, $SD = 1.07$). Participant characteristics are presented in Table 1.

Measures

The semi-structured interview guide included altogether 36 questions covering Gunderson's components (Gunderson 1978) and autonomy. In addition to these questions, the interview guide also included introductory questions concerning informants' interests and activities. The full interview guide can be seen in Appendix 1.

Procedure

All interviews were conducted individually by either the first or the last author, both clinicians with extensive experience working with the population in question. All participants were familiar with the interviewers prior to the interviews, but neither of the interviewers had been directly involved in any of the participants' treatments. Participants were allowed to choose where the interview took place and whether to be accompanied by a trusted staff member. Eight interviews took place in the SPID with a trusted staff member present. The two (three) remaining interviews were conducted in patients' homes, alone with the interviewer. Participants were provided with a snack during the interview. Seven of the ten participants agreed to interviews being audio recorded, while the remaining three allowed the interviewer to take notes. Interviews were conducted during the last month of each participant's stay in the SPID or during the first month after discharge.

Informants' response patterns varied considerably: four consistently gave brief responses, using few words to answer each question. Interviews for these informants lasted approximately 15–25 min each. The remaining six informants provided more extensive and detailed answers, with total interview time approximating 40–90 min. Two informants using more words started talking about topics during the interview which the interviewer(s) found challenging to relate to the questions asked, requiring careful probing, structuring and reminders of the question.

Analyses

Interviews were analysed using directed content analysis (Hsieh and Shannon 2005), with predefined categories based on Gunderson's five components plus autonomy. Participants' responses were analysed using a two-step procedure: all transcripts were read thoroughly and repeatedly by the first and last authors, and then all responses were organized by the six components for each interview. In step two, all responses were sorted by question in each variable and then finally summarized. Responses were interpreted in the context of the questions asked, and any interpretation in light of more abstract concepts not directly uttered by participants is described in the presentation below.

Results

No meaningful differences in the patients' response patterns were identified as being associated with level of ID or adaptive functioning. All informants contributed with descriptions for all six components, but informants varied as to which questions elicited answers within each component, and components varied as to the frequencies of responses elicited. For instance, only four

of the informants provided answers to questions 1 and 5 regarding *containment*. In general, questions starting with 'how' or 'why' seemed to elicit fewer answers.

In the presentation below, informants are identified by numbers following each quote. Quotes were chosen by author one in collaboration with two other authors to display nuances and variability within each component. All informants are represented by at least two quotes and quotes from at least four different informants were included for each component.

In response to the introductory questions, nine participants described positive experiences from the SPID. Interviewed after discharge, one patient expressed: 'You were more in agreement on what to do. The best thing about the ward. There were nice chats. And there, I didn't have those thoughts about taking my own life' [7]. Another, still admitted, used few words but smiled and nodded eagerly when asked about whether he was OK in the SPID: 'Long walks. Yes, good here.' [3]. A third patient was admitted twice in a short period, the first time voluntarily. 'It wasn't good when I was here voluntarily. [...] I left and I didn't come back. I think it's quite good to be here now. I think it's good that they make it work for me being sectioned. Now I feel that they are helpful and that they listen to me. No, you see, they have made me more motivated to manage things' [9].

The first component, *containment*, concerns provision of food, shelter, and protecting the patient from harm. All ten informants expressed generally feeling safe and protected in the SPID, even if a majority also expressed that they had also felt restless or afraid during their stays. 'Very safe. I liked everyone there' [1]. Nursing staff making time for them was described as contributing to the feeling of safety: 'The staff always made time. There was always someone I could ask' [7]. None of the informants made negative utterances regarding staff members or fellow inpatients. However, one of the informants spontaneously described an episode where the staff had been perceived as insecure: 'I remember some summer temps who hadn't understood how to test the alarms' [5], indicating that staff confidence may have contributed to the informant's feeling of safety. One informant also indicated that they occasionally felt misunderstood by staff: 'It [misunderstandings] happens easily. Not often, but sometimes' [6]. Several informants talked about the food served in the ward, which included some negative utterances: 'It's very basic food, too much bloody carrots and potatoes' [8].

The second component, *support*, aims to strengthen the patient's ego-functions, and consequently to make the patient feel better about themselves. This component included several questions about staff behaviour, with answers indicating that the informants experienced staff as having sufficient knowledge of their needs to

provide adequate assistance and support. 'Yes, I get a lot of assistance. To go to the store and go home. It's nice to be here' [10]. Nine informants answered the question about practical support, expressing that they got the practical assistance they needed. 'When I say that there is something I want to do, it usually happens. It's like a regular life being here. Just different rules' [3]. A question concerning whether it was helpful for informants to be committed to the inpatient ward elicited no direct answers regarding *how* they found it helpful, but several informants answered this question positively in indirect ways, implying that they perceived their stay as helpful: 'I hear it from a lot of people in my surroundings that I have gotten more mature and much more happy, and that I like myself more. So it's very good, and I feel it myself, too' [9]. One informant expressed dreading the discharge from the SPID: 'But it's going to go back to the same old things when I get home' [7]. One patient used few words, but answered these questions by nodding, smiling and saying 'I like it here' [4].

Structure may represent predictability through rules, daily schedules and fixed appointments. Six patients expressed that they thought there were a lot of rules and restrictions in the SPID. 'Rules are: Don't speak too loud, be kind and helpful' [1]. One informant talked about how he was not allowed to smoke during the night: 'Yes, there were a lot of rules. No smoking after 11 at night and no entering the kitchen.' [5]. Three informants expressed that there were some rules, while one did not think there had been many rules at all: 'Got to do what I wanted. And it was okay.' [7]. Six patients had a fixed, daily schedule for their activities Monday through Friday: 'Yes, I have a schedule. Every day. I think it's nice' [1]. 'It was sort of like home. There's a plan with bowling and stuff like that. There's swimming too. And I work out a little. I need a lot of help, you see' [3]. Several informants made indirect utterances indicating that they found this structure helpful: 'I give up very easily and get tired and bored. And we've agreed that I am going to school to be able to have a hobby' [9]. The remaining four either had a weekly schedule or no schedule at all: 'Few rules here. I get to decide what I am going to do. I don't do much during the day. The usual: music, lessons, computer games.' [2]. Weekends were described in a positive light, with particular emphasis on social activities and the food being different than weekdays: 'The staff makes pizza or something. It's nice.' [10].

Involvement concerns improving social skills: frequently breaking out of isolation, for the most part through activities outside the ward. Six of the informants expressed that the staff had gotten to know them well and knew their preferred activities: 'The best things were all the trips and that I got help' [5]. Two patients answered that they did not know whether staff

was aware of their preferred activities, while two thought staff did not know them well: 'I don't know if the staff knows me well' [2]. However, all informants talked positively about interactions with staff, and provided examples of activities they had done with staff members: 'I do all kinds of things with "Mary Ann". We always come up with something fun. I think they are very kind and understanding. A lot of different activities, going places to do things. The staff members are very kind and understanding' [9]. Doing activities together with the staff was perceived as important, and examples included playing cards, chess, table tennis, swimming, running, hiking or other outdoor activities such as visiting amusement parks or shopping malls. Activities across different arenas were mentioned, including inside the wards or the activity centre of the SPID. Informants expressed how these activities gave them positive experiences: 'I get the feeling of being on a cabin trip when I am playing cards, and it feels good. It's the good feeling' [3].

Validation affirms the patient's personality, thoughts and feelings through acceptance of the patient and viewing their symptoms as meaningful. The questions concerning this component seemed to elicit less extensive responses from informants, with more answers of 'don't know' or similar. Of the examples provided, most were concerned with positive experiences from activities or feedback the informants had received from staff members, including comments about emotional expressions or achievements. 'They say I am good. Look after me. "You look very happy today"' [1]. 'I get these notes from my team "Today you've done well controlling your impulses" and blah blah and stuff like that. It gives me motivation' [9]. Another patient nodded and smiled when staff was mentioned. He was accompanied by his primary nurse: 'I think they care how I feel' [4]. These examples indicate that informants experienced positive feedback regarding their achievements, as well as staff being interested in understanding how they were feeling, as validating experiences. However, one patient was not so sure of being understood by staff members 'No, nobody sees what I am feeling. No, you see, my body language is apparently not very clear' [8].

Autonomy concerns the ability to make one's own decisions and influence one's surroundings. Eight of the informants expressed that they felt staff listened when they talked about topics that were important to them. A majority also expressed that they could decide for themselves how to spend their days and what activities they wanted to attend: 'Yes, I could decide for myself' [6]; 'Yes, I got to decide more in the ward than here [in a group home]. We agreed what we were going to do that shift and it felt safe and good. And you, you made time, you didn't just guess what I was going to say' [7]. As for who was making decisions in the SPID, three

informants thought it was the psychiatrist, psychologist or the team leader who had the final word: 'The doctor decides the most. I decide a little' [1]. Six informants did not answer this question or answered that they did not know, while one informant expressed not caring about who makes decisions: 'I don't care about who makes decisions here. I trust the staff and know them well. They listen to me' [3]. Questions regarding what staff members make decisions *about* were only answered by two informants: one expressed that staff decided when there was a need to be quiet, and one that they decided the subject of conversations. Three patients expressed feeling angry or sad when they were not allowed to make decisions, while others expressed the opposite: 'It's the doctor and psychologist and team leader who make decisions. I don't get angry when I'm not allowed to decide for myself' [1]. Several informants also talked about lack of economic autonomy or about the differences between the ward and living in a group home.

Discussion

Aspects of the six components explored were described by all participants, but the respective components varied considerably as to how many and how elaborate responses they elicited. For all participants, descriptions of their relationships with ward staff permeated throughout the six components and their descriptions of them, underlining the centrality of developing personal relationships between patients and staff in creating a therapeutic ward atmosphere also for individuals with co-occurring ID and mental illness. The current findings highlight several areas for further exploration in future research on adaptation of mental health nursing practices for individuals with ID.

Components involving specific conditions, such as containment, were described by a number of participants and were generally described more extensively. As examples of containment, several participants mentioned food, staff always making time, and staff members being easily accessible. However, few participants described how this contributed to make them feel safe. It is possible that difficulties in abstraction, which are often present in individuals with ID, made it challenging for the participants to describe the more abstract aspects of this component (Finlay *et al.* 2001). However, it is also possible that these difficulties affected participants' subjective experiences of the ward and their relationships with nursing staff, making concrete conditions more important to their experience of containment, i.e. the provision of food they enjoy, continuous availability of staff members, and staff explicitly showing that they were making time for the patients may thus have been important as concrete signifiers of containment.

These results suggest that use of and adherence to concrete signifiers, such as keeping appointments and being physically and visually available for patients, may be one way to reach through to patients in ways that go beyond spoken language (Donner and Gustin 2020). Joint activities with staff may be another, including systematic observation of patients' reactions to stimuli and activities, while using gestures, posture and facial expressions to communicate (Birnbaum 2017). A third way to facilitate communication, although sparsely studied, is to *name the elements* in the ongoing communication, attempting to aid patients in putting into words experiences they may have difficulties expressing verbally themselves (Alnes *et al.*, 2011, Axberg *et al.* 2006). For example if the patient does not want to get out of bed and seems sad, the nurse may interpret this and attempt to put their experience into words 'I see that you want to stay in bed today. I wonder if you are feeling sad or afraid.' However, these approaches require mental presence, creativity and continuous reflection by nursing staff, going beyond technical and procedural approaches (Donner and Gustin 2020, Birnbaum 2017, Bakken and Smeby 2004).

Several participants described how they had felt understood and validated by ward staff, while some participants expressed that they did not think staff understood what they were feeling. The participants in the present study mostly had mild or moderate ID and were included because they were assumed to be able to answer the questions in the interview (Finlay *et al.* 2001). However, several participants had difficulties answering more abstract questions about validation and being understood. This is in line with previous qualitative research involving interviews with patients with ID (Ptomey *et al.* 2017, Robertson *et al.* 2014). Donner and Gustin (2020) described the experiences of psychiatric nurses working with individuals who have difficulties communicating verbally, finding that nurses' understanding of the unspoken narrative relied on compassion and willingness to engage while remaining in the uncertainty of not knowing. Furthermore, the participants in the study by Donner and Gustin conveyed that even though a person may have difficulties in verbally communicating their needs, this does not mean that they are unaware of their needs or what they find helpful.

Nurses' understanding of patients' non-verbal communication has previously been found to increase patients' experiences of safety and trust (Pounds 2010), and findings from Bakken *et al.* (2017) suggest that also nonverbal communication by staff may facilitate validation in individuals with ID. A previous study on nurse communication skills, which involved patients mostly communicating non-verbally, found emotional support, responding meaningfully, performing joint attention, and task sustenance were all effective

communication strategies in patients with ID, autism and psychosis (Bakken *et al.* 2008). Participants in the current study describing that they felt safe, listened to, and enjoyed being in the ward may be interpreted as an indication that they felt validated and understood, in spite of having difficulties describing this more explicitly. In patients with more limited verbal language skills, both due to ID and co-occurring severe mental illness, nonverbal communication by nursing staff is likely to be central in creating a therapeutic ward atmosphere. This highlights the importance of further research into nonverbal communication by staff in inpatient settings for individuals with ID.

In response to questions relating to autonomy, most participants described being able to decide what activities to do and how to spend their time. However, none of the participants described being involved in shared decision-making regarding treatment choices. This finding is reflected in previous research finding that shared decision-making for patients with ID requires substantial support from professional and informal caregivers (Bigby *et al.*, 2019), suggesting significant potential for improvement in mental health nursing for patients with ID. However, questions remain as to how to adapt and customize the often highly complex and academic information involved in decision-making in psychiatric treatment to these individuals.

Awareness that decisions are being made and what these entail is a prerequisite for participation in shared decision-making, suggesting that procedures for clear communication of treatment decisions and their implications is an important first step in the process of developing more appropriate interventions for shared decision-making in people with ID and co-occurring mental illness. Moreover, the current findings highlight the importance of autonomy in areas that are not directly treatment related, such as patients having influence on their daily activities, what foods they eat, etc. Focusing on the patient's strengths and special interests (Koegel *et al.* 2013) may be an area of unused potential when assessing areas for intervention in mental health nursing for patients with ID and aid in increasing patients' experiences of being able to impact their surroundings, which is a core element of autonomy (Lefcourt, 2014).

The current study has several limitations. The participants all had mild or moderate ID, and while this group constitute the overwhelming majority of the ID population, these findings are not necessarily applicable to individuals with severe or profound ID. The interview guide was highly structured, and while the experiences from the interviews suggest that the participants profited from a more concrete and structured approach in the interview setting, important aspects of the participants' experiences may have been overlooked. The researchers conducting the interviews were affiliated

with the wards in question, which may have led to participants under-reporting negative aspects of their experiences. On the other hand, several of the participants were insecure with strangers, and an unfamiliar interviewer may have elicited less exhaustive accounts, at least from some of the participants. Several of the participants also had difficulties describing some of the components investigated, indicating that the current findings need to be supplemented by exploration of these components among ward staff and family members of the participants.

In conclusion, this qualitative study indicates that Gunderson's components of ward atmosphere in inpatient psychiatric wards may be a useful framework for explorations of the experiences of individuals with ID in such settings. Findings indicate that concrete signifiers and nonverbal communications are important, and to date under-researched, aspects of adapting mental health nursing practices to the ID population. Considerable work also remains regarding the involvement of people with ID in shared decision-making in psychiatric treatment and care. The interview used in this study, especially the autonomy component, may assist mental health nurses in relation to information about decision-making. The current findings are in line with previous suggestions that although individuals with limited verbal language skills may not always be able to verbalize their needs, they are aware of what they experience as helpful. Finally, the current results suggest that admission to a specialist ward may be feasible for individuals with ID and co-occurring mental illness when necessary, and that individuals' experience of their relationships with ward staff is a central aspect of their experience of such admissions in general.

Disclosure statement

No potential conflict of interest was reported by the authors.

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Appendix 1

Questionnaire

Introduction

1. What makes you happy?
2. How are you now?
3. Do you have any special interests?
4. How old are you?
5. How long have you been here in the SPID?
6. Do you know any of the other patients?
7. What do you like to do when you are at home?

Containment

Containment includes provision of food, shelter, screened windows, and seclusion if necessary, i.e. to protect the patient from harm. Containment should endorse self-regulation in the patient in vulnerable phases.

1. What is it like for you here in SPID?
2. Do you feel safe? Are you restless? How do the staff members approach if you are restless?
3. What do you think about the other patients?
4. Are you often afraid? If your answer is “yes”, do you know why?
5. Do you often experience arguing in SPID? Do you often argue?
6. Is the food OK?

Support

Support aims at supporting and strengthening the patient’s ego-functions; hence it makes the patient feel better. Support emphasizes experiences of wellbeing and feeling safe.

1. Do you think well about yourself?
2. How do you feel being admitted here?
3. Do you get enough help and support here?
4. Are there any of the staff members that you know well?
5. Do the staff members know when you need help?
6. Is being a patient in the SPID useful for you?

Structure

Structure may change inappropriate milieus for the patient. The ward structure may represent predictability. Structure is defined roles, daily schedules, fixed appointments etc.

1. Are there many rules here?
2. Is there a regular meeting for all patients?
3. Do you decide yourself how you spend the day when you are admitted here?
4. Describe your day – when you get up and what you do.
5. Are there any common events for the patients during the week-ends?
6. Do you have a daily schedule?

Involvement

Involvement is the process of helping the patient to improve social skills: frequently breaking out of isolation. Staff members contribute by facilitating and participating in activities with the patient.

1. What do you enjoy doing together with staff members?
2. Can you tell something about the staff members in SPID?
3. Can you tell about the activities you attend?
4. Are there many common activities here?
5. Which activities do you attend together with staff?
6. Do you know staff members well; do they know what you like?

Validation

Validation affirms the patient’s personality. Staff members accept the patient’s failures, and respect the patient’s need to be alone. The patient’s symptoms are viewed as meaningful, rather than signs of illness.

1. Is staff concerned about your well-being? If “yes”, how do they show it?
2. Are you allowed to be yourself?
3. Are staff members good at feed-back?
4. Are you getting nice comments?
5. Do staff members catch the mood you are in?
6. Do you get more help when needed? Are staff closer to you?

Autonomy

Autonomy is included as a milieu variable in this study because of new research that points out autonomy as vital for experiencing good mental health. Both clinical experience and research underpin being able to influence one’s surroundings as positive for good mental health. For people with ID, autonomy is especially important as lack of cognitive capacity often leads to important decisions being taken by proxy.

1. Who is the most deciding person here (in the SPID)?
2. What does the staff decide?
3. Do you have confidence in the people working in the SPID?
4. Do you know the people here (in the SPID) well?
5. Do you think the staff members listen, when something is important to you?
6. Do you get angry or unhappy if you are not allowed to decide for yourself?