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Background: Research shows that psychiatric staff lack clinical confidence working with voice hearers. Simulation training is promising but staff input is limited.

Aim: The present study aimed to qualitatively investigate ward staff experience of working with voice hearers and their perspectives on simulation training.

Method: Multidisciplinary psychiatric ward staff participated in semi-structured interviews on their experience of working with voice hearers and their views and recommendations on simulation training. Participants included seven nurses, five healthcare assistants, and three activities co-ordinators.

Results: Following thematic analysis, staff experience themes included Negative impact on therapeutic relationship, Clinical experience improves understanding of voice hearing, Empathy for voice hearers, Challenges of managing risk, Lack of subjective understanding of voice hearing, Limited training for working with voice hearers and Lack of clinical confidence. Views on simulation training themes included Potential to improve subjective understanding, Anxieties about emotional responses, Keenness to participate and Potential to improve clinical confidence. Simulation training recommendation themes included Incorporate practical, skills-based elements, Invite all mental health staff to participate, and Use genuine voice hearer experiences.

Conclusion: Lack of subjective understanding and clinical confidence was linked to training limitations, but skills-based simulation training was endorsed as a valuable method to improve staff understanding, confidence, and quality of care.
Keywords: inpatient services; auditory hallucinations; mental health; psychosis; qualitative research; simulation training

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Ethics: Ethical approval for this study was granted by the King’s College London Research Ethics Committee (Ref: LRS/DP-20/21–21665)

Declaration of interest: None

Introduction

Voice hearing is a complex phenomenon, which is present across a variety of cultural and historical contexts (Longden 2017). The Hearing Voices Movement has encouraged change in the ways voice hearing is conceptualised and understood, highlighting that the experience is subjectively real and meaningful (Longden 2017; Armstrong et al. 2021). A cultural shift has occurred towards understanding voice hearing as common and existing on a spectrum of experience (Armstrong et al. 2021) and it is estimated that 10% of people have experienced voice hearing at some point in their lives, including in childhood (Fisher et al. 2013; Maijer et al. 2018).

Differences in frequency, intensity and distress associated with hearing voices predict who will access mental health services (McMullan et al. 2018). Hearing voices is a common experience among patients on psychiatric wards (Csipke et al. 2014; Jacobsen et al. 2016). Distress caused by voices can lead to anxiety, fear, withdrawal and challenging behaviours from inpatients, with high prevalence of aggressive incidents incurring significant financial costs, especially with regards to staffing issues (de Bles et al. 2020). Patients benefit from talking openly about their experiences of voice hearing; however, many individuals find this difficult due to a fear of others not understanding (Mawson et al. 2011). Research indicates that patients may feel more comfortable exploring the content and meaning of their voices with mental health professionals where it is possible to create a coherent narrative of their experience (Coffey et al. 2004; Place et al. 2011; Corstens et al. 2014); and talking openly about voices in this way has a positive impact on the therapeutic relationship, which can enable staff to de-escalate challenging incidents more effectively (Place et al. 2011).

However, staff report limited willingness to engage in discussions with patients about their voices due to anxiety, self-doubt about their skills to explore voice content, and concerns that they may make symptoms worse (Coffey & Hewitt 2008). Research shows that working in acute environments can lead to staff experiencing increased levels of stress (McMullan et al. 2018). Inpatient staff report feelings of powerlessness and helplessness when they are unable to reduce patient distress, which can lead to staff burnout (McMullan et al. 2018). While patients may require support in identifying effective strategies to cope with hearing voices, staff tend to rely on medication and a limited range of behavioural techniques (Turkington et al. 2016; Kramarz et al. 2022). For instance, distraction techniques are often employed despite limited evidence for their effectiveness (Hayward 2018; McCluskey & de Vries 2021). Staff also report anxieties around managing risks they perceive to be associated with voice hearing without utilising medication and restrictive practices, such as restraint (Muir-Cochrane et al. 2018; Dix 2019). Although these restrictive practices may conflict with person-centred care, staff feel that they do not receive adequate support, resources, or have a sufficiently equipped workforce to manage risk without these measures (Muir-Cochrane et al. 2018). Moreover, the increased acuity and greater complexity of needs within psychiatric wards, combined with limited resources such as staff shortages and time constraints, may further contribute to these challenges (White et al. 2019; McCluskey & de Vries 2021).

Despite having empathy and being motivated to improve quality of care, research indicates that staff lack subjective understanding of voice hearing and this is associated with lack of clinical confidence (Kramarz et al. 2021). These challenges have been attributed to lack of specific training related to working with patients who hear voices (Chambers et al. 2015; Muir-Cochrane et al. 2018). Therefore, it is necessary to develop and implement new training techniques. Simulation training is an enhanced experiential learning technique which uses technology to replicate voice hearing (e.g. using audio played through headphones, or a virtual reality environment). This replication enables participants to experience voice hearing first-hand through realistic and immersive simulations. This method of training enables learners to gain subjective understanding, which has the potential to improve clinical confidence and compassion for voice hearers (Riches et al. 2022). In studies, these simulations have been shown to increase empathy, improve...
therapeutic relationships, and reduce mental health stigma (Ando et al. 2011; Orr et al. 2013; Riches et al. 2018; Riches et al. 2019a, 2019b; Skoy et al. 2016; Bradshaw et al. 2021) and have been deemed an acceptable and valuable method of learning (Riches et al. 2019a; Bortolon et al. 2021; Bradshaw et al. 2021). Despite this promising research, there is limited feedback from clinical staff about how this training might be implemented in practice. The present study aimed to qualitatively investigate psychiatric ward staff experience of working with people who hear voices. Previous qualitative research on ward staff experiences has included only small samples, interviews of limited scope, and focused almost exclusively on nurses (McMullan et al. 2018; Kramarz et al. 2021; McCluskey & de Vries 2021). Therefore, the present study aimed to recruit a multidisciplinary sample from a broad range of ward-based psychiatric professions, to explore their experience of working with people who hear voices and their perspectives on simulation training.

Method
Participants
The study aimed to recruit participants who were working clinically on a psychiatric ward with patients who hear voices. Participants were recruited online through Twitter and emails. Participants were paid £20 in shopping vouchers for their participation.

Materials
A semi-structured interview guide was developed by researchers based on clinical experience and previous research (Kramarz et al. 2021). A patient panel reviewed the guide, and it was adapted to accommodate their feedback by adding clarity to questions, adding prompts, and ensuring anonymity of participants. The first part of the interview focused on staff experience of working with voices hearers. Interview questions included ‘How much do you understand about what it feels like to hear voices?’, ‘How do you feel about working with people who hear voices?’ and ‘What are the challenges?’. The subsequent parts of the interview focused on staff views and recommendations on simulation training. Questions included ‘How would you feel about experiencing a simulation of the experience of voice hearing?’ ‘What are the benefits?’ and ‘Do you have any recommendations?’ Regular follow-up questions and prompts were used to elicit further detail. See Box 1 for all interview questions included in the semi-structured interview guide.

Procedure
All interviews were conducted on Microsoft Teams due to COVID-19 restrictions. Interviews lasted up to 45 minutes. Participants initially completed an online consent form and a brief demographics survey including questions on gender, ethnicity, occupation, and years working with people who hear voices.

Analysis
The record and transcription functions on Microsoft Teams were used to collect data. Transcriptions and recordings were downloaded, and the data was manually cleaned by a researcher (RC). Data cleaning involved the researcher checking each transcript thoroughly while listening to the recording. Transcripts were edited by the researcher to ensure that they were an accurate transcription of the recorded interview. All transcriptions and recordings were anonymised using participant numbers and recordings were deleted once transcription was complete. Transcripts were uploaded to qualitative analysis software NVivo12 (QSR International). Thematic analysis was conducted, allowing patterns to be identified in the data, offering in depth insights into participant experiences and perspectives (Braun & Clarke 2014). Researchers ensured familiarisation with the data by repeatedly reading transcripts and documenting interpretations. Resulting themes were organised by researchers into categories of Staff experience of working with people who hear voices, Views on simulation training and Recommendations for simulation training to align with the structure of the interview and to allow for analysis of common themes identified in each category. Interviews were independently and systematically coded, capturing the richness of the data. One researcher (RC) coded all transcripts. A second researcher (RH) coded two transcripts and this was discussed to check preliminary findings. A third researcher (SR) oversaw the analysis and regular discussions were held within the research team (SR, RC, RH) throughout the process. This ensured that alternative interpretations were explored, and any discrepancies were resolved by checking findings with the raw data. Themes were reviewed and refined to ensure they accurately reflected participants’ views. Level of endorsement (i.e. number of participants) for each theme was reported.

Results
Participants included seven nurses, five healthcare assistants, three activities co-ordinators, and representatives from other professions. Fourteen participants were from public sector psychiatric hospitals that were based in several different National Health Service Trusts in England; and six participants were from a private sector psychiatric hospital in the north of England. Most participants were female and of White ethnicity. On average, participants had worked with people who hear voices for over seven
Box 1. Semi-structured interview guide for psychiatric ward staff. Main questions in **bold**, prompts indicated by bullet points.

**Part 1: Staff experience of working with people who hear voices**

How much do you understand about what it feels like to hear voices?
- Could you tell me a bit more about that?

How do you feel about working with people who hear voices?
- What are the challenges? How does it make you feel? Could you tell me more about that?
- How have you understood your feelings when patients have talked about their voices?

Can you tell me about any experience of working with people on the ward who heard voices?
- What was your experience of this like? How did you work with them? Could you tell me more about that?

How would you describe your relationships with service users who hear voices?
- Can you tell me a little bit about your relationship or interactions with people who hear voices?

Could you tell me about any differences you may have found amongst patients who hear voices?
- Do your relationships or interactions with patients differ? Why do you feel this is?

Can you tell me about any times when any service users have talked to you about their experiences of hearing voices?
- What was that like for you? How have you felt when a service user has told you about the content of their voices? Could you tell me more about that?

How do patients who hear voices impact on the ward?
- How does this impact on ward staff? How does this impact on other service users? Could you tell me more about that?

**Part 2: Training experience**

Can you tell me about your experience of training for working with people who hear voices?
- Did the training aid your understanding of voice hearing? What are the benefits of this?
- Were there any useful techniques that you learnt? Do you feel there are any disadvantages?
- How supported do you feel working with people who hear voices? Is there any other support you feel you would need?

How did your training affect your understanding of the experience of hearing voices?
- Did your training aid your understanding of this experience?

How would you feel about experiencing a simulation of voice hearing – for both benign and distressing voices?
- How do you think you might feel? Can you tell me more about that?

How do you feel about simulation technology being used in training?
- What do you think the challenges might be? What do you think the benefits might be?

How do you think simulation training could apply to your day-to-day practice working with voice hearers?
- Can you think of any particular examples?

Do you have any recommendations for how simulation training could support you working with people who hear voices?
- Could you give any specific examples? Could you tell me more about that?

Could you tell me about any potential positives that you feel could arise from simulation training?
- Could you tell me more about this?

Could you tell me about any potential negatives that you feel could arise from simulation training?
- Could you tell me more about this?
Thirteen themes were identified (Data Table S1). All participants reported that they had a Negative impact on therapeutic relationship. All participants stated that Clinical experience improves understanding of voice hearing and endorsed this learning as their best method for enhancing understanding. Almost all participants felt Empathy for voice hearers, as they appreciated patients’ difficulties with this experience. Almost all participants reported that there were Challenges of managing risk and keeping everyone on the ward safe, particularly due to the unpredictable nature of voice hearing and its behavioural consequences. Most participants reported a Lack of subjective understanding of voice hearing and found it difficult to grasp due to never having experienced voice hearing themselves. The Importance of team support was stated by most participants. Feeling supported was deemed beneficial to staff when working with voice hearers and a lack of support increased challenges. Most participants said that they had received Limited training for working with voice hearers and the training they had received provided them with limited understanding, knowledge and skills for working with this population. Two thirds of participants reported a Lack of clinical confidence, and felt unsure of how to approach and respond to voice hearers. Two thirds of participants were also Motivated to receive further training on working with people who hear voices. Just over half of participants stated that there were Limited techniques available to support their work with voice hearers and their distress, and that they primarily relied on distraction techniques, which did not always help. Just over half the participants reported an Enjoyment of working with voice hearers and found it rewarding to support patients’ recoveries. Half the participants discussed difficulties due to Limited resources and staff capacity and this negatively impacted quality of care. Just under half of participants reported a Need for emotional resilience, which often involved becoming desensitised to voice hearers’ distress.

Views on simulation training

Six themes were identified (Data Table S1). Almost all participants reported that simulation training had the Potential to improve subjective understanding by providing them with an experience of how voice hearers feel. Most participants reported Anxieties about emotional responses that they or their colleagues might experience during a simulation of voice hearing, such as feeling scared or anxious. These participants felt that they were sufficiently emotionally resilient to cope with these feelings; however, they were concerned that other staff might not be. Most participants reported Keenness to participate in simulation training and that it had the Potential to improve clinical confidence in approaching and responding to voice hearers. These participants said that simulation training would be particularly beneficial to empower new staff and give them more confidence. Just over half of participants reported that simulation training had the Potential to improve empathy, leading to greater compassion when working with people who hear voices. Just over half of participants reported potential Limits to authenticity and believability of simulations due to their view that voice phenomena may not be accurately reproduced by simulations. These participants were concerned that simulations may trivialise the experience and lead to misconceptions. They also stated that if staff did not believe that the simulation was real, then this could limit the benefits of the training.

Recommendations for simulation training

Five themes were identified (Data Table S1). Two thirds of participants recommended that simulation training could Incorporate practical, skills-based elements such as knowledge checks, role play, and resources to provide staff with more effective skills. Half of the participants recommended that training organisers Invite all mental health staff to participate, including those who do not work directly with people who hear voices, to ensure

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<th>Demographic characteristics of psychiatric ward staff who work with people who hear voices (N = 20).</th>
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<td>Demographics</td>
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<td>Mixed/multiple ethnic groups</td>
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<td>Other</td>
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<td>Occupation</td>
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<td>Activities Co-ordinator</td>
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<td>Psychiatrist</td>
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<td>Trainee Clinical Psychologist</td>
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<tr>
<td>Smoking Cessation Clinician</td>
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<td>Mean (SD, range)</td>
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SD, standard deviation

years. Table 1 reports full demographic characteristics. Data Table S1, at the end of the paper, reports all themes, explanations, and illustrative quotes. Themes are summarised below.
everyone receives the same level of understanding and knowledge. A third of participants recommended that the training should ensure staff feel supported throughout the experience by providing full explanations of what the training and the simulations would entail and why it is important, as well as debriefs and follow-ups. A third of participants reported that the training should use genuine voice hearing experiences as the authenticity and patient involvement would provide greater understanding for staff into voice hearers’ experiences. These participants highlighted that it would be important to use examples of different voices to enhance understanding of the diversity of voice hearing experiences. Just under a quarter of participants suggested that it would be important to acknowledge the limits of simulation training to avoid trivialising genuine voice hearing experiences and prevent staff completing the training with misconceptions or overestimations about their level of understanding.

**Discussion**

This study employed a qualitative methodology to explore psychiatric ward staff experience of working with people who hear voices and their views and recommendations on simulation training. Participants reported that they have empathy for people who hear voices and their clinical experience had improved their understanding of voice hearing over time; however, they reported that this understanding remained limited and did not enable them to understand the subjective experience of voice hearers. They reported a lack of clinical confidence and limited skills in how to support voice hearers and felt that they had received inadequate training, but they were motivated to improve their understanding and skills. Simulation training was considered a potentially valuable method of training. Staff reported that the first-hand experience of voice hearing that they would receive from the simulation had the potential to improve their subjective understanding and this could increase their confidence, compassion, and quality of care when working with people who hear voices.

These findings are consistent with previous studies indicating associations between inadequate training, lack of subjective understanding, and lack of clinical confidence (Kramarz et al. 2021). These staff perspectives impact negatively on quality of care as staff are unsure about how to respond to voice hearers, worrying they may do the wrong thing and worsen symptoms (Coffey & Hewitt 2008; Kramarz et al. 2021). Limited resources increase difficulties managing risk which is consistent with previous studies that highlighted staff anxieties about risk management without restrictive measures (Muir-Cochrane et al. 2018), indicating that staff need more knowledge and skills to provide this support (Turkington et al. 2016; McDonald et al. 2021; Riches et al. 2021). Staff anxieties about their skills in risk-management techniques might be exacerbated by the limited evidence in support of these techniques (Hayward 2018). Staff feelings of powerlessness and helplessness highlights the importance of effective staff support (McMullan et al. 2018). Although direct clinical experience, consultation with patients, and observation of more experienced staff was deemed to enhance understanding, staff reported that this was qualitatively different from the subjective understanding that would be gained from having a voice hearing experience themselves. Therefore, participants endorsed simulation training as a valuable method of gaining experiential knowledge that would differ in kind from the knowledge derived from their clinical experience. Simulation training could provide insight into the experience of voice hearers and allow staff to make sense of how patients feel and the difficulties they encounter. Participants reported that this would improve their confidence in approaching and engaging in conversations with patients about voice hearing, which is likely to lead to greater empathy (Orr et al. 2013; Riches et al. 2019a). Increases in subjective understanding and empathy may improve quality of care, encourage more effective therapeutic relationships, and may be particularly beneficial when working in acute inpatient settings with limited resources (Riches et al. 2019a, 2022).

**Future applications**

Simulation training provides first-hand experiential learning within a safe environment (Riches et al. 2022). It is important that the simulation is authentic and believable to promote greater subjective understanding. However, the findings of this study highlight that participation in simulation training may be anxiety provoking for staff. Although a simulation should not undermine its believability and realism, knowledge that the simulation is not real may alleviate staff anxieties about engaging in the training. Given participants’ feedback, it may be important to directly address the limits of a simulation in training sessions, such as explaining that the simulated voices are not real and that those attending the training are not genuinely experiencing auditory hallucinations, to prevent staff misconceptions about the relationship between a simulated voice and genuine voice hearing. There is some precedent for this idea of straddling between these two seemingly paradoxical ideas (of believing in the simulation while concurrently knowing that it is not real) from studies of virtual reality exposure therapy. Virtual reality exposure therapy enables participants to be exposed to feared stimuli that they may otherwise avoid in the real world. The virtual reality provides a safe environment that enables people to habituate to, and become
less fearful of, the feared stimuli (Freeman et al. 2017). A consequence of being aware that a potentially anxiety provoking virtual environment is not real, is that participants may be more likely to enter it and experience a positive outcome of tackling their avoidance of the feared stimuli and habituating to it, thus reducing their anxiety. Therefore, in the case of simulation training, explaining to participants that the simulation is not real may promote greater involvement in the training, encourage staff to engage with the simulation to a greater degree, and optimise the likelihood of staff gaining greater subjective understanding through this experiential learning. According to this approach, it may be crucial in briefing participants to strike a balance between promoting the idea that the simulation is realistic and believable, while ensuring staff anxieties are managed by making it clear what a simulation is.

The findings of this study highlight how important it is for patients to be involved in every stage of the development and implementation of this training, so that simulations feel genuine, authentic, and provide a variety of voice hearing experiences. Simulation training should make it clear that any simulated voice is only one instance of a voice hearing experience among many. In fact, by using a variety of genuine voice hearer experiences, this may avoid misconceptions by illustrating the diverse range of voice hearing experiences (Orr et al. 2013; Riches 2019a, 2019b). During simulation training sessions, patient facilitators could share their lived experience with those attending the training, who will have gained subjective experience of what voice hearing is like from the simulation. This psychoeducation by individuals with lived experience of voice hearing could improve knowledge on the topic and avoid further misconceptions. Therefore, future research should develop and test an authentic voice hearing simulation which incorporates the views and lived experiences of many patients. Future studies may also incorporate simulations of other unusual perceptual experiences (e.g. seeing images) so that clinicians can better understand a range of hallucinatory experiences.

There are also many practical issues that future simulation training should consider. For example, performing daily tasks whilst experiencing the simulation, including while on the ward, would enhance staff understanding of the difficulties encountered by voice hearers, such as distraction, and support staff to understand the need for developing personalised coping strategies that they would find effective (Orr et al. 2013; Bradshaw et al. 2021). In planning such training, some consideration would need to go into how to incorporate the simulation in a naturalistic setting such as a ward. As well as managing the setting of the training, it is crucial to ensure that those attending the training feel supported and any potential risks are managed. Future training should therefore provide support, clear explanations, debriefs and follow-ups, especially given potential staff anxieties about negative emotional responses to the simulation (Orr et al. 2013; Riches et al., 2019a, 2019b).

Following participant recommendations, this training could be offered to everyone working in mental health to ensure that all staff have equal knowledge and understanding. In future research, simulation training should be piloted on clinical staff, both inpatient and community, to gain their feedback on experiencing the simulation and its impact on their clinical confidence and empathy. Subsequent studies could also investigate whether simulation training has an impact on staff clinical practice and, by extension, the quality of care that patients feel they receive.

**Strengths and limitations**

This is one of the few studies to have explored psychiatric ward staff experience of working clinically with voice hearers. Strengths of the study are its larger sample than previous studies, reported perspectives from a diverse range of multidisciplinary staff, and recruitment from a variety of wards and hospitals across England, both in the public and private sector, unlike much of the previous literature, which focused almost exclusively on nurses and acute wards within single hospitals (McMullan et al. 2018; Kramarz et al. 2021; McCluskey & de Vries 2021). This improves the generalisability of the findings. Use of video call-based interviews was accessible, cost-effective, and not detrimental to establishing rapport, as has been found previously (Archibald et al. 2019). For many participants, remote interviews were more accessible as they allowed for greater flexibility when arranging interview times, with participants able to join from home, at work, and in between other meetings, which enabled recruitment of busy staff (Baker et al. 2019). Remote interviews and online recruitment enabled participants from various geographical locations to engage in interviews, which would not have been possible otherwise, thus improving recruitment and generalisability of the results. Use of the Microsoft Teams transcription function was helpful in reducing time and optimising limited researcher capacity. It allowed researchers to spend more time being immersed in the complete and accurate data, as well as completing a larger number of interviews than would otherwise have been feasible. However, it is possible that exclusive use of video call-based interviews may have excluded some potential participants. However, as remote work has become increasingly popular and necessary, most participants are able to access and use this technology. As with all qualitative research, there is the possible limitation of researcher bias. However, best
efforts were made to ensure rigour by keeping a reflective log throughout the research process, using a second coder, and regularly discussing analysis and themes within the research team. Another limitation may be the inexperience of some participants, which may affect perceived understanding and skills. However, these participants may have better recollections of training experiences as these are likely to be more recent.

Conclusion

The present study used a qualitative methodology and identified that psychiatric ward staff lack subjective understanding of voice hearing and clinical confidence for working with this population. This was largely attributed to training limitations and staff reported limited knowledge, understanding, and skills for working with people who hear voices. Staff believed that this limitation in their knowledge had a negative impact on their therapeutic relationships, as they felt unsure about how to approach and respond to voice hearers. Staff were motivated to improve their knowledge and skills with further learning, and simulation training was endorsed as a potentially valuable method for staff to receive first-hand experience of voice hearing, promoting greater understanding, empathy and clinical confidence; ultimately with the potential to improve the quality of inpatient care delivered to people who hear voices.

Acknowledgements

We are grateful to FAST-R for their useful feedback on our participant documents and to all ward staff who participated in the interviews.

References


Kramarz, E., Lyles, S., Fisher, H. L. and Riches, S. (2021) Staff experience of delivering clinical care on acute psychiatric


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### Data Table S1. Thematic analysis of psychiatric ward staff's experiences of working with people who hear voices and their views and recommendations for simulation training (N = 20).

<table>
<thead>
<tr>
<th>Theme</th>
<th>N (%)</th>
<th>Explanation</th>
<th>Illustrative quotes</th>
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<tr>
<td><strong>Staff experience of working with people who hear voices</strong></td>
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<tr>
<td>Negative impact on therapeutic relationship</td>
<td>20 (100)</td>
<td>Participants reported that there is an unpredictable nature to voice hearers due to changes in their voices and their responses to them. It was reported that this can affect engagement and cause difficulties in communication and the therapeutic relationship.</td>
<td>“I would say I don’t understand it that much…it’s quite difficult to actually understand the experience itself since it’s something I’ve never experienced.” [#1] “It’s difficult to sort of interact with them because you’re trying to get their attention, but obviously they’re elsewhere.” [#2] “When people talk to their voices if it’s quite abrupt…suddenly this person’s shouting out or unreachable because they’re lost and listening to them…it impacts on your relationship with the person…and it impacts on how they communicate with you.” [#12] “The volume of them, it’s like sometimes it’s almost like the patient...is just so distracted by what’s being said to them that they can’t even really register.” [#16] “Working with people who don’t have much insight into their psychosis, I feel like they can be more unpredictable and harder to communicate with and harder to sort of develop a rapport based on mutual understanding.” [#20]</td>
</tr>
<tr>
<td>Clinical experience improves understanding of voice hearing</td>
<td>20 (100)</td>
<td>Participants reported that direct clinical experience of working with people who hear voices has improved their understanding of voice hearing. Their learning occurred through observing and speaking with voice hearers.</td>
<td>“Some of them might be in a constant state of hearing voices…in which case that relationship is more difficult to build and to maintain.” [#1] “Over time I’ve got to see it a lot clearer and understand how different it can look for different people.” [#10] “Speaking to patients over the years and getting their understanding of it and seeing people when they’re highly distressed from hearing voices, I think I’ve kind of gathered quite a good understanding of it from the view of someone who’s never experienced it.” [#13] “I think actually like I do think that being there and seeing it in person is the best way to learn about it really...to speak to people about it and what their experience of it is.” [#16]</td>
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<tr>
<td>Empathy for voice hearers</td>
<td>19 (95)</td>
<td>Participants acknowledged the difficulties of hearing voices and felt empathy for patients and their experiences.</td>
<td>“I felt really strong empathy towards him.” [#6] “You always feel some kind of empathy...because it must be difficult hearing these things constantly.” [#7] “I feel like a lot of empathy for them.” [#9] “A lot of empathy really because it’s incredibly difficult for them.” [#20] “It can lead to more stigmatisation by staff as well and changing the way staff view and interact with them because of how difficult it can be to manage.” [#1] “When you can see somebody that’s getting a bit preoccupied with something that’s going on that the rest of us can’t see, you do think ‘something’s going to start here’...so I think it can sometimes make the staff a bit on edge like a bit like ‘oh an incident’s going to start here.’” [#15] “It makes me feel uneasy to be honest...you don’t really know where that might head to.” [#17] “I had to go on two-to-one with him at one point until we worked out where this was going to go, the extent of the bizarre behaviour...I was very alert in those sessions...I felt I needed to be extremely alert.” [#20] “I would say I don’t understand it that much...it’s quite difficult to actually understand the experience itself since it’s something I’ve never experienced.” [#1] “I feel like you can’t fully understand it unless you’ve experienced it yourself.” [#4] “It can be quite challenging working with people with voices because we don’t understand it that well.” [#7] “I don’t think I understand as much about the actual experience and what would be helpful in that experience or what would it be helpful to help that person manage that experience better or maybe even understand their experience better.” [#13] “A bit helpless at times...I think to myself ‘what would I do if I had the voices?’ and I can’t even imagine it.” [#17]</td>
</tr>
<tr>
<td>Challenges of managing risk</td>
<td>19 (95)</td>
<td>Participants reported difficulties and anxieties in managing people who hear voices particularly due to the unpredictable nature of their presentations. Command hallucinations leading to incidents were reported to be particularly anxiety-provoking. Restrictive methods were frequently used to maintain safety.</td>
<td>“I felt really strong empathy towards him.” [#6] “You always feel some kind of empathy...because it must be difficult hearing these things constantly.” [#7] “I feel like a lot of empathy for them.” [#9] “A lot of empathy really because it’s incredibly difficult for them.” [#20] “It can lead to more stigmatisation by staff as well and changing the way staff view and interact with them because of how difficult it can be to manage.” [#1] “When you can see somebody that’s getting a bit preoccupied with something that’s going on that the rest of us can’t see, you do think ‘something’s going to start here’...so I think it can sometimes make the staff a bit on edge like a bit like ‘oh an incident’s going to start here.’” [#15] “It makes me feel uneasy to be honest...you don’t really know where that might head to.” [#17] “I had to go on two-to-one with him at one point until we worked out where this was going to go, the extent of the bizarre behaviour...I was very alert in those sessions...I felt I needed to be extremely alert.” [#20] “I would say I don’t understand it that much...it’s quite difficult to actually understand the experience itself since it’s something I’ve never experienced.” [#1] “I feel like you can’t fully understand it unless you’ve experienced it yourself.” [#4] “It can be quite challenging working with people with voices because we don’t understand it that well.” [#7] “I don’t think I understand as much about the actual experience and what would be helpful in that experience or what would it be helpful to help that person manage that experience better or maybe even understand their experience better.” [#13] “A bit helpless at times...I think to myself ‘what would I do if I had the voices?’ and I can’t even imagine it.” [#17]</td>
</tr>
<tr>
<td>Lack of subjective understanding of voice hearing</td>
<td>18 (90)</td>
<td>Participants reported that they experience difficulties understanding the experience of voice hearing as they have never personally experienced it. Participants reported feeling that they cannot relate to and connect with patients due to their lack of understanding and find the experience difficult to imagine.</td>
<td>“I had to go on two-to-one with him at one point until we worked out where this was going to go, the extent of the bizarre behaviour...I was very alert in those sessions...I felt I needed to be extremely alert.” [#20] “I would say I don’t understand it that much...it’s quite difficult to actually understand the experience itself since it’s something I’ve never experienced.” [#1] “I feel like you can’t fully understand it unless you’ve experienced it yourself.” [#4] “It can be quite challenging working with people with voices because we don’t understand it that well.” [#7] “I don’t think I understand as much about the actual experience and what would be helpful in that experience or what would it be helpful to help that person manage that experience better or maybe even understand their experience better.” [#13] “A bit helpless at times...I think to myself ‘what would I do if I had the voices?’ and I can’t even imagine it.” [#17]</td>
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Data Table S1. (Continued)

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</table>
| Importance of team support                 | 18 (90) | Participants reported that feeling supported within their role was beneficial when working with voice hearers and found a lack of support difficult. It was highlighted that reflective spaces to discuss challenges arising from working with voice hearers was useful. | 'It depends what team you’ve got... if you’ve got a really good team... they’re very supportive. If you haven’t got the most skilled team or there is a lot of people who are new and haven’t experienced people with voices before then it can be quite difficult.' [#7]
|                                            |       |                                                                                                                                             | 'I'm a big believer in reflective practice and giving staff space to talk about... how it can be really tough and how there’s certain people that we just really don’t know what to do with... trying to give a little bit of breathing space for that kind of conversation amongst teams.' [#9]
|                                            |       |                                                                                                                                             | 'I find it helpful as well to have regular supervision... to say ‘are we doing the right thing here cause it doesn’t seem like we’re helping’?' [#15]
|                                            |       |                                                                                                                                             | 'We’ve got a really good range of staff who have varying levels of experience, which I think is really supportive... we’re able to kind of really support each other.' [#16]
|                                            |       |                                                                                                                                             | 'That was something that I definitely felt was lacking going into the job, is I learned about the theory and the technical things... more like writing notes down and making sure that’s confidential and anonymous, rather than... how to talk to people who hear these experiences.' [#1]
|                                            |       |                                                                                                                                             | 'We’ve never had any training for anything like that. You’re sort of thrown into the deep end.' [#2]
|                                            |       |                                                                                                                                             | 'There’s no specific training to deal with someone who hears voices.' [#5]
|                                            |       |                                                                                                                                             | 'A lot of people who come into mental health probably feel like they don’t get enough training.' [#8]
|                                            |       |                                                                                                                                             | 'You want... them to have confidence in you, that you understand, you have some understanding of what they’re going through, and I think you really don’t because you’ve had no training in it.' [#12]
|                                            |       |                                                                                                                                             | 'I’ve never had real training on what to say, what to do with people with hearing voices.' [#19]
|                                            |       |                                                                                                                                             | 'I don’t want to make it worse... you don’t know what the right thing is to say sometimes.' [#4]
|                                            |       |                                                                                                                                             | 'It’s not nice because like you’re there to help people and when you can’t help someone... you just feel like you’re not doing your job properly.' [#5]
|                                            |       |                                                                                                                                             | 'I feel like I should have more skills... I feel like I’m not really doing as good enough a job as I could be doing... you worry about saying the wrong thing and making it worse.' [#12]
|                                            |       |                                                                                                                                             | 'At times it’s quite hard, just because they’re distressed, and you don’t really know how to help.' [#17]
|                                            |       |                                                                                                                                             | 'I think I was just like ‘oh my gosh’... what do I do, what do I say?’' [#18]
|                                            |       |                                                                                                                                             | 'It’s horrible if you don’t think you’re helping... you’re not sure it’s going to be a benefit to them.' [#20]
| Limited training for working with voice hearers | 18 (90) | Participants reported a lack of training specifically for working with people who hear voices. The training received was limited in improving staff understanding and skills. | 'I would have definitely appreciated more training at the start of the role and maybe a little disclaimer-type training: this is what some people experience, these are some ways to handle it.' [#1]
|                                            |       |                                                                                                                                             | 'There’s definitely a lot of room for training... any sort of training around hearing voices would be really useful I’m sure.' [#6]
|                                            |       |                                                                                                                                             | 'More organic understanding of what it means to experience a voice, how they can impact their communication, I think that would have been helpful.' [#11]
|                                            |       |                                                                                                                                             | 'This is just a big gap... I haven’t had any training in around this... I would love there to be something.' [#12]
|                                            |       |                                                                                                                                             | 'More training. Someone could come in externally and give us more training that would be useful on how to help... I do think that would be beneficial.' [#18]

| Lack of clinical confidence                  | 13 (65) | Participants reported that they were unsure about how to approach and respond to voice hearers. Participants reported worrying that they may make symptoms worse; and felt powerless and helpless when they were unable to reduce voice hearers’ distress. | 'You don’t want to make it worse... you don’t know what the right thing is to say sometimes.' [#4]
|                                            |       |                                                                                                                                             | 'It’s not nice because like you’re there to help people and when you can’t help someone... you just feel like you’re not doing your job properly.' [#5]
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|                                            |       |                                                                                                                                             | 'It’s horrible if you don’t think you’re helping... you’re not sure it’s going to be a benefit to them.' [#20]
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|                                            |       |                                                                                                                                             | 'More training. Someone could come in externally and give us more training that would be useful on how to help... I do think that would be beneficial.' [#18]

| Motivated to receive further training         | 13 (65) | Participants reported that they would appreciate more training specifically for working with voice hearers to improve their understanding and skills. | 'I would have definitely appreciated more training at the start of the role and maybe a little disclaimer-type training: this is what some people experience, these are some ways to handle it.' [#1]
|                                            |       |                                                                                                                                             | 'There’s definitely a lot of room for training... any sort of training around hearing voices would be really useful I’m sure.' [#6]
|                                            |       |                                                                                                                                             | 'More organic understanding of what it means to experience a voice, how they can impact their communication, I think that would have been helpful.' [#11]
|                                            |       |                                                                                                                                             | 'This is just a big gap... I haven’t had any training in around this... I would love there to be something.' [#12]
|                                            |       |                                                                                                                                             | 'More training. Someone could come in externally and give us more training that would be useful on how to help... I do think that would be beneficial.' [#18]
### Limited techniques available

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<tbody>
<tr>
<td>Limited techniques available</td>
<td>11 (55)</td>
<td>Participants reported that they felt there are a limited number of techniques that they can use when working with people who hear voices; and they encountered difficulties when these techniques were not working. Participants reported frustration when medication did not work and there was a reliance on techniques such as distraction despite this feeling limited. Participants felt powerless when they had exhausted all their options and were unable to reduce voice hearers’ distress.</td>
<td>‘The best thing I think we can do is try and distract them from it initially, which is normally quite a challenge.’ [#7] ‘I wonder whether there’s a bit of a sense of helplessness among staff as well… if the meds aren’t working to get rid of voices then what are we going to do?’ [#9] ‘Makes me feel… powerless… when you’ve suggested everything there is to suggest with all the skills, all the medication and nothing seems to be… relieving the stress of them voices… what is going to help if we’ve exhausted all our options?’ [#15] ‘Apart from positive distraction to take their mind off… the thoughts that distress them or the things that distress them, not quite sure where I stand and what I can best do.’ [#20]</td>
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### Enjoyment of working with voice hearers

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<tbody>
<tr>
<td>Enjoyment of working with voice hearers</td>
<td>11 (55)</td>
<td>Participants reported that they enjoy working with people who hear voices and found it rewarding, particularly when they observe voice hearers recovering.</td>
<td>‘I enjoy working with people with voices cause it tends to be one of them mental health problems that you can manage and overcome.’ [#3] ‘You go home knowing that you’re doing it to help someone.’ [#5] ‘I really enjoyed working with that patient… it was really amazing, and you could make a massive breakthrough.’ [#14]</td>
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### Limited resources and staff capacity

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<tbody>
<tr>
<td>Limited resources and staff capacity</td>
<td>10 (50)</td>
<td>Participants reported difficulties with the ward environments due to a lack of resources and staff lacking capacity. This impacted on the quality of care delivered to patients, and participants expressed frustration about this.</td>
<td>‘I think sometimes ward environments don’t function very well because they’re often very understaffed and you almost can’t expect people to be doing this really complex problem solving when they’ve not got the resources to do so.’ [#9] ‘Sometimes other patients that might be hearing voices but are not having incidents on the same level might get a bit forgotten about, and then they’re struggling on their own because you’re not having the time to help them.’ [#15] ‘Frustrated I guess, like that’s the main one, sometimes with the lack of resources because you know that if you had more staff, maybe the patient wouldn’t be in that state.’ [#17] ‘It’s just frustrating to be honest… sometimes there’s not enough resources, there could be staff shortages, it could be the ward is just too acute to be able to manage.’ [#18] ‘You build up a tolerance.’ [#3] ‘I think the nature of the job… you kind of, not get used to it, but more like emotionally resilient over time.’ [#4] ‘I’m slightly desensitised by it.’ [#7]</td>
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### Need for emotional resilience

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<th>Explanation</th>
<th>Illustrative quotes</th>
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<tr>
<td>Need for emotional resilience</td>
<td>8 (40)</td>
<td>Participants reported that over time they had become emotionally resilient when hearing about or observing distressing voice hearing experiences.</td>
<td>‘You build up a tolerance.’ [#3] ‘I think the nature of the job… you kind of, not get used to it, but more like emotionally resilient over time.’ [#4] ‘I’m slightly desensitised by it.’ [#7]</td>
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### Potential to improve subjective understanding

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<tbody>
<tr>
<td>Potential to improve subjective understanding</td>
<td>19 (95)</td>
<td>Participants reported that simulation training would provide more in depth understanding of the experience of voice hearing. It was reported that the first-hand experience would allow for insight into how patients feel.</td>
<td>‘It would be useful for... understanding... because currently I have no idea what that's like.’ [#2] ‘That level of understanding and appreciation for what people are going through. I just think that's so helpful.’ [#3] ‘It would give me a better understanding as to what the service users go through... it would help me understand how they’re feeling.’ [#5] ‘It’s always different to experience something... to understand what patients are experiencing.’ [#11] ‘It’ll really give me a more in-depth understanding because I think there’s only so much you can experience seeing it, but I think when you go through it yourself... you’ll be able to walk in that person’s shoes.’ [#14] ‘I think feeling all of that first-hand would definitely give you better insight of what a person might go through.’ [#17] ‘I think it’d be such a good idea to know exactly how they’re feeling, or at least get close to knowing what they’re feeling.’ [#19]</td>
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**Views on simulation training**

- It would be useful for... understanding... because currently I have no idea what that’s like. [#2]
- That level of understanding and appreciation for what people are going through. I just think that’s so helpful. [#3]
- It would give me a better understanding as to what the service users go through... it would help me understand how they’re feeling. [#5]
- It’s always different to experience something... to understand what patients are experiencing. [#11]
- It’ll really give me a more in-depth understanding because I think there’s only so much you can experience seeing it, but I think when you go through it yourself... you’ll be able to walk in that person’s shoes. [#14]
- I think feeling all of that first-hand would definitely give you better insight of what a person might go through. [#17]
- I think it’d be such a good idea to know exactly how they’re feeling, or at least get close to knowing what they’re feeling. [#19]
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</table>
| Anxiety about emotional responses         | 18 (90) | Participants reported that there may be negative emotional responses during the simulation training, particularly if voices were distressing. Participants often attributed these anxieties to staff other than themselves and reported that this experience could discourage people from working in mental health. | ‘It might put people off nursing… there’s a possibility people could be distressed by it and… it might put them off.’[#3]  
‘I think I would find it really scary.’[#6]  
‘I do think, for some people, it could be very destabilising in a way, even if they’ve never been destabilised before.’[#13]  
‘It might be quite anxiety provoking and quite scary.’[#15]  
‘I’m not gonna lie, it would upset me.’[#18]  
‘It’s a brilliant idea, I would be 100% up for it, 100%.’[#5]  
‘I think the benefits would outweigh the negatives. I think it really would benefit people.’[#8]  
‘I think people engage with trainings a bit more if they are active… hopefully that would then make it have a bit more of an impact.’[#9]  
‘I would welcome it. I think it’s a really good idea. It’s not really anything I’ve done before.’[#10]  
‘I’d be more than happy to… I’d love to do the training.’[#19]  
‘If we understood better, we might be able to even come up with sort of coping strategies… if you’ve been through this simulation and you’ve used the coping strategies… you can recommend it better… you might be able to give them a little bit more hope.’[#3]  
‘I wonder if it would shift how I would approach things; I wonder if it would give me a bit of a better sense of, like, pace and how much information you can actually take in when you’ve got other voices happening in your mind… I wonder if it might help in that sense to have a bit more of a personal understanding of… how possible it is to answer complex questions when you’ve got a whole other conversation happening elsewhere.’[#9]  
‘Being much more helpful to patients, being much more willing to engage with the topic itself… not so worried, being more effective.’[#12]  
‘More confidence in addressing it with patients because… you never really know whether to say something’s real or whether to say something is not real.’[#16]  
‘Empowering new staff… all staff actually, but especially in new staff who haven’t had that much exposure. I think they’ll just come onto the wards a lot more confident… they’ll be better able to interact with the service users on a better level.’[#18]  
‘To be more compassionate in that moment and with those people and form better relationships.’[#1]  
‘I just think it would make you more patient and more understanding.’[#4]  
‘More empathy for what someone might be experiencing.’[#9]  
‘Might increase the empathy having had experience, having been in their shoes.’[#11]  
‘It would be helpful in increasing people’s compassion for all mental health because I think it would really reinforce the idea that people aren’t choosing to be distressed… people don’t just choose to have these experiences, it’s an experience they’re having and they need support with it.’[#13]  
‘I don’t know if I would feel that fear that people who do hear voices might feel, just because I will have that knowledge of how external it is… so it would still be difficult to put myself in their shoes.’[#1]  
‘When somebody hears voices, they vary so much… there’s only so much simulation you can do… somebody could take away from it a certain picture or view or idea of ‘oh this is what it’s like’ whereas actually… in reality could look quite different.’[#10]  
‘It could trivialise the experience because… this phenomena is more than just hearing something in your ear… so I’m not really sure how this could be reproduced in training.’[#11]  
‘I don’t know how you would do that because you would know it’s not real. The scary thing is it’s feeling real… I don’t know how you’d do it so that it felt real.’[#20] |
| Keenness to participate                    | 17 (85) | Participants reported that they would be keen to take part in a simulation of voice hearing. It was felt that staff would engage well, and the training would have a positive impact. | ‘I just think it would make you more patient and more understanding.’[#4]  
‘More empathy for what someone might be experiencing.’[#9]  
‘Might increase the empathy having had experience, having been in their shoes.’[#11]  
‘It would be helpful in increasing people’s compassion for all mental health because I think it would really reinforce the idea that people aren’t choosing to be distressed… people don’t just choose to have these experiences, it’s an experience they’re having and they need support with it.’[#13]  
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‘I don’t know how you would do that because you would know it’s not real. The scary thing is it’s feeling real… I don’t know how you’d do it so that it felt real.’[#20] |
| Potential to improve clinical confidence    | 16 (80) | Participants reported that simulation training may increase their confidence in approaching and responding to voice hearers. It was reported that staff may utilise coping strategies during the experience, enabling them to recommend these and elicit more hope among patients. It was noted that improved confidence could be particularly valuable to new staff when interacting with patients. | ‘I just think it would make you more patient and more understanding.’[#4]  
‘More empathy for what someone might be experiencing.’[#9]  
‘Might increase the empathy having had experience, having been in their shoes.’[#11]  
‘It would be helpful in increasing people’s compassion for all mental health because I think it would really reinforce the idea that people aren’t choosing to be distressed… people don’t just choose to have these experiences, it’s an experience they’re having and they need support with it.’[#13]  
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‘I don’t know how you would do that because you would know it’s not real. The scary thing is it’s feeling real… I don’t know how you’d do it so that it felt real.’[#20] |
| Potential to improve empathy               | 11 (55) | Participants reported that simulation training could increase empathy towards voice hearers and allow staff to be more patient when supporting them. Participants reported that this may increase compassion for all mental health difficulties through reinforcement that individuals do not choose to be distressed. | ‘I just think it would make you more patient and more understanding.’[#4]  
‘More empathy for what someone might be experiencing.’[#9]  
‘Might increase the empathy having had experience, having been in their shoes.’[#11]  
‘It would be helpful in increasing people’s compassion for all mental health because I think it would really reinforce the idea that people aren’t choosing to be distressed… people don’t just choose to have these experiences, it’s an experience they’re having and they need support with it.’[#13]  
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‘I don’t know how you would do that because you would know it’s not real. The scary thing is it’s feeling real… I don’t know how you’d do it so that it felt real.’[#20] |
| Limits to authenticity andbelievability of simulations | 11 (55) | Participants reported that voice hearing may not be accurately simulated. Participants reported that it may be challenging to truly appreciate the experience due to the knowledge that the simulation is not real, and they are choosing to experience the simulation. It was reported that a simulation may trivialise the experience of voice hearing and lead to misconceptions such as staff taking away a specific view of voice hearing which could be very different in reality. | ‘I just think it would make you more patient and more understanding.’[#4]  
‘More empathy for what someone might be experiencing.’[#9]  
‘Might increase the empathy having had experience, having been in their shoes.’[#11]  
‘It would be helpful in increasing people’s compassion for all mental health because I think it would really reinforce the idea that people aren’t choosing to be distressed… people don’t just choose to have these experiences, it’s an experience they’re having and they need support with it.’[#13]  
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‘I don’t know how you would do that because you would know it’s not real. The scary thing is it’s feeling real… I don’t know how you’d do it so that it felt real.’[#20] |
Incorporate practical, skills-based elements

- Participants recommended that the simulation training should include practical elements to improve staff understanding and skillsets. These included aspects such as knowledge checks, attempting to perform tasks during the simulation, and additional practical resources.

- Recommendations: Accompanying it with practical tools, practical information... on different ways to handle it, different things to try, different things that are helpful to say... practical information that it does vary case-by-case... a little resource book of things that can be done and things that shouldn't be done.' [#1]

- Illustrative quotes: 'Alongside the simulation training, you've got like ways to manage and cope.' [#2]

- Include knowledge checks, attempting to perform tasks during the simulation, and additional practical resources.

Invite all mental health staff to participate

- Participants recommended that simulation training would be beneficial for all staff who work in mental health to allow everyone to have an equal understanding.

- Recommendations: 'I do think that as a whole, anyone who works in any type of mental health service definitely should try and experience some sort of simulation like that.' [#4]

- Illustrative quotes: 'It should be something that everyone does, no matter their role... I think it would be good for everyone to do.' [#6]

- Include knowledge checks and attempts to perform tasks during the simulation.

Ensure staff feel supported

- Participants highlighted the importance of promoting staff wellbeing throughout the training; and ensuring they felt safe, supported, and able to opt out.

- Recommendations: 'It's important to always look after everybody's wellbeing, including that of staff.' [#1]

- Illustrative quotes: 'As long as it was like bracketed with proper support around it.' [#9]

- Include opportunities for staff to opt out.

Use genuine voice hearer experiences

- Participants recommended using genuine voice hearer experiences and patient involvement in the training. Participants recommended using a variety of examples (e.g. positive and negative voices) to highlight the diversity in voice hearing.

- Recommendations: 'I would think maybe it would be really helpful to have someone who has experienced psychosis... make sure that they know the differences that exist between experiencing it or not... I think having insight of someone who experiences psychosis... would definitely help understand it more, and understanding the real differences between the simulation and real voice hearing.' [#1]

- Illustrative quotes: 'It would be interesting to hear from someone who hears voices because obviously they know best.' [#2]

- Include genuine voice hearer experiences and patient involvement.

Acknowledge the limits of simulation training

- Participants recommended that there should be an acknowledgement that a simulation of voices is not the real experience of voice hearing. This would avoid misconceptions and trivialisations of the experience.

- Recommendations: 'Acknowledging that it's not the real experience of people who hear voices. You wouldn't want staff to... inflict more judgment on people who hear voices based on misinterpreting or simplifying that training into something that is different to what it really is.' [#1]

- Illustrative quotes: 'Letting people know that that might not be like that to people... how it could affect people completely differently.' [#7]

- Include acknowledgement that simulation is not the real experience.