



**The British
Psychological Society**
Promoting excellence in psychology



**Division of
Clinical Psychology**

Commissioning and Delivering Clinical Psychology in Acute Adult Mental Health Care

*Guidance for Commissioners, Service Managers,
Psychology Managers & Practitioners*

December 2012

Compiled by:

**British Psychological Society Division of Clinical Psychology
Faculty of Psychosis and Complex Mental Health**

**The Inpatient Practitioners and the Crisis Resolution and Home
Treatment networks (CRHT)**

Main authors:

Isabel Clarke *Southern Health NHS Foundation Trust*

Dr John Hanna *Camden & Islington NHS Foundation Trust*

Dr Carol Valinejad *North Essex Partnership Foundation Trust*

With contributions from:

Dr Kate Butt *Oxleas NHS Foundation Trust*

Dr Nicky Hartigan *Berkshire NHS Foundation Mental Health Trust*

Dr Carolyn Hurcom *Acute Psychology Lead,
Sandwell Crisis Resolution/Home Treatment Team*

Dr Stuart Whomsley *Cambridge and Peterborough NHS Foundation Trust*

...and others

If you have problems reading this document and would like it in a different format, please contact us with your specific requirements.

Tel: 0116 2254 9568; email mail@bps.org.uk.

Executive summary

Aim

In recent years there have been an increased emphasis on mental health and on in-patient services within mental health across all the four nations within the UK. Whilst legislation, policies, strategies and frameworks for mental health are slightly different within the four nations in the UK there are strong common themes emerging from all of these documents:

- recovery and Inclusion of service users and carers;
- access to psychological intervention in all areas of mental health;
- development of a workforce competent in psychological understanding and interventions; and
- quality of care improvements.

The aims of this document are two-fold:

Firstly, to inform Commissioners and managers about the contribution of clinical psychology to the acute care pathway.

Secondly, to provide a toolkit for service managers, psychology managers and clinical psychology practitioners to demonstrate how psychological expertise support key areas.

Recommendations for psychology staffing

The DCP recommends that the mental health acute care pathway should have access to qualified clinical psychologists who have the specialist psychological skills to lead on access to psychological interventions.

Earlier reports, such as *Acute Care 2004: A National Survey of Adult Psychiatric Wards in England* (Sainsbury Centre for Mental Health, 2005), recommended a 1:20 full-time clinical psychologist to in-patient ratio by 2010. While the DCP recognises that this ratio may be difficult to achieve in times of increasing financial and resource pressures, we assert that acute wards should not simply comply with the basic minimum standard recommended by the Royal College of Psychiatrists (2009) as mandatory for accreditation: ‘the services of a trained, supervised and accredited psychological therapist to provide

evidence-based interventions to in-patients for at least a half a day per week per ward'. One half day is a likely insufficient but necessary baseline; given most wards in England are without any psychology service, it is an important marker to both meet and to surpass. Specific needs will of course be determined locally, but the DCP recommends that psychologists are commissioned to serve at least one full day, and ideally two or two and a half days, on each ward.

This document utilises the structure in the *Acute Care Declaration* (NHS Confederation Mental Health Network and National Mental Health Development Unit, 2009), which is based on five key themes, but these themes would be applicable within any of the four nations. They are:

1. to further encourage the commissioning and provision of high quality acute care;
2. to promote recovery and inclusion for people using acute mental health services;
3. to support the development of a specialist acute care workforce;
4. to champion positive perceptions of acute care services; and
5. to support quality improvement, service development and research in sensitive care.

The headings in this Executive Summary correspond directly to these themes and highlight the main features.

1. Further encourage the commissioning and provision of high quality acute care

Clinical psychologists have the specialist skills to work across the field, both directly with diagnosis and treatment of complex cases and indirectly in establishing services, protocols and pathways, and supervising and supporting the development of staff within the area.

Clinical psychological expertise within a recovery-focused acute care pathway will:

- inform interventions by developing a psychological understanding of mental health issues in collaboration with service users;
- support staff so that they can create a safe and therapeutic environment;

- ensure that staff have the necessary skills in how to incorporate psychological understanding within their competencies.

These basic psychological skills need to be distributed across the workforce and this requires on-going expert clinical psychological supervision and support to ensure that practice development derived from training is used and maintained in the workplace.

Clinical psychologists are equipped to provide assessment and management in cases of diagnostic uncertainty and where risk and complexity are combined. They offer skilled and high intensity interventions, and they can address the full range of issues leading to repeated use of the service in terms of the complexity of the individual's problems.

2. Support the development of a specialist acute care workforce

Ideally, everyone admitted to acute in-patient services in an acute mental health crisis would have access to psychological interventions provided by an expert practitioner trained in a range of different approaches. In most cases this is not realistic and it is necessary to attempt to provide access to psychological interventions from practitioners with a range of skill levels. As specialists in the development and delivery of specialist psychological interventions, clinical psychologists take a lead in supporting the dissemination of psychological intervention skills across the workforce, and also in the clinical governance of the delivery of such skills (NICE, CG82, *Schizophrenia – Core Interventions in the Treatment and Management of Schizophrenia in Primary and Secondary Care*).

Making use of an in-house clinical psychologist to support training initiatives is both cost-effective and advantageous in that:

- Training will be tailor made to the needs of the ward team and designed to be relevant to everyday practice, thus increasing the likelihood that the training will lead to an improvement in practice.
- Training will be supplemented by follow-on support and supervision, thus transferring skills into clinical work and to sustaining psychological practice.

Working in acute mental health care with potentially challenging scenarios and service users in states of high distress can increase levels of sickness, absence and turnover among staff as well as incidents and complaints. By using in-house clinical psychologists to contribute to practice development and staff training initiatives, staff moral will be maintained at higher levels and the ward milieu improved. This can help reduce instances of sickness, absence and turnover.

Clinical psychologists are able to make a significant contribution to practice development, using their well-developed training skills and in-depth knowledge of the application of psychosocial interventions on a range of levels. This, together with support from management, can serve to increase staff competencies, confidence in applying skills and motivation, and thus maintain and improve the quality of patient care.

3. Support quality improvement, service development and research in sensitive care

Doctoral level training gives clinical psychologists a high level of research skills which can be used in areas such as:

- audits;
- clinical quality; and
- investigative research

However, the main area in which more psychological research is needed is in enhancing the service user experience within in-patient acute care. According to the stepped care model, an in-patient admission highlights the point at which clients require the highest level of mental health care. Interestingly, even though recent governmental policy points to the need for patients to encounter a more therapeutic experience during an admission, the evidence base to help guide clinicians to what this constitutes remains limited.

The involvement of clinical psychologists, working alongside in-patient ward teams, presents a good opportunity for evaluation studies of psychological and other contributions to enhanced care.

This will help to inform the development of NICE guidelines that relate to in-patient settings.

4. Promote recovery and inclusion for people using acute mental health services

By using the wide range of therapeutic interventions available to them, clinical psychologists enable service users to actively participate in their treatment and recovery, thus reducing length of stay and improving the patient experience.

The inclusion of a clinical psychologist in the staff team can ensure distribution of psychological thinking and expertise throughout the staff group, leading to collaborative working at all stages of the care pathway and resulting in service user experiences being more likely to be taken seriously and received with open minded listening.

5. Champion positive perceptions of acute care services

Clinical psychologists are trained to formulate systemically by contributing systemic psychological expertise. Where the systemic perspective is ignored, the service may be drawn into repeating cycles of pathology, becoming ‘part of the problem’. Such a systemic approach will promote positive perceptions through:

- A service user and carer experience of collaborative care, skilful listening and availability of a range of therapeutic options to promote the individual path of recovery
- A service run by staff skilled in therapeutic interventions, with high morale, and good systems to work smoothly across the care pathway
- A culture of psychological understanding of mental distress that empowers and de-stigmatises the individual
- A growing body of practice-based research to promote continuous improvement of the service.

This will support mental health managers in promoting units as providers of quality acute care with a systematic and inclusive

approach allowing for the full spectrum of psychological intervention therapies to be applied.

Acute care pathway and the future

The pace of change within mental health, and especially within in-patient services, maintains its pace, and this is likely to continue with innovations nationally including:

- establishing dedicated assessment teams and triage wards;
- the splitting of the crisis and home treatment functions of crisis resolution and home treatment;
- the possible demise of Assertive Outreach teams and Early Intervention in Psychosis services; and
- the anticipation of payment by results with the split between diagnostic groups in terms of resources allocated.

More recently, the pace of change has accelerated with Trusts required to make substantial and immediate savings, and a renewed emphasis on closing in-patient beds and establishing alternatives to hospital provision.

This document is intended as a guide to support the promotion of greater access to psychological input in acute crisis services. The current and local context will need to be considered when thinking about the most effective means of utilising the contents of this document.

Introduction

In-patient services within mental health are facing major challenges in the current and future. The shift towards providing support within the community to prevent admission and to allow early discharge means that those people who are admitted are more distressed and disturbed, the length of stay is briefer so that wards are required to keep a high focus on addressing very acute needs. The economic stringencies within most facilities necessitate a clear justification for the staffing levels and effective deployment of staff on the wards

This document identifies the role and contribution of clinical psychology to assist in the effective operation of acute in patient wards, to provide support and skills for the workforce on the wards and to enhance the patient experience of an admission.

Policy context

England

The underpinning legislation in England is the Mental Health Act 2007 (Clause 12) and The Mental Capacity Act 2005. However, in 2011 the Government published *No Health Without Mental Health*, a cross-Government mental health outcomes strategy for people of all ages with its supporting document, *Talking Therapies: A Four-year Plan of Action* (2011). Both documents emphasise the importance of access to psychological interventions across all mental health services.

Northern Ireland

Until the new *Mental Capacity (Health, Welfare and Finance) Bill* is enacted, Northern Ireland's underpinning legislation is *The Mental Health Order* (1986). However, while the new legislation is being developed, the Government of Northern Ireland has published *The Service Framework for Mental Health and Wellbeing* (2011) which sets out 58 standards for mental health services. These standards are divided into five sections:

- **Section 1:** Standards for health improvement and mental health promotion.
- **Section 2:** Standards for improving the experience of service users and carers.

- **Section 3:** Standards for specific conditions – Children and young people.
- **Section 4:** Standards for specific conditions.
- **Section 5:** Standards for people with specific needs.

For this guideline the standards on specific conditions and for people with specific needs address early psychological intervention and continuing treatment as material to improving mental health outcomes in these areas.

Scotland

In Scotland the following legislation and policy drivers underpin all mental health services:

- *The Mental Health (Care and Treatment) (Scotland) Act, 2003.*
- *The Adults with Incapacity (Scotland) Act, 2000.*
- *Rights, Relationships and Recovery – the Report of the National Review of Mental Health Nursing in Scotland (SEHD, 2006a).*
- *Delivering for Mental Health – The Mental Health Delivery Plan for Scotland (SEHD, 2006b).*
- *Better Health, Better Care: Action Plan (Scottish Government, 2007).*

The Scottish Government recently published (2011) *The Mental Health Strategy for Scotland 2012–2015*, in which they commit to deliver faster access to psychological intervention for those with mental illness or disorder. By 2014, the target is access to psychological intervention within 18 weeks irrespective of age, illness or therapy. *The Matrix: A Guide to Delivering Evidence Based Psychological Therapies in Scotland* (2011) sets out the guidelines for delivering psychological therapies in accordance with the 2012–2015 strategy document.

Wales

Like England, the underpinning legislation in Wales is *The Mental Health Act 2007* (Clause 12) and *The Mental Capacity Act 2005*.

However, the Welsh government has published later strategies and policies which now guide mental health services in Wales, notably *Adult Mental Health Services for Wales 2001*, *Implementing Mental Health (Wales) Measure, Guidance for Local Health Boards and Local Authorities* (2011) and *Psychological Therapies in Wales; Policy Implementation*

Guidance (2012). The latter document emphasises the importance of access to a broad range of psychological therapies across mental health services in Wales.

Common theme

While legislation, policies, strategies and frameworks for mental health are slightly different in the nations in the UK there are strong common themes emerging from all of these documents and they are:

- Access to psychological intervention in all areas of mental health
- Recovery and inclusion of service users and carers
- Development of a specialist psychological workforce
- Quality of care improvements

Across the UK the policy context is not dissimilar in that all four nations face financial and resource pressures. However, the emphasis on the importance of psychological intervention is the same for all four nations and should be used to inform commissioning and mental health service delivery.

Evidence for and Access to Psychological Intervention

Evidence for psychological intervention

The National Institute for Health and Clinical Excellence (NICE) has recommended the delivery of cognitive behavioural therapy (CBT) for individuals diagnosed with schizophrenia (2002), bipolar disorder (2006), depression (2004), eating disorder (2004), post-traumatic stress disorder (2005), self-harm (2004), and personality disorder (2007). These descriptors are dominant in any ward's list of reasons for admission, yet actual delivery is behind schedule as compared to other Department of Health recommended NICE policy implementation. NICE has also recommended the delivery of CBT for anxiety (2004) and for obsessive compulsive disorder (2005), which are usually not primary reasons for admission but are often secondary features of an in-patient episode. The NICE guidance updates for schizophrenia (2010) and depression (2009)

state that recommended psychological interventions can commence during an acute phase as well as after a crisis period, so long as the intervention can be concluded despite discharge or transfer. In 2003, the National Institute for Mental Health in England (NIMHE) stated in *No Longer a Diagnosis of Exclusion* (2003) that individuals diagnosed with personality disorder should be able to access cognitive therapy among a variety of other psychological therapies. It is probable that the Care Quality Commission will begin to regulate all services along a mental health care pathway against standards of NICE concordant practice.

Access to psychological intervention

Despite the emphasis in NICE guidelines on psychological therapies for a range of mental health problems (many of which are seen for the first time in acute mental health services), the evidence indicates that access to such therapies in these services is disappointingly low. According to the Sainsbury Centre for Mental Health (SCMH, 2005), less than 20 per cent of ward managers surveyed could report that their ward's in-patients have access to CBT (and this statistic counts access to, not universal delivery of, CBT – those who actually get CBT is a fraction of this 20 per cent). More recently, the Healthcare Commission's survey of mental health acute in-patient services *Pathway to Recovery* (HCC, 2008) noted that 29 per cent of in-patients received some form of 'talking therapy'. This was less than half of those who sought psychological support. Marion Janner, a service user and creator of Star Wards (Bright, 2006) called for access to psychological therapies for anyone admitted to an in-patient ward who needs it. This led into Star Ward publishing *Talk Well: Encouraging the Art of Conversation on Mental Health Wards* (Bright, 2009).

The Department of Health's *National Service Framework* (DH, 1999) states that service development for people with severe and enduring mental illness (SEMI) is first priority. This would presumably include people with SEMI who are in acute distress. Regrettably, the DH's policy implementation guide for adult acute in-patient wards (2002) made no explicit provision for psychology, unlike implementation guides for community teams. Lord Darzi's *Next Stage Review*

(DH, 2008) gives emphasis to the importance of quality, innovation, productivity and prevention, leading to clear agreed care pathways best able to deliver more clinically effective and efficient acute services. *New Horizons* (DH, 2009), the successor to the *National Service Framework* (NSF), stresses improving the quality and efficacy of acute care pathway while championing improved access to psychological therapies as a means of enhancing recovery from psychological distress. Yet again, neither of these documents nor numerous linked implementation strategies have offered explicit standards or guidance on delivering better access to psychological interventions on acute in-patient wards.

Access to psychological practitioners

The Sainsbury Centre for Mental Health (1998, 2001, 2004) and MIND (2004, 2011) all condemn the lack of therapeutic input to wards.

All professions have a role to play in delivering psychological interventions. The Chief Nursing Officer's review of mental health nursing (DH, 2006) stated that mental health nurses need to widen their skills to provide more evidence-based psychological therapies.

The DH has regularly indicated the need for clinical psychologists on wards; its *Mental Health Policy Implementation Guide: Adult Acute In-patient Care Provision* (DH, 2002a) stated 'clinical psychology input needs to be increased to assist ward staff with the acquisition and practice of the necessary skills and to input into group and individual treatment and care arrangements'.

In its *Community Mental Health Teams Mental Health Policy Implementation Guide* (DH, 2002b), the DH noted that a CMHT should include a clinical psychologist as part of its multidisciplinary team (MDT), and that this psychologist's practice should include input into the relevant acute in-patient ward linked to catchment area and/or service specification. Without regulation of standards based on these orders of government, however, the situation is that few clinical psychologists are employed for dedicated work on wards or with ward-based staff, and where those attached to CMHTs

generally offer only limited, and oftentimes no, input to their link ward.

A recent review of 136 out of 550 acute mental health wards in England found that 87 per cent of the surveyed wards had no dedicated clinical psychologist (Bowers et al, 2006). Onyett (2007) found that only eight per cent of crisis resolution and home treatment (CRHT) services received input from a clinical psychologist.

The Manpower Advisory Service (MAS, 1989) argued that all service users should have access to three levels of psychological therapy:

1. basic interventions provided by all service providers;
2. focal interventions provided by trained service providers; and
3. complex interventions provided by highly trained service providers.

MAS states that clinical psychology is ideally equipped to implement training requirements for multidisciplinary staff. NIMHE (2004) asserts that workforces must be planned by competencies and led by all professions, and that training is required to adapt psychological interventions to the acute ward context.

Section 1. Further encourage the commissioning and provision of high quality acute care

1.1 High quality care means distributed expertise

Psychological expertise within a recovery-focused acute care pathway will:

- inform treatment by developing a psychological understanding of mental health issues in collaboration with the service user;
- support staff so that they can create a safe and therapeutic environment; and
- train its staff in basic psychological intelligence.

These basic psychological skills need to be distributed across the workforce and this requires ongoing, expert psychological supervision and support to ensure that practice development derived from training is used and maintained in the workplace.

The availability of these skills will underpin the delivery of the type of service encouraged by the Accreditation for In-patient Mental Health Services project (AIMS, Royal College of Psychiatry (RCPsych), 2009), Star Wards' service user led initiative (Bright, 2006), *New Ways of Working* (NIMHE 2005) and the Healthcare Commission (now Care Quality Commission (CQC)) review of acute in-patient care *Pathway to Recovery* (HCC, 2008).

1.2 Clinical interventions

As well as skills distributed through the workforce, a high quality service needs access to specialist therapeutic interventions. Clinical psychologists are equipped to provide assessment and management in cases of diagnostic uncertainty and where risk and complexity are combined. They can offer skilled, high intensity interventions for individuals, families and couples. In this way they can address the full range of issues leading to repeated use of the service in terms of the complexity of the individual's problems and of the family, cultural and social systems that can maintain these problems.

1.3 Providing high quality acute care by increasing access to applied psychological approaches and thinking across the acute care pathway

The Increasing Access to Psychological Therapies (IAPT) initiative in primary care recognises the efficacy of talking therapy in the treatment of mental health problems, and the right to availability of such help. Developments in the CMHT are extending the initiative to the clients of these teams. This paper makes the case for a similar right in respect of those accessing mental health services at the acute in-patient or crisis service stages of the care pathway. It addresses the questions of how the defining principles of IAPT, of stepped care and evidence base, can be applied in the acute setting, as follows:

- 1. The recovery approach**, which guides treatment of severe and enduring health problems, parallels the IAPT agenda in its emphasis on meaningful life and participation in society.

2. **Stepped care.** Skills-based approaches to psychological therapies offer manualised treatments that can be delivered by a wide range of staff with appropriate training, supervision and guidance.
3. **Training and Supervision.** This distribution of psychological care would free the expert psychological therapist to provide the training and supervision necessary to support this, along with psychological formulation, expert individual therapy, and facilitation of reflective practice.
4. **Evaluation.** Evaluation of in-patient psychological therapy, though challenging, is possible (e.g. Durrant et al., 2007).

1.3 A skills-based approach to psychological interventions in acute care: Promotion, maintenance and role across the acute care pathway

In an ideal world, everyone admitted to acute in-patient services in acute mental health crisis would have access to psychological interventions provided by an expert practitioner, trained in a range of different approaches. In most cases, this is not a realistic scenario, and it is necessary to attempt to provide access to psychological interventions with practitioners with a range of skill levels, ensuring that competency and access to expert supervision are maintained.

As specialists in the development and delivery of specialist psychological interventions, clinical psychologists will take a lead in supporting the dissemination of psychological intervention skills across the workforce, and also in ensuring clinical governance.

The recent development of skills-based approaches to therapies for severe mental health conditions makes possible a stepped care approach across the acute care pathway, allowing for the distribution and utilisation of therapy skills across the staff group, according to individual level of expertise and interest. Such a model requires the availability of expert psychological support to provide ongoing embedded, supervision and skills development. The availability of psychological expertise makes it possible to initiate the episode of care with a psychological formulation, in collaboration with the service user. This has the advantage of conveying to the service user

from the outset the hopeful message that they have a vital role to play in their own recovery – and outlining what this role can be.

Use of skills-based approaches

Recent developments in therapy for personality disorders (such as Metallisation Based Therapy (MBT; Fonagy et al., 2004) and dialectical behaviour therapy (DBT; Linehan, 1993) rely on skills teaching and skills generalisation coaching as a core mode of therapy delivery. For example, DBT skills target management of troublesome emotions and interpersonal problems. As emotion management and personal relationships lie at the heart of most mental health symptoms, the application of DBT skills transdiagnostically is being developed and evaluated in the in-patient setting. (Dimeff & Koerner, 2007; Durrant et al., 2007; Clarke & Wilson, 2008, Chapters 6, 7, 8, 13 and 14.).

This approach makes a division of labour in the delivery of psychological therapy particularly easy because:

- the skills to be taught are manualised; this is so that the psycho-educational aspects of the programme can be delegated to staff who are trained in the approach, but do not necessarily have a wider psychotherapy qualification; and
- the coaching of skills in the natural environment plays a crucial part. This is well-suited to facilitation by either ward or team staff, with some level of induction in the model, whose role it is to support the individual.

This frees the expert clinical psychologist to:

- provide training and supervision for the wider staff group to enable them to deliver the skills training and coaching;
- formulate complex cases for the benefit of the individual and of the team; and
- offer treatment in the case of individuals deemed to be in need of that level of intervention.

Application of this stepped care approach

The developmental stage of the ward with regard to psychological approaches will dictate which level(s) of intervention are possible. It will be necessary to work on the therapeutic basics where these are lacking before offering higher level training such as CBT or DBT.

Direct interventions

Basic level

Progressive nursing programmes stress the importance of one-to-one sessions between the allocated nurse and each person on the ward, ideally occurring each shift for each patient. Such sessions require the following skills of staff to be effective and therapeutic:

- Engagement skills.
- Listening skills (e.g. using the *Talk Well* document, Bright 2009).
- Motivation enhancing skills.
- Enhancing the knowledge base of non-mental health trained staff: support workers, non-clinical workforce (domestics, canteen staff, maintenance staff, administration staff) e.g. through basic mental health awareness training – a forum to give information, air queries, amend preconceptions. Service users should be involved in the development and delivery of such training.
- An understanding of the impact of cultural values on a service user's understanding of their condition.

Low intensity interventions

Some staff will have the interest and ability to develop more advanced psychological ways of working provided the necessary support is available.

Psychological skills that could be developed include:

- arousal management;
- emotion regulation;
- psychotic symptom management;
- problem solving;
- assertiveness and self esteem building;
- activity scheduling;

- graded exposure;
- confidence building; and
- working with any spiritual aspect of their condition via the Chaplaincy.

Such interventions can be delivered in a group or individual format. Manuals, either published or site/team specific, facilitate the consistent delivery of such programmes. The clinical psychologist can introduce these and provide teaching for their use.

High intensity interventions

Direct intervention by clinical psychology or other staff with a qualification in psychological therapy in cases of:

- complexity and risk combined;
- severe motivational deficit; and
- psychological formulation of complexity to facilitate effective team working (e.g. diagnostic uncertainty; cases of team splitting, etc.).

1.4 Formulation

Formulation can best be understood as ‘a tool used by clinicians to relate theory to practice’, generating hypotheses to be tested (Butler, 1998). Kinderman (2005) argues that psychologists are uniquely placed to effectively formulate service users’ difficulties, and Johnstone (2008) asserts that psychologists ‘can offer a valuable way of conceptualising people’s problems that is an alternative to psychiatric diagnosis’. Onyett (2007) suggests that psychologists should use formulation to ‘advance a principled alternative approach to diagnosis, particularly in situations where biogenic factors are afforded an unwarranted central role’, such as in the in-patient setting. Underlying the process of formulation is the belief that on some level, the person’s difficulties make sense and can be understood in relation to their own life history and personal context. This can be extremely empowering for both the individual in crisis and for staff, as it provides hope that what is understandable can be addressed and worked with.

Psychologists can work with individual service users to develop formulations that seek to make sense of their current crisis. This can then be fed back to the team in meetings, through letters/reports and through case presentations, in order to facilitate psychologically informed thinking and a unified approach to understanding the person's difficulties. Psychologists can also support teams to develop unified and psychologically informed formulations and treatment plans through a formal consultation process. Lake (2008) describes a model of team formulation where the MDT are encouraged to come to the consultation with questions and, through a careful process of psychologically informed questioning and reflection, a team formulation emerges which attempts to answer these questions and highlight ways forward. Lake (2008) found that the 'formulation model quickly becomes familiar to everyone in the team', fostering a shared psychological language and unified approach to thinking, talking about and working with service users.

Although formulation is recognised as a core skill for clinical psychologists in all specialties, it has not been the subject of any official guidelines or professional standards until the DCP published *Good Practice Guidelines for the Use of Psychological Formulation* (2011). This guideline serves a wide range of purposes for individuals, teams and organisations across many different healthcare settings. However, it is a complex area, and even the definition of formulation varies across clinicians and professions. The document establishes broad principles in a number of areas including multi-model and single model formulation, problem-specific and person-specific formulation, formulation in teamwork, and formulation and diagnosis. The guidelines conclude with a checklist of best practice in formulation, which is intended for use in clinical work, evaluation, supervision, training, audit and research.

Good Practice Example

Woodhaven acute care pathway formulation

This service employs a simplified, trans-diagnostic, ‘third wave’ CBT approach to formulation, which can be introduced early in contact and without much preliminary information (a frequent circumstance in acute work). The formulation starts from the observation that at times of crisis the individual usually feels overwhelmed by circumstances and emotions, and so unable to make sense of their situation. They are attempting to cope – but often in ways that make things worse.

Using a simple diagram that first identifies the intolerable emotion driving unhelpful behaviours, therapist and service user work collaboratively together to:

- identify the factors leading to the crisis, both outside life events and internal (e.g. past trauma and including any cultural diversity issues – such as a south Asian woman being forced by family members to marry and bring a husband to the UK); and
- identify the immediate, understandable, reactions of the person to feeling overwhelmed, such as withdrawing, drinking too much alcohol, and so on, that make things worse.

These ways of coping are drawn on the diagram as vicious circles. Precipitating factors (losses, abuse, etc.) are named, but explicitly not explored, as this is not the time for such exploration. Clarifying this leads on to discussion of how to break the vicious circles, and so to identifying better, more skilful ways of coping. See (Clarke & Wilson, 2008 pp.68–71; and Clarke, 2009, for more detail).

As this is a third wave CBT approach, mindfulness (the skill of being able to take a step back within the mind and so not be swept along by out of control emotions or thoughts) is often a first line approach to breaking the circles. There are mindfulness sessions, and other programmes within the hospital open to those under the CRHT as well, that make available teaching in the requisite coping skills. Additionally, a proportion of the staff is trained in approaches such as mindfulness and emotional coping skills and so can provide individual coaching.

Section 2. Support the development of a specialist acute care workforce

2.1 Clinical psychology can support the development of a specialist acute care workforce

Clinical psychologists can:

- enhance psychological mindedness of all acute care staff;
- teach specific psychological concepts and offer supervision and support with the implementation and maintenance of these skills; and
- facilitate the development of a psychologically skilled workforce.

2.2 Training for acute care pathway staff in applied psychological approaches

A number of initiatives point to the need for in-patient staff to receive training in evidence based nursing care (NIMHE, 2004; CQC, 2007; Clarke, 2004; RCPsych, 2009; *Chief Nursing Officers Review*, 2009; *Ten Shared Capabilities* (Department of Health, 2004a); Star Wards, Bright, 2006). Whilst a number of courses have developed nationally to address this need (see Clarke, 2004), some advantages of making use of an in-house clinical psychologist to support training initiatives include the following:

- training can be tailor made to the needs of the ward team and designed to be relevant to everyday practice, thus increasing the likelihood that the training will lead to an improvement in practice;
- training can be supplemented by follow-on support, thus transferring skills into clinical work and sustaining psychological practice; and
- it is cost effective.

These, together with support from management, can serve to increase staff interest and motivation to stay in the post and improve the quality of patient care.

The National Audit Office document *Helping People Through Mental Health Crisis: The Role of Crisis Resolution and Home Treatment Services*, advocates ‘integrating training for CRHT and acute in-patient service to equip staff to operate in both settings’ (National Audut Office, 2010, Section 1.vi, p.8). Joint psychological training of the two staff groups, delivered by clinical psychologists, would affect this and promote joined up working across the pathway.

What are the training needs of acute in-patient staff?

Clarke (2004) sets out levels of competencies that are required to deliver a high quality acute in-patient service (see Table 1).

Clinical psychologists work at Level 4 and have expertise to develop teaching programmes to support staff in developing their therapeutic and intervention competencies. In addition to this competency framework, further routes that can identify training needs of acute in-patient practitioners are: clinical governance/guideline implementation, practice development group initiatives, recommendations from serious incident reports, complaint responses, perceived needs of training recipients and the cultural diversity of the service users of that service.

Training can focus on one-to-one work with service users, group work and work with the MDT. In addition, the expert research and audit skills of these practitioners will enable them to use training to improve the service.

Table 1: Levels of competencies that are required to deliver a high quality acute in-patient service

Level 1	All staff in acute in-patient care	Leadership and intervention awareness
Level 2	Post registered practice	Leadership and intervention skills
Level 3	Advanced practice	Leading services and intervention skills
Level 4	Independent practice	Excellence in leadership, developing others, advance clinical skills

1. One-to-one work with service users

In line with Star Ward's and AIMS' accreditation frameworks, more and more wards are delivering protected one-to-one time with service users. Some competencies that can be useful for this intervention includes:

For Level 1 staff

How to establish a therapeutic relationship:

- engagement skills;
- listening skills;
- collaborative alliance building skills;
- motivation enhancing skills;
- counselling skills;
- introduction to evidence-based therapy approaches; and
- recovery principles.

For Level 2 and 3 staff

In addition to the above, particular intervention skills include knowledge of:

- manualised treatment approaches (e.g. anxiety management);
- motivational interviewing;
- cognitive behavioural intervention approaches (e.g. activity scheduling);
- relapse prevention approaches;
- problem solving approaches;
- DBT approaches (e.g. emotion regulation);
- shared risk-taking/collaborative risk management;
- de-escalation;
- managing/care planning around challenging behaviour;
- coping strategies, including coping with psychotic symptoms;
- recovery action planning;
- mindfulness;
- spirituality/philosophy;

- suicide prevention; and
- formulation driven care planning.

For Level 4 staff

- Staff at this level will have obtained postgraduate level qualifications and work as independent practitioners who engage in supervision and CPD to update their high level training.
- Level 4 staff are qualified to provide the expert supervision necessary for staff at other levels to develop and use therapeutic skills acquired through the training.

2. *Group work interventions*

The in-patient ward constitutes a group of service users who all share the unfortunate experience of being in crisis, so one approach to ameliorate this is to create a therapeutic community. Group work is one way to help achieve this. Where services are organised across the acute care pathway, CRHT clients can access these groups, either following or independent of admission.

Staff can be trained in basics of running groups, such as:

- how to develop protocols for group work;
- useful groups for in-patient wards; for example, community meetings;
- facilitation skills for group work; and
- developing groups based on service user needs.

3. *Team-based interventions*

There will be occasions when a team approach to care will be helpful for the service user. An example of this is to offer regular case discussion meetings to help formulate the clients' needs within a biopsychosocial framework, with the intention of arriving at a team-based intervention to help move the client on.

An example of this is the RAID approach to challenging behaviours (Davis, 2001), which promotes focus on behaviours to increase, with secondary attention to behaviours to decrease.

4. Follow-on supervision

Ongoing supervision is clearly important for any professional undertaking psychologically informed work. There are various ways of providing this, including:

- Consider when live supervision is required for successful adherence;
- ‘Consultation Group’ (for example, following DBT training);
- Rotating case presentations in group supervision; and
- Using Socratic dialogue in professional supervision.

5. Evaluation of training sessions and outcome/adherence

Evaluation of this work is crucial to establish that the work is making a positive difference and ensure adherence to the model. Evaluation can be challenging on acute in-patient units, as described below. However, it is possible to an extent. Suggested methods include:

- workbooks as post-training, new practice implementation tools;
- measuring changes in attitude post-training;
- self-rating on new skills development/knowledge (pre- and post-); and
- conducting an audit to ‘revisit’ the training’s impact on practice.

2.3 Reflective practice and clinical/case discussion: Psychological thinking and reflective practice

The psychologically informed thinking described above can be fostered and maintained by reflective practice and clinical/case discussion meetings, supported by psychologically skilled staff in facilitation. There is a recognised need for support for psychological thinking within the MDT. As Cowdrill and Dannahy (2008) put it: For example, in the Department of Health (2002) document *Mental Health Policy Implementation Guide: Adult Acute In-patient Care Provision* the importance of reflection within the working environment is highlighted:

‘Time should be identified within the working week for an on-going programme of structured multidisciplinary learning opportunities... creating a space that allows for reflection, thinking and understanding and the thoughtful application of skills, knowledge and timely interventions’ (p.21).

Such opportunities for psychological reflection and formulation can:

- validate strong emotions inevitably generated in the acute setting;
- enable them to be voiced in a constructive context;
- facilitate the emergence of constructive solutions from within the staff group; and
- promote effective MDT care planning, informed by psychological models and formulation.

What is reflective practice?

Actually, reflective practice groups on wards tend to include elements of each of these activities (staff development, formulation of both individual case and organisational issues, and staff support) as the examples below indicate, but it is important to be clear about the distinction between them. Hartley and Kennard (2009) suggest that the role of facilitator may be viewed as somewhat different depending on what is taking place. In reflective practice, the group may be more structured, focused on learning and development, and more emotionally detached. In staff support, the group is likely to be less structured and more focused on expression of emotional responses with the emphasis on learning from experiences.

2.4 Contribution to maintaining staff morale and the ward milieu

Staff morale and retention and the linked issue of the ward milieu are essential issues when considering the efficiency of the acute care pathway. A ward that is not working efficiently and to capacity will not be able to manage the demanding throughput of service users required by economical use of in-patient beds.

Staff morale

Staff retention is undermined where acute in-patient work is seen as a temporary stage towards a more fulfilling community role. This can be a barrier to individual staff development in the skills specific to the acute in-patient role, and hence to building a skilled team. In addition, frequent staff changes undermine the close and efficient team working essential to safety and morale in in-patient and crisis work.

Availability of coherent practice development and the chance to develop skills relevant to the setting will help to make in-patient nursing a satisfactory specialty in its own right. Clinical psychologists are able to make a significant contribution to this practice development, with well-developed training skills and in-depth knowledge of the application of psychosocial interventions on a range of levels.

Ward milieu

A skilled and dedicated staff team, who feel valued, will go on to promote a more therapeutic ward milieu in a number of ways, including:

- Greater level of job satisfaction leading to greater staff retention and more consistency of approach on the ward.
- Provision of higher levels of meaningful activity on the wards (this has been shown to reduce the risk of violent incidents on wards).
- Development of a more considered rather than reactive approach to risk management.
- Helping staff teams to understand how being an in-patient on a psychiatric ward differs from being an in-patient on a physical health ward because of the level of interaction with other patients required. This will bring into play social psychological processes and group dynamics such as being in the in- or outgroup. These may be linked to issues of cultural diversity.

2.5 Developing and supporting higher level skills across the workforce

Staff with partial qualifications to deliver psychological therapy (such as nurses developing their CBT or other therapy skills, psychology assistants, and so on), may assist at this level, provided adequate supervision is available from the clinical psychologist.

Training and supporting staff in the delivery of such interventions will:

- Increase the availability of psychological treatments, both in the form of groups and individual sessions, on the ward
- Examples of such groupwork include interventions for psychosis (e.g. Chadwick et al., 2005; Clarke, 2010), for emotional dysregulation (Rendle & Wilson, 2008), and self-esteem (Hill et al., 2008).

Availability of such development opportunities should serve to maintain morale and motivation for skilled staff to remain within the acute sector.

Meaningful activity

The availability of the sort of psychological programmes listed above, targeted at identified clinical needs on the in-patient ward will do much to remedy a deficit in meaningful activity, which has been a criticism of in-patient units. Such a programme fits well with the objectives of the Star Wards approach (Bright, 2006). Meaningful activity in a cultural context is also vital and should be given full consideration; for instance, a refugee service user from Afghanistan may not find it culturally appropriate to take part in an art session but may be happy to share an Afghani meal served in traditional crockery.

Good Practice Example

Reflective practice groups for staff

Topaz Ward – Crisis Resolution/Home Treatment Team, Newham Centre for Mental Health

Anyone who has embarked upon the challenge of setting up a staff reflective practice group will be familiar with the challenges that this presents:

1. incorporating the group into the ward routine;
2. maintaining attendance levels;
3. managing the presence or absence of figures of authority in the group;
4. handling the divide between the personal and the professional;
5. attending to the personal as well as to the organisational issues;
6. highlighting and working on parallel processes between patients groups and staff groups; and
7. being the facilitator of the group and also part of the team.

These were a few of the challenges facing the CRHT team at Topaz Ward when setting up this reflective practice group. *Staff Support Groups in the Helping Professions: Principles, Practice and Pitfalls* (Hartley, P. & Kennard, D., 2009) was used as the guide through a difficult but necessary journey. The clinical psychologist establishing this group asked why it was necessary to run a staff group and how to set it up so that people found it useful and non-threatening.

Since ward staff are exposed to high levels of distress and challenging behaviour on a daily basis, what was needed to alleviate the stressors was to provide everyone with a space to reflect on how this often difficult environment impacts on the ward environment and on each individual/professional and their practice.

Initial meetings with the staff and brainstorming on a name resulted in the name *OUR SPACE*. Staff wanted to keep it as informal as possible and talk about whatever emerged from the hour spent together.

The group has now been running for three-and-a-half years and topics have ranged from talking about how the group is and how it is perceiving

the atmosphere on the ward, to organisational issues, case formulations and managing challenging behaviour effectively on the ward. This group also identified a need to hold regular away days, which were facilitated for the past two years (twice a year) by the clinical psychologist, who took a person-centred approach and a solution-focused stance to this group, as the staff found this quite helpful.

So far, the feedback has been very positive. It has been easier to manage all the points above simply because the staff have come to own the group as *OUR SPACE*, and they have been very grateful to have someone whom they know quite well to run the group as opposed to an external facilitator.

Section 3. Support quality improvement, service development and research in sensitive care

3.1 Clinical psychology can support quality improvement, service development and research in acute care

Clinical psychologists who are integral to acute care delivery can lead a culture of service evaluation and audit using the information collected to inform continuous improvement of the service and publication to inform the wider scientific discourse. In this way, a body of practice based evidence can be collected and disseminated

As the practice studied will have developed out of the needs of the particular service, it will be well suited to those needs and deliver improvement more efficiently and over a longer period than ideas from outside trialled by external researchers for a limited period.

3.2 Research and evaluation to support quality improvement

Evaluation and the development of practice-based evidence

Where NICE adherent, evidence-based therapies are recommended in this document, the evidence for these therapies has mostly been collected in settings other than the in-patient unit or CRHT.

Evaluation of therapeutic approaches within the in-patient setting is challenging (Durrant and Tolland, 2008) but possible (Durrant et al., 2007). Currently, there are very few studies demonstrating the effectiveness of specific psychological interventions on acute in-patient units.

One difficulty is that standard outcomes such as symptomatic change do not distinguish between the impact of different interventions (e.g. medical, psychological, occupational), the ward environment and the many other factors that may influence recovery and stabilisation from acute mental health crisis. The use of measures such as the Mental Health Confidence Scale (Carpinello et al., 2004) and Locus of Control (Craig et al., 1984) enable us to measure

outcomes that are specifically targeted by psychological interventions.

Clinical psychologists can also play a vital role in facilitating evaluation and audit of more generic aspects of acute mental health services (for example impact of care pathways, models of service delivery, in-patient experience). As a result of their training, clinical psychologists have well developed research skills and therefore the ability to take the lead on research, evaluation and audit of developments within acute mental health units.

Research

According to the stepped care model, an in-patient admission highlights the point at which clients require the highest level of mental health care. Interestingly, even though recent governmental policy point to the need for patients to encounter a more therapeutic experience during an admission, the evidence base to help guide clinicians to what this constitutes remains limited. The appointment of applied psychologists, who work alongside in-patient ward teams, presents a good opportunity for evaluation studies of psychological ways of working to be carried out. This will help to inform the development of NICE guidelines which is more appropriate for in-patient settings.

In-patient psychologists have identified the potential for therapeutic work at three levels: work with the individual, the ward team and with the ward milieu.

Good Practice Example

Using narratives on an acute psychiatric ward

Background: Mental health professionals are looking at more ways in which clients' voices can be heard throughout their treatment. One of the ideas being suggested is through narratives. Narratives are a way people can derive meaning from events by retelling their story putting their experience in chronological order. The 2002 NICE guidelines also suggest encouraging clients to write their own accounts of their admission to hospital.

This service evaluation discusses the idea of using narratives in in-patient care and evaluates how useful it has been for both staff and patients to be involved in the narrative process. The main aims in introducing the 'Narrative Project' were to determine if the process of creating a narrative impacted upon therapeutic relationships between staff and clients, whether narratives could improve client's insight and if the process could improve staff confidence in their skills.

Method: Questionnaires were used to determine if the aims of our 'Narrative Project' were being met. The findings of the questionnaires were analysed using content analysis to draw upon themes.

Findings: Despite environmental/systemic challenges, the process of collecting narratives has highlighted the importance of a good therapeutic relationship between staff and clients.

Conclusion: It is important to note that it is not the number of narratives collected which is important but the quality of the narratives and what both staff member and client gain from the process which is key.

Keywords: Narrative; in-patient; therapeutic relationship; insight.

Section 4. Promote recovery and inclusion for people using acute mental health services

4.1 Clinical psychology can promote recovery and inclusion for people using acute mental health services

The inclusion of a clinical psychologist in the staff team can ensure distribution of psychological thinking and expertise throughout the staff group, leading to collaborative working at all stages of the care pathway. This will mean that:

- service user experience is more likely to be taken seriously and received with open minded listening;
- acute care delivery is more responsive to individuals' needs and aspirations;
- smoother care pathway planning can lead to earlier and more successful discharge and better attention to social inclusion needs;
- a psychological understanding of mental health issues leads to the empowerment of the service user as an active partner in their recovery journey.

4.2 Service user and carer involvement

Psychology plays an important role in supporting service users and carers to be actively involved in the delivery and development of psychologically informed care. Trained and supported service user and carer involvement facilitates the delivery of effective personalised, recovery focused acute care services. This is particularly important with service users from some minority ethnic backgrounds where family ties may remain very close throughout life and many family members such as parents and siblings may be contributing significantly to the care of the service user.

Service users and carers are able to support psychologically informed care by:

- Offering to meet patients individually to share their experiences of treatment and recovery.

- Working alongside trained practitioners delivering group therapies to encourage and motivate individuals to try new skills and engage with psychological interventions.
- Meeting carers to share their experiences of support and recovery.
- Promoting recovery focused and collaborative interventions through co-facilitation of staff training.
- Presenting service user perspectives at Trust workshops and national conferences.
- Contributing to the planning and delivery of service evaluations and research into psychologically informed practices.
- Contributing to and offer leadership in relation to the governance agenda (service evaluation, audit, client satisfaction work, research, outcomes).
- Help services deliver their Key Performance Indicators (KPIs) and offer solutions where there are blocks to achieving KPIs.
- Contributing to CQC reviews and remediation of issues arising from review feedback.
- Having core membership of Acute Care Forum (ACF) groups. Service users and carers should be supported to have a voice in ACF groups and contribute to policy development to ensure that these are psychologically informed (e.g. recruitment, selection of volunteers).

Crucially, service user involvement in psychologically informed care normalises and de-stigmatises the experience of distress, focuses staff on the service user's perspective of care within the acute pathway, and can powerfully instil hope of recovery.

Good Practice Example

CAST: A service user led consultancy and support team

A network of service users in the Southampton area have been supported and trained by local clinical psychologists to offer consultancy and support to mental health services in the area. CAST provides a highly regarded service in the locality.

Members of the group:

- support practitioners in in-patient and community therapeutic groups by sharing their stories of recovery and encouraging engagement in skills;
- speak at carers' groups about their journey of recovery;
- regularly contribute to training for mental health staff, offering service user perspectives on approaches to care;
- sit on research planning and governance groups, contributing to the development of new initiatives;
- present at local and national conferences, particularly those which address stigma and personalised approaches;
- represent service users on interview panels for recruitment of Trust staff at all levels;

CAST members have become an important part of adult mental health service provision in the city and beyond.

Section 5. Champion positive perceptions of acute care services

5.1 Clinical psychology support and inform positive perceptions of acute care services

By improving the quality of acute care through early psychological intervention, supporting the development of a specialist acute care workforce, quality improvement, service development and research as well as promoting recovery and inclusion for service users, clinical psychologists can support the organisation in championing positive perception of acute care services by the activities outlined below.

Work with the individual

- Carrying out brief psychological therapy, suitable for an in-patient setting.
- Identifying the key mechanisms of brief/single-session therapy for application in in-patient settings.
- Using patient stories to bring a person-centred ethos to in-patient systems.
- Recognising that understandings of mental distress can vary across cultural groups and the significance of family and community networks in how interventions may be put into practice.
- Using transdiagnostic therapy approaches that cater for the range of presentations on acute in-patient wards.
- Supporting staff to use person planning frameworks to work with the individual, such as the Wellness Recovery Action Planning(WRAP).
- Developing a sensitive outcome measure to measure the impact of engagement with psychological therapy on the in-patient unit.
- Supporting staff to bring psychological models into their risk assessments; for example, collaborative approaches.
- Understanding how the experience of acute mental health crisis impacts on the individual's (and her/his family's) confidence in her/his ability to cope with life after hospital.

Work with the ward team

- Measuring and improving the psychological mindedness and formulation skills of in-patient staff.
- Promoting best practice attitudes such as recovery focused care.
- Promoting best practice when working with individuals with a diagnosis of personality disorder. (What works best for short term crisis and for longer term rehabilitation admissions?)
- Monitoring differences in staff attitudes between working with clients with a diagnosis of personality disorder in comparison with clients with other diagnoses.
- Monitoring the impact of personal mindfulness training for staff on acute wards.
- Investigating the impact of providing psychological assessments (e.g. risk, neuropsychological, case consultation and psychological formulation) on outcome for both staff and patients (e.g. whether improved knowledge about the nature of the client's difficulties leads to improved well-being for both staff and patient and shorter length of stay for patients).
- Measuring the clinical and cost benefit of running reflective practice staff groups to the individual, staff team and ward milieu.

Work with the ward milieu

- What do recovery focused in-patient services look like?
- Developing an ethos of true psychological partnership/collaboration within in-patient care.
- Developing a short measure of the therapeutic environment to capture how supportive and structured the ward is from the patient and staffs' perspective and, hence, help generate solutions to make improvements.
- Measuring the secure base effect of an in-patient ward to identify appropriate attachments between staff and patients, possibly by using the Service Attachment Questionnaire (Goodwin et al., 2003) (Appropriate attachment to staff can predict positive outcome for patients.)

- Studying the link between psychological well-being, supervision and absenteeism in staff.

5.2 Clinical psychology can champion positive perceptions of acute care services

Positive perceptions will follow from:

- a service user and carer experience of collaborative care, skilful listening and availability of a range of therapeutic options to promote the individual path of recovery;
- a service run by staff skilled in therapeutic interventions, with high morale and good systems to work smoothly across the care pathway;
- a culture of psychological understanding of mental distress that empowers and de-stigmatises the individual; and
- A growing body of practice based research to promote continuous improvement of the service.

5.3 How the availability of dedicated psychological expertise can contribute to the efficiency of the care pathway

By promoting CRHTs, the Nation Service Framework has led to service developments designed to promote thoughtful planning around mental health crisis and possible in-patient admission as opposed to automatic reaction to symptomatic presentation. Psychologically informed thinking and psychological formulation have a crucial role to play in such planning.

Psychologically informed care planning will ensure:

- admissions are planned to maximise effectiveness;
- obstacles to discharge are identified and tackled, including community re-integration challenges (housing, employment, social support, etc.);
- preparation for discharge, liaison with community staff and relapse prevention work are carried out to reduce the need for re-admission;

- service users are empowered in the context of institutionalisation; and
- there is a clear, recovery focused role for ward and team staff.

5.4 Contribution of systemic psychological expertise: Improving care and positive perceptions of acute care services

Clinical psychologists are trained to formulate systemically and are, therefore, well placed to support the team to take account of this dimension. Where the systemic perspective is ignored, the service is often drawn into repeating cycles of pathology, becoming ‘part of the problem’. For instance, automatic in-patient admission as a response to self-harm has been identified as potentially perpetuating the problem by reinforcing the behaviour (Linehan, 1993).

Similarly, the team or unit can become part of repeating cycles of dysfunction arising within relationship and family systems. Availability of a clinician with the expertise to provide formulation driven psychological interventions from a systemic perspective to those who repeatedly present to acute in-patient mental health units can contribute substantially to reduction in admissions and/or length of stay. For example, a common scenario occurs where the couple or family system is managing difficult emotions or transitions in a dysfunctional or avoidant manner and the dysfunction can apparently become located within one of the parties (usually the most vulnerable and least assertive family member). Labelled as ‘ill’, that member is removed for treatment, so relieving the tension or diverting energies and providing an external source of blame (the service which inevitably fails to ‘cure’ the person). However, relief is temporary and the service is locked into a hopeless cycle of providing repeated episodes of care that resolve nothing, waste resources and perpetuate misery.

Availability of a systemic perspective can:

- help the system to look at interface issues across the acute care pathway (i.e. in-patient and crisis team delivery of care);

- identify and trouble shoot interface issues (e.g. poor communication, poor relationships, misunderstandings of role, alternative understanding of mental illness and suffering);
- help hospital management to think more systemically and strategically;
- contribute to policy development as above (e.g. supervision, use of volunteers); and
- deliver or support couple and family work to facilitate discharge.

Conclusion

This document highlights the contribution of clinical psychology to in patient ward work, through direct clinical provision, working to support the competencies and capabilities of other staff and through contributing a systemic perspective to the organisation and operation of such services.

It is intended that it is used flexibly as a ‘tool kit’ to highlight the range of activities that can be undertaken and to promote a positive image of how the in-patient patient pathway might develop. The DCP hopes that this will provide information to commissioners and managers in their consideration of resourcing the psychology provision for in patient wards.

It is intended that the document should also assist psychologists working on the wards in determining with colleagues the most effective use of their time by identifying options for their contribution.

References

- Allie, S. & Whittall, S. (2011). Using narratives on an acute psychiatric ward. *Counselling Psychology Review*, 26(3). Leicester: The British Psychological Society.
- Bowers, L., Whittington, R., Nolan, P., Parkin, D., Curtis, S., Bhui, K. et al. (2006). *The City 128 Study of Observation and Outcomes on Acute Psychiatric Wards*. London: City University.
- Bright (2009). *Talk Well: Encouraging the Art of Conversation on Mental Health Wards*. Publisher details missing.
- Bright (2006). *Star Wards: Practical Ideas for Improving the Daily Experiences and Treatment Outcomes of Acute Mental Health In-patients*. London: Bright. Retrieved June 2007 from www.starwards.org.uk.
- British Psychological Society (2004). *Estimating the Applied Psychology Demand in Adult Mental Health*. Leicester: Author.
- Butler, G. (1998). Clinical formulation. In A.S. Bellack & M.E. Hersen (Eds.) *Comprehensive Clinical Psychology* (pp.1–23). New York: Pergamon Press.
- Cardell, R. & Pitula, C.R. (1999). *Suicidal In-patients' Perceptions of Therapeutic and Nontherapeutic Aspects of Constant Observation*. Arlington, VA: American Psychiatric Association.
- Care Quality Commission (2009). *Supporting Briefing Note: Issues Highlighted by 2009 Survey of Mental Health Acute In-patient Services*. London: Author.
- Carpinello, S.E., Knight, E.L., Markowitz, F.E. & Pease, E.A. (2000). The Development of the Mental Health Confidence Scale: A Measure of Self-efficacy in Individuals Diagnosed with Mental Disorders. *Psychiatric Rehabilitation Journal*, 23, 236–243.
- Chadwick, P.D.J., Newman-Taylor, K. & Abba, N. (2005). Mindfulness Groups for People with Distressing Psychosis. *Behavioural and Cognitive Psychotherapy*, 33, 351–360.
- Clarke, I. (2009). Coping with crisis and overwhelming affect: Employing coping mechanisms in the acute in-patient context. In A.M. Columbus (Ed.), *Coping Mechanisms: Strategies and Outcomes*. Huntington, NY: Nova Science [Originally published in *Advances in Psychological Research*, 63].

- Clarke I. (2008). Pioneering a cross-diagnostic approach founded in cognitive science. In I. Clarke & H. Wilson (Eds.) *Cognitive Behaviour Therapy for Acute In-patient Mental Health Units: Working with Clients, Staff and the Milieu* (pp.65–77). Hove: Routledge.
- Clarke, I. (2010). ‘What is real and what is not’: Towards a positive reconceptualisation of vulnerability to unusual experiences. In I. Clarke (Ed.) *Psychosis and Spirituality: Consolidating the New Paradigm*. Chichester: Wiley.
- Clarke, I. & Wilson, H. (Eds.) (2008). *Cognitive Behaviour Therapy for Acute In-patient Mental Health Units: Working with Clients, Staff and the Milieu*. London: Routledge.
- Clarke, S. (2004). *Acute In-patient Mental Health Care: Education, Training and Continuing Professional Development for All*. London: National Institute for Mental Health in England/Scottish Commission for Mental Health.
- Clouder, L. (2000). Reflective practice in physiotherapy. *Studies in Higher Education*. 25(2), 211–223.
- Connor, R. & Sheehy, N. (2000). *Understanding Suicidal Behaviour*. Leicester: The British Psychological Society.
- Cowdrill, V. & Dannahy, L. (2008). Running reflective practice groups on an in-patient unit. In I. Clarke & H. Wilson (Eds.), *Cognitive Behaviour Therapy for Acute In-patient Mental Health Units: Working with Clients, Staff and the Milieu*. London: Routledge.
- Craig, A.R., Franklin, J.A. & Andrews, G (1984). A scale to measure locus of control of behaviour. *British Journal of Medical Psychology*, 65, 131–145.
- Davis, W. (2001). *The RAID Manual: A Relentlessly Positive Approach to Working with Extreme Behaviour* (3rd Ed). Leicester: Association for Psychological Therapies.
- Department of Health (2009). *New Horizons: A Shared Vision for Mental Health*. London: Author.
- Department of Health (2008). *High Quality Care for All: NHS Next Stage Review – Final Report*. London: Department of Health.
- Department of Health (2006a). *From Values to Action: The Chief Nursing Officer’s Review of Mental Health Nursing*. London: Her Majesty’s Stationery Office.
- Department of Health (2006b). *Our Health, Our Care, Our Say: A New Direction for Community Services*. White paper. London: Department of Health.

- Department of Health (2004a). *Creating Capable Teams and Ten Shared Capabilities*. London: Author.
- Department of Health (2004b). *The National Service Framework for Mental Health – Five Years On*. London: Author.
- Department of Health (2004c). *Organising and Delivering Psychological Therapies*. London: Author.
- Department of Health (2002a). *Community Mental Health Teams Mental Health Policy Implementation Guide*. London: Her Majesty's Stationery Office.
- Department of Health (2002b). *Mental Health Policy Implementation Guide: Adult Acute In-patient Care Provision*. London: Her Majesty's Stationery Office.
- Department of Health (2002c). *National Suicide Prevention Strategy for England*. Department of Health. London.
- Department of Health (2001). *Treatment Choice in Psychological Therapies and Counselling: Evidence-Based Practice Guideline*. London: Author.
- Department of Health (2000). *The National Plan for the NHS*. London: Author.
- Department of Health (1999). *National service framework for mental health: Modern standards and service models*. London: Her Majesty's Stationery Office.
- Department of Health (1996). *NHS Psychotherapy Services in England: Review of Strategic Policy*. London: Author.
- Dimeff, L.A. & Koerner, K. (2007). *Dialectical Behavior Therapy in Clinical Practice: Applications Across Disorders and Settings*. New York: Guildford Press.
- Driscoll, J. & Teh, B. (2001). The potential of reflective practice to develop individual orthopaedic nurse practitioners and their practice. *Journal of Orthopaedic Nursing*, 5, 95–103.
- Durrant, C. & Tolland, A. (2008) Evaluating short-term CBT in an acute adult in-patient unit. In I. Clarke & H. Wilson (Eds.), *Cognitive Behavior Therapy for Acute In-patient Mental Health Units: Working with Clients, Staff and the Milieu*. Hove: Routledge. 185–197.
- Durrant, C., Clarke, I., Tolland, A. & Wilson, H. (2007). Designing a CBT service for an acute in-patient setting: A pilot evaluation study. *Clinical Psychology and Psychotherapy*, 14, 117–125.

- Evans, K., Tyler, P., Catalan, J., Schmidt, U., Davidson, K., Dent, J. et al. (1999). Manualised assisted cognitive-behaviour therapy (MACT): A randomised controlled trial of a brief intervention with bibliography in the treatment of recurrent deliberate self-harm. *Psychological Medicine*, 29, 19–25.
- Fonagy, P., Gergely, G., Jurist, E.L. & Target, M. (2004). *Affect Regulation, Mentalisation, and the Development of the Self*. London: Karnac.
- Freemantle, B. & Clarke, I. (2008). Making sense of psychosis in crisis. In I. Clarke & H. Wilson (Eds.) *Cognitive Behaviour Therapy for Acute In-patient Mental Health Units: Working with Clients, Staff and the Milieu*. London: Routledge.
- Gilbert, P. (2006). Compassionate mind training for people with high shame and self-criticism: Overview and pilot study of a group therapy approach. *Clinical Psychology and Psychotherapy*, 13, 353–379.
- Goodwin, I., Guy, H., Cochrane, R. & Mason, O. (2003). The ability of adult mental health services to meet clients' attachment needs: The development and implementation of the Service Attachment Questionnaire. *Psychology and Psychotherapy: Theory, Research and Practice*, 76, 76–145.
- Hartley, P. & Kennard, D. (Eds.) (2009). *Staff Support Groups in the Helping Professions: Principles, Practice and Pitfalls*. Sussex: Routledge.
- Healthcare Commission (2008). *The Pathway to Recovery: A Review of NHS Acute Mental Health Services*. London: Commission for Healthcare Audit and Inspection.
- Hill, G., Clarke, I. & Wilson, H. (2008). The 'Making Friends with Yourself' and the 'What is Real and What is Not' groups. In I. Clarke & H. Wilson (Eds.), *Cognitive Behavior Therapy for Acute In-patient Mental Health Units: Working with Clients, Staff and the Milieu* (pp.161–173). Hove: Routledge.
- Johnstone, L. & Dallos, R. (2008). *Formulation in Psychology and Psychotherapy: Making Sense of People's Problems*. London: Routledge.
- Kinderman, P. (2005). A psychological model of mental disorder. *Harvard Review of Psychiatry*, 13, 206–217.
- Lake, N. (2008) Developing Skills in Consultation 2: A Team Formulation Approach. *Clinical Psychology Forum*, 186.
- Layard, R. (2006). The case for psychological treatment centres. *British Medical Journal*, 332, 1030–1032.

- Linehan, M.M. (1993). *Cognitive-behavioural Treatment of Borderline Personality Disorder*. New York: Guildford.
- Manpower Advisory Service (1989). *Review of Clinical Psychology Services*. Cheltenham: Author.
- Mental Health Network and National Mental Health Unit (2009). *Acute Care Declaration*. London: Author.
- Mind (2011). *Listening to Experience: An Independent Inquiry Into Acute and Crisis Mental Health Care*. London: Author.
- Mind (2004). *Ward Watch: Mind's Campaign to Improve Hospital Conditions for Mental Health Patients*. London: Author.
- Mind (1999). *Creating Accepting Communities: Social Exclusion and Mental Health Problems*. London: Author.
- National Audit Office (2010). *Helping People Through Mental Health Crisis: The Role of Crisis Resolution and Home Treatment Services*. London: Author.
- National Institute for Clinical Excellence (2010). *Schizophrenia: Core Interventions in the Treatment and Management of Schizophrenia in Adults in Primary and Secondary Care (update)*. London: Author.
- National Institute for Clinical Excellence (2009a). *CG78 Borderline Personality Disorder Quick Reference Guide*. London: Author.
- National Institute for Clinical Excellence (2009b). *Depression: Management of Depression in Primary and Secondary Care (update)*. London: Author.
- National Institute for Clinical Excellence (2006). *The Management of Bipolar Disorder in Adults, Children and Adolescents in Primary and Secondary Care*. London: Author.
- National Institute for Clinical Excellence (2005a). *Anxiety: Management of Post-traumatic Stress Disorder in Adults in Primary, Secondary and Community Care*. London: Author.
- National Institute for Clinical Excellence (2005b). *Obsessive Compulsive Disorder: Core Interventions in the Treatment of Obsessive Compulsive Disorder and Body Dysmorphic Disorder*. London: Author.
- National Institute for Clinical Excellence (2004a). *Anxiety: Management of Anxiety in Adults in Primary, Secondary and Community Care*. London: Author.
- National Institute for Clinical Excellence (2004b). *Depression: Management of Depression in Primary and Secondary Care*. London: Author.

- National Institute for Clinical Excellence (2004c). *Eating Disorders: Core Interventions in the Treatment and Management of Anorexia Nervosa, Bulimia Nervosa and Related Eating Disorders*. London: Author.
- National Institute for Clinical Excellence (2004d). *Self Harm: The Short-term Physical and Psychological Management and Secondary Prevention of Self-harm in Primary and Secondary Care*. London: Author.
- National Institute for Clinical Excellence (2002). *Schizophrenia: Core Interventions in the Treatment and Management of Schizophrenia in Primary and Secondary Care*. London: Author.
- National Institute for Mental Health in England. (2005). *Guidance on New Ways of Working for Psychiatrists in a Multi-disciplinary and Multi-agency Context*. London: Author.
- National Institute for Mental Health in England (2004a). *Acute In-patient Mental Health Care*. London: Author.
- National Institute for Mental Health in England (2004b). *Emerging Best Practices in Mental Health Recovery*. London: Author.
- National Institute for Mental Health-England (2003). *Personality Disorder: No Longer a Diagnosis of Exclusion*. London: Author.
- NHS Scotland (2011). *Local Delivery Plan Guidance for 2012/13*. Edinburgh: The Scottish Government.
- Onyett, S. (2007). *Crisis Resolution Teams in England – Why Do They Work? What Is The Current State Of Implementation? Presentation To The Oxleas Nhs Foundation Trust*. Leicester: The British Psychological Society.
- Rendle, A. & Wilson, H. (2008). Delivering dialectical behavior therapy based emotional coping skills group across diagnostic groups. In I. Clarke & H. Wilson (Eds.) *Cognitive Behavior Therapy for Acute In-patient Mental Health Units: Working with Clients, Staff and the Milieu* (pp.173–183). Hove: Routledge.
- Romme, M. & Escher, S. (1989) *Accepting Voices*. London: Mind Publications.
- Royal College of Psychiatrists Centre for Quality Improvement (2009). *Accreditation for Acute In-patient Mental Health Services. Standards for Acute In-patient Wards – Working age adults*. (3rd ed.) London: Author.
- Sainsbury Centre for Mental Health (2005). *Acute Care 2004: A National Survey of Psychiatric Wards in England*. London: Author.
- Sainsbury Centre for Mental Health (2004). *Acute In-patient Mental Health Care: Education, Training and Continuing Professional Development for All*. London: Author.

- Sainsbury Centre for Mental Health (2002). *An Executive Briefing on Adult Acute In-patient Care for People with Mental Health Problems*. London: Author.
- Sainsbury Centre for Mental Health (2001). *Users' Voices: The Perspective of Mental Health Service Users on Hospital and Community Care*. London: Author.
- Sainsbury Centre for Mental Health (1998). *Acute Problems: A Survey of the Quality of Care in Acute Psychiatric Wards*. London: Author.
- Scottish Government and NHS Education Board for Scotland (2008). *Delivering Psychological Therapies – The Matrix*. Edinburgh: Author.
- Samuelsson, M., Wiklander, M., Asberg, M. & Saveman, B.I. (2000). Psychiatric care as seen by the attempted suicide patient. *Journal of Advance Nursing*, 32(3).
- Wilkinson, J. (1999). Implementing reflective practice. *Nursing Standard*, 10(13), 36–39.

Glossary

ACF	Acute care forum
AIMS	Accreditation of In-patient Mental Health Services
AOT	Assertive Outreach Team
BPS	British Psychological Society
CAST	Consultancy and Support Team
CBT	Cognitive behavioural therapy
CMHT	Community Mental Health Team
CPD	Continuing professional development
CQC	Care Quality Commission
CRHT	Crisis Resolution and Home Treatment
DCP	Division of Clinical Psychology
DH	Department of Health
ECS	Emotional coping skills
EIP	Early intervention in psychosis
HCC	Health Care Commission
IAPT	Improving Access to Psychological Therapies
KPI	Key performance indicators
MAS	Manpower Advisory Service
MDT	Multi-disciplinary team
MHP	Mental health practitioner
Mind	A national mental health charity
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NIMHE	National Institute for Mental Health in England
NSF	National Service Framework
PICU	Psychiatric Intensive Care Unit
RCPsych	Royal College of Psychiatrists
RCT	Randomised controlled trial
SCMH	Scottish Commission for Mental Health
SEMI	Severe and enduring mental illness
WRAP	Wellness Recovery Action Plan

The British Psychological Society

St Andrews House, 48 Princess Road East, Leicester LE1 7DR, UK

Tel: 0116 254 9568 Fax: 0116 227 1314 E-mail: mail@bps.org.uk Website: www.bps.org.uk