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LITERATURE REVIEW

Psychological services within the Acute Adult Mental Health Care Pathway

Guidelines for service providers, policy makers and decision makers.

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1. Introduction

This paper will review the literature on psychological services within three areas of the Acute Adult Mental Health Care Pathway; Acute Mental Health Inpatient Services (AMHIS), Crisis Resolution Home Treatment Teams (CRHTT) and then Mental Health Liaison Services (MHLS).

2. Acute Mental Health Inpatient Services

It has been recommended that inpatients should have access to a range of evidence based therapeutic interventions, and resources should be sufficient to ensure a psychologist is part of the Multidisciplinary Team (MDT) to 'contribute to the assessment and formulation of the patients' psychological needs and the safe and effective provision of evidence based psychological interventions' (RCP, 2019). Also, that ward leadership teams have a ward manager, psychiatrist and senior professional such as a consultant psychologist (Crisp et al., 2016). Currently access to psychology differs across services, with some poorly resourced.

2.1 DIRECT INTERVENTIONS

Practitioner psychologists have the training and skills to deliver a range of adapted brief direct interventions with service users. Psychologists have identified that developing a psychologically informed formulation of current problems, how these relate to past experiences, the factors that might be maintaining difficulties, the strengths people have and their goals can be helpful in guiding treatment (Ebrahim, 2021). Formulations should be developed in collaboration with service users and carers wherever possible (BPS, 2011; ACP-UK, 2021). There are a range of models which can enable the shared understanding process (e.g. Clarke & Nicholls, 2018; Kuyken et al., 2009). Psychologically informed formulation can support service users to feel understood and engagement in treatment goals (Bullock et al., 2020). A Cognitive Behaviour Therapy based 'Comprehend, Cope and Connect' single session intervention developing a shared formulation using the model was evaluated with 23 acute inpatient and crisis team service users (Bullock et al., 2020). The service user group is described as having a range of complex mental health difficulties including depression, personality and psychosis related issues. There was a significant increase in positive mood, moderate to high level of acceptance of the formulation, and a positive engagement goal based activity post intervention to promote stabilisation of mental health crisis. Neuropsychological assessment when appropriate can help to inform staff about cognitive strengths and weaknesses supporting improved communication and person centred behavioural support plans.

Psychologists have noted the value of adapted brief interventions to support individuals skill development, for example, to manage emotions, manage anxiety or build problem solving ability (Ebrahim, 2021). Group based and family interventions can all be helpful in supporting positive outcomes and transitions to community. For example, a brief CBT intervention to improve sleep (Sheaves et al., 2017). Provision of emotion-focused formulation sessions as well as groups (e.g. DBT, mindfulness, anxiety management and psychotic symptom management), or individual skills work with service users has been linked to decrease in distress, and significant increases in confidence in self-management of mental health (Araci & Clarke, 2017, Paterson et al., 2018). There is also evidence of a positive impact of psychological interventions with people experiencing psychosis (Wood et al., 2020), and EMDR to enable processing of trauma (Proudlock & Peris, 2020). Evaluation of the use of

virtual reality in enabling coping with anxiety and psychosis for people in inpatient services is currently underway (Brown et al., 2020). This could help promote confidence in people who avoid situations in the community, for example, cafes or shops due to anxiety.

Service user feedback has also indicated the value of psychologists working within acute mental health inpatient settings. A qualitative study indicated service users during admission noted access to talking therapies, the integration of their social context and trauma into care, and improved collaboration about their care as priorities (Wood et al., 2019). It was noted that psychological therapy played an important role in meeting these priorities. Another study which focused more specifically on service users and therapists' experiences of psychological therapy delivered during an inpatient admission identified a number of aspects of therapy which were valued. This included the importance of developing a human relationship, the opportunity to make sense of their mental health crisis, and shared decision making within the therapeutic process (Small et al., 2018).

While there is debate about the legitimacy and utility of diagnosis (Johnstone, 2019), people who present in acute mental health wards with a difficulties meeting the criteria for Emotionally Unstable Personality Disorder (EUPD) have been associated with the highest level of risk of harm, and readmission rates (Tulloch et al., 2016). Furthermore, research indicates that long admissions can be detrimental and psychological interventions are indicated as helpful in supporting this group of service users in developing positive ways of coping (NCISH, 2018). It has been recommended that risk of suicide and self-harm are always assessed biopsychosocially (BPS, 2017), and systematic reviews evidence that psychological therapies help prevent the repetition of self-harm in adults (which is linked to increased risk of suicide) and reduce psychological distress (Hawton et al., 2016, 2016a). This indicates that without adequate access to psychological interventions within acute inpatient services service users may be more likely to experience harmful effects of admissions.

2.2 INDIRECT INTERVENTIONS

The value of a range of indirect interventions by psychologists has been noted including attendance at team and service meetings, provision of consultation and supervision to help embed skills into practice, training to increase psychological understanding and skills in the workforce, service development and evaluation (Ebrahim, 2021). Working with the wider system, and adapting psychological therapies for the inpatient environment have also been seen as important (Wood et al., 2019). Being an integral part of inpatient teams, for example, through attendance at daily MDT meetings has been identified as influencing the culture and understanding of individual's difficulties within teams, and fostering joint working.

Psychologists have noted the value of their skills in delivering a range of training for clinical staff, for example, on assessment and formulation, understanding trauma, psychosis, developing motivation and working collaboratively with clinical risk, CBT, using psychometric tools, and responding to behaviour that teams find challenging to help de-escalate conflict (Ebrahim, 2021). Group facilitation skills are also developed in other staff which enables increased availability of skills coaching for service users (Araci & Clarke, 2017).

A study of Multi-Disciplinary Team (MDT) perspectives (e.g. psychiatrists, nurses and occupational therapists), identified that psychology was seen as a valued part of the team (Wood et al., 2018). Integrated psychological working where the psychologist was visible and accessible, offered of formal and informal consultation and feedback, support for the staff team, and regularly shared psychological perspectives of service user's difficulties was particularly valued. The MDT also valued the development of psychological formulations about service users' difficulties, and the delivery of individual and group psychological interventions, similar to earlier findings (Clarke, 2015).

2.3 EVALUATION OF PSYCHOLOGICAL INTERVENTIONS IN ADULT MENTAL HEALTH INPATIENT SERVICES

Evaluation of psychological interventions in inpatient services is fairly limited with studies lacking methodological rigour, and reporting on a range of outcomes making comparisons difficult (Jacobsen et al., 2018). Adaptations to treatment delivery were noted including increased frequency of sessions, shorter sessions, briefer interventions and use of single-session formats.

A range of measures have been used to evaluate gains from direct psychological interventions, while recognising it is difficult to isolate their impact when a range of interventions are being provided during an inpatient admission. ReQol (2015) helps to assess confidence in ability to undertake personal goals and meaning in life. The Mental Health Confidence Scale, focuses on self-efficacy (Carpinello et al., 2000) and the Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS), Stewart-Brown et al. (2009), measures wellbeing. Psychological practitioners also endorse using measures of progress towards self-identified goals, for example, Deane et al. (1997). Evaluating the impact of indirect interventions is complex; measures such as the Team Formulation Quality Scale (Bucci et al., 2019) enable this.

A systematic review indicated that psychological therapies were effective for reducing depression and anxiety symptoms as well as re-admissions in acute inpatient settings. There were also significant reductions symptoms of psychosis during admissions, however this benefit was not present at a six month follow-up, suggesting ongoing intervention may be important for this client group (Paterson et al., 2018). How evidenced-based psychological therapies are adapted and delivered in inpatient services and other areas of the acute care pathway requires further research (Berry & Raphael, 2019).

3. Crisis Resolution Home Treatment Teams (CRHTT)

3.1 DIRECT PSYCHOLOGICAL INTERVENTIONS

Psychological practitioners in CRHTT's have indicated the value of a range of direct and indirect interventions similar to those within acute inpatient services (Ebrahim, 2021). Research suggests a number of potential beneficial areas for psychological intervention with service users accessing CRHTT services, such as factors linked to suicidal ideation like perceived burdensomeness and entrapment (O'Connor & Portzky, 2018). Psychological practitioners are well-placed to meet the challenge of developing and evaluating such interventions. Indeed, practitioners within CRHTTs may be particularly well-placed to reach parts of the population who may not typically come into contact with mental health services, such as middle-aged men (Sullivan & Whiteley, 2019), which is a priority area for suicide prevention (Struszczyk et al., 2019).

Beneficial direct interventions include crisis assessment and formulation, promoting safety planning, problem solving and psychoeducation, addressing essential social needs and promoting social connection (Sullivan, 2018). Group based interventions may be helpful in increasing access to scarce psychological resources for service users, for example,. Solution Focussed Therapy, increasing the cost effectiveness of treatment (Proudlock & Wellman, 2011). One example was a carers group co-facilitated with a carer, focused on positive risk taking within day-to-day life decisions, balancing 'intervening' with empowerment and enabling responsibility to be held by the individual to promote recovery (Preston, 2019). Brief interventions such as Eye Movement Desensitisation and Reprocessing (EMDR) can be delivered with CRHTT service users expressing a strong desire and intent to die by suicide, with good outcomes (Proudlock & Hutchins, 2016).Offering immediate access to specialised treatment can reduce costs associated with further psychological treatment in the community, however more research is needed in this area (Proudlock & Peris, 2020).

3.2 INDIRECT PSYCHOLOGICAL INTERVENTIONS

The value of a psychological perspective in multi-disciplinary team working has also been noted (Murphy et al., 2013). Practitioners have emphasised their role in supporting team wellbeing, for example, through facilitating sessions on mindfulness, stress management and resilience. They also provided reflective practice and team supervision, supporting systemic formulations. They identified enabling broader delivery of psychologically informed approaches through training provision for other staff, and service development, for example, promoting a trauma-informed care approach (Ebrahim, 2021).

4. Mental Health Liaison Services (MHLS)

4.1 BACKGROUND TO PSYCHOLOGY WITHIN MENTAL HEALTH LIAISON SERVICES

MHLSs are effective in providing mental health assessment and brief intervention for patients presenting with mental health difficulties within a general hospital setting (Mehboob, 2020). This often involves assessing people urgent mental health needs, usually presenting to the Emergency Department, people with complex co-morbid physical and mental health difficulties, medically unexplained symptoms, cognitive impairment (including delirium, depression and dementia) and people frequently attending hospital with complex social, physical and psychological needs link (JCP-MH, 2012).

There is significant variation in the configuration of MHLSs across the UK based on hospital size, acuity, location and speciality (House et al., 2018; Walker et al., 2018), with only 23 per cent of MHLSs in England reported to have psychological therapists (Walker et al., 2018). These differences are also reflected in the clinical activity of Practitioner Psychologists in MHLS. For example, the remit of psychological input may depend on the MHLS model adopted, as well as specialist services within the hospital such as whether the hospital has a major trauma centre or a Clinical Health Psychology service.

4.2 DIRECT INTERVENTIONS

Despite limited published research about the role of psychologists within MHLS, practitioner psychologists advocate for a breadth of psychological input. This includes direct psychological assessment, formulation and (where appropriate) brief intervention across ward-based setting for adults and older adults, including neuropsychological assessment (Browne, 2019; Ebrahim, 2021). Other direct psychological input includes the provision of outpatient clinics specifically for people who have presented to the Emergency Department with urgent mental health needs. Usually this will focus on clinical complexity and self-harm presentations, with the aim of reducing need to represent to liaison services in the future, or to enable access to other parts of the crisis care pathway. McCabe et al. (2018) presented a meta-analysis of four international controlled studies looking into the impact of brief psychological interventions for people presenting at emergency departments with suicidal ideation. They found the main interventions were therapeutic engagement, provision of information provision, and safety planning development with follow-up contact. The interventions drew on psychological theory and techniques. Two of the studies showed fewer suicide attempts, one showed fewer suicides and one found an effect on depression indicating brief psychological interventions appear to be effective in reducing suicide and suicide attempts. Psychological input is also valuable into the case management and care planning of frequent attenders to acute hospitals. Psychologists can assist with correctly identifying onward referrals to meet psychological needs through being part of the MDT.

Psychologists can provide neuropsychological assessments where delirium is not suspected but cognitive problems persist (this may include effort testing where memory difficulties are queried to be functional). Psychologists can provide more detailed formulations which can help identify factitious disorder and less conscious secondary gain to ensure patients are moved out of hospital and on correct pathways (Ebrahim, 2021). Some liaison services support patients with persistent

physical symptoms and long term conditions, and with Medically Unexplained Symptoms; psychology can enable assessment, formulation with outpatient clinics to provide brief interventions where appropriate (Ebrahim, 2021). These psychological provisions are in line with national recommendations that MHLS models (Core, Enhanced and Comprehensive) should offer brief evidence-based psychological interventions as inpatient or short-term outpatient follow up (NICE, 2016; RCP, 2020).

4.3. INDIRECT INTERVENTIONS

The importance of having psychologists as a fully integrated part of MHLS multi-disciplinary teams has been consistently highlighted (Aitken et al., 2014; Parsonage et al., 2012). Practitioner psychologists emphasise the need for psychology to be integral to liaison services and that they provide psychological understanding to all aspects of the delivery of care (Ebrahim, 2021). They are skilled in delivering a range of indirect interventions including consultation, clinical supervision, post incident support, and training both to MHLS and acute trust colleagues (Aitken et al., 2014; Browne, 2019; O'Neill et al., 2018; RCP, 2020). Provision of clinical supervision supporting assessment, formulation and brief interventions ensuring a biopsychosocial model with person centred formulation at its core can enable effective care (Ebrahim, 2021).

Training, for example, in mental health awareness, understanding trauma and its impact on relationship patterns and personality, and managing behaviour which is challenging to teams can be helpful for acute hospital staff, promoting more compassionate care for those with mental health needs. Contributing to teaching of psychiatry trainees is also important. This can help to challenge misconceptions, for example, on mental health and psychological responses to physical illness, raising the profile of evidence based interventions for the various conditions that present in acute hospital settings (Ebrahim, 2021).

5. Summary

There is a need for further research about the effectiveness of adapted evidence based psychological interventions within AMHISs, CRHTT and MHLS contexts. However, the research available suggests that such interventions can have direct benefits for service users in supporting the development of shared understandings of mental health difficulties, skills development and resolution of trauma based difficulties, and collaborative crisis planning which can decrease the need for repeated service use.

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