

Psychologists' perspective on the delivery of psychological therapy for psychosis in the acute psychiatric inpatient setting.

Abstract

Psychological therapies should be delivered in psychiatric inpatient settings to people experiencing psychosis. However, inpatient populations present with complex needs, and usually admitted only briefly. This makes the delivery of psychological therapies for people experiencing psychosis particularly challenging. Our aim with this study was to explore the adaptations required to deliver psychological therapies to this population from the perspective of inpatient psychological practitioners. Twelve participants were recruited, and a qualitative semi-structured interview schedule was administered examining their perspectives on important factors required to deliver psychological interventions in this context. Data were analyzed using thematic analysis. Three superordinate themes were identified “crisis-focused psychological approaches, “working with and supporting the wider system”, and “environmental adaptations”. Traditional psychological therapies are a challenge to deliver in inpatient environments due to complex needs, essentiality of team working, and brief admission. Several adaptations are required to ensure psychological therapy is effective in this setting.

Introduction

Psychiatric inpatient care has changed dramatically over the last two decades due to a significant reduction in inpatient beds and rise in compulsory detention (Department of Health, 2017). As a consequence, psychiatric hospitals are often caring for people with extremely complex acute difficulties with only an average window of three weeks to provide care and support recovery (The Kings Fund, 2017). Patients and staff often report that hospitalization is not optimizing its opportunity to provide high quality and effective care to inpatients (Care Quality Commission, 2009). The government's five year forward view (2016) stated that there was a systematic failure in the delivery in psychiatric inpatient care, and the recent Mental Health Act (MHA) review (2017) demonstrated that there need to be interventions which reduce admissions to psychiatric hospital. Approximately 62% of people hospitalized experiencing psychosis (NHS Benchmarking, 2016) and as a result, psychiatric inpatient care is the largest direct cost of psychosis with costs continuing to rise (Mangalore & Knapp, 2007).

Psychological therapies for psychosis, such as Cognitive Behavioral Therapy (CBT), are recommended by the National Institute of Health and Clinical Excellence (NICE, 2014) for psychosis, and can begin in the acute stages. There is extensive evidence that psychological therapies for psychosis are effective with both inpatient and community populations, and effect sizes are comparable to medical treatments (Wykes et al., 2008). However, there are significant barriers to delivering NICE-recommended psychological interventions, with a recent systematic review demonstrating that implementation rates for NICE-recommended psychological therapies range from 4% to 100%. They identified barriers to the delivery of CBT included negative management and poor team attitudes towards psychology, psychological needs not being prioritized by teams, and lack of resource (Ince, Haddock, & Tai, 2015). Problematically, the inpatient setting has similar

and if not more implementation barriers. For example, it is recommended that 16 to 24 weekly sessions of therapy are offered, which is not achievable within the current inpatient context of brief admissions.

A recent systematic review of the evidence base demonstrated that psychological therapies are effective for the inpatient experiencing psychosis in reducing overall symptoms, depression and functioning. However, there were limited psychological therapies which had been adapted to be delivered in the present psychiatric inpatient context (Jacobsen et al., 2018). In other words, there has not been the development of a brief intervention deliverable within the three-week inpatient treatment window. Given the context of forced treatment, brief admission, complex presentation and risk, there is a need to examine what adaptations are required to deliver psychological therapies within the acute psychiatric inpatient setting for the psychosis population.

To the author's knowledge, only one relevant qualitative study has been conducted to examine psychologist's experiences of psychological therapies in the acute psychiatric inpatient setting (Small et al., 2018). The authors identified that key components of inpatient psychological interventions were psychological formulation and the promotion of a therapeutic relationship. However, this study did not aim to examine whether adaptations are required to deliver psychological therapies effectively in this setting. Other qualitative studies have been conducted to identify some of the important roles of an inpatient psychologist, including conducting staff formulation sessions (Berry, Barrowclough, & Wearden, 2009) and attending ward rounds to share psychological perspectives (Christofides, Johnstone, & Musa, 2012), but again no studies have examined the collective role of a psychologist to deliver psychological therapies in this setting. The aim of this study was to examine the key adaptations required to deliver psychological therapies to people with psychosis within the acute psychiatric inpatient setting from the perspective of psychological practitioners.

Method

Design: Qualitative semi-structured interviews were conducted with psychology practitioners to identify adaptations required to undertake psychological therapies for psychosis within the acute psychiatric inpatient setting. This study was approved by the Health Research Authority (IRAS 222917).

Participants: Participants were psychological staff recruited from psychiatric inpatient services in an inner London locality. Twelve psychological practitioners were recruited and met the following inclusion criteria (a) had a relevant British Psychological Society/Health and Care Professions Council/British Association of Behavioral and Cognitive Psychotherapies accredited qualification in psychology or psychological therapy (including undergraduate degrees), (b) were either a clinical psychologist, counselling psychologist, psychological therapist, CBT therapists, trainee clinical psychologist, trainee counselling psychologist, or assistant psychologist, (c) had at least six months clinical experience working in a psychiatric inpatient setting, (d) had at least six months experience of working therapeutically with people who experience psychosis. No exclusion criteria were specified.

Data collection and Procedure: The research was undertaken by four mental health professionals and academics that all practice in mental health settings¹. This undoubtedly impacted on this research and this has been accounted for by reflecting upon this in the discussion.

A semi-structured interview schedule was developed by authors LW and CW. A Patient and Public Involvement Panel (PPI), as well as inpatient psychologists, were consulted about the schedule and contributed to the final version. As independent researchers, authors JB and SJ also refined the interview schedule to ensure it was reflective of the broader inpatient

setting. The interview examined the therapeutic needs of psychiatric inpatients with psychosis and the adaptations required to deliver cognitive-behavioral therapies within the ward setting. Prompts were used when the area of interest was not raised by the participant. The interview length ranged from 36 to 66 minutes. Patient participants were recruited through inpatient ward staff who identified potential participants and informed them of the study. Participants gave full informed consent was given before undertaking the interview.

Data analysis: All interviews were recorded and transcribed verbatim. All data was entered into NVivo 11 (2017) for purposes of analysis. A thematic analysis approach was utilized to analyze data (Braun & Clarke, 2006). Thematic analysis was used from a critical realist position which states that which assumes that individuals have idiosyncratic interpretations of their reality but that there are tangible constructs which can be measured and observed (Braun & Clarke, 2006). An inductive approach to data analysis was taken with latent themes being identified. Data analysis was primarily undertaken by LW. LW read transcripts several times to be fully immersed in the data. Line-by-line coding was undertaken for each individual interview. Once all interviews were coded, codes were collapsed across interviews and categorized. Analytical themes were developed and discussed with the independent members of the research team to ensure analysis was data-driven. The analysis was presented to half of participants who took part in the study who commented on the overall structure and individual themes. They all reported that the analysis captured the key adaptations required for psychological therapy. They felt the focus on crisis and risk management needed to be emphasized, as well as the crucial role of working with the multidisciplinary team. From this the final theme structure was developed.

Results

Participant Demographics

Twelve participants took part in the study and their demographics can be found in table 1. Most participants were qualified psychologist (66.66%), female (75%) and had an average of 4.88 (SD: 6.20) years working in psychiatric inpatient settings. All participants practiced Cognitive Behavioral Therapy (CBT) but differed in their therapeutic orientations.

[INSERT TABLE 1 HERE]

Participant Analysis

Three superordinate themes were identified from the analysis, “crisis-focused psychological approaches”, “working with and supporting the wider system” and “environmental adaptations” (table 2).

[INSERT TABLE 2 HERE]

Crisis-focused psychological interventions

The first superordinate theme outlined the important adaptations to routine psychological interventions required to meet the needs of patients who are in crisis. These adapted psychological approaches had to be person-centered and had to be delivered within the context of a quickly established therapeutic relationship.

Discharge goals, distress reduction and crisis planning

The dominant goal for therapy was to facilitate discharge through distress reduction and crisis management. Participants described a conflict in goals between inpatient staff and patients, but that discharge was a priority for all stakeholders and therefore an appropriate goal for psychological therapy.

“I think the things that stand out are people want to get discharged”

“it’s about crisis intervention, it’s about risk managing, it’s about thinking about the longer term discharge plan, because you’re only serving someone at a stage in their recovery, or a stage in their crisis and it’s about thinking about how that care pathway is going to translate once they move hospital, it’s a small (s.l. stove) in the context of larger things, if that makes sense”.

Developing a crisis narrative

A more informal narrative assessment was imperative to both develop an immediate rapport with the patient whilst also gathering important assessment information to inform psychological work and the wider team care plan.

“people come into the ward at different stages of crisis, and it’s ... I suppose, for me, it’s about finding a window of opportunity – as I often call it – about how to engage with these inpatients who’ve come in. My experience has been that people are at different stages. And often, when I think back, with the people I have managed to engage with, there is ... it’s just helping them to try and form a narrative of their experience of what’s going on right now, and looking at their levels of distress at the time – and then how does one engage with that”

Crisis and risk formulation development

Participants spoke about the importance of developing a maintenance formulation – over a longitudinal one – which focused on the reasons for admission. This incorporated key crisis symptoms and risk factors based on a cognitive-behavioral framework.

“like a hot cross bun type formulation developed with him to show him okay, well I suppose all the while you’re, you’ve got this thought that the neighbors are in danger, you’re perhaps feeling highly concerned and anxious about them, so what you do is you sit

outside and guard their house, you're probably really tense and hyper vigilant and aroused, looking out for the danger..."

Crisis-focused change mechanisms

All participants spoke about adapting key change mechanisms for use with people experiencing an acute crisis. The most dominantly used change mechanisms were psychoeducation, normalization, mindfulness and behavioral activation, which were seen as the most important strategies to be utilized within an inpatient setting.

"I guess psychoeducation is an important part. I guess I feel like psychoeducation about all sorts of different things is really helpful"

"I always try to do a making sense of this admission session. Why now? Why this time? What's different about this time to maybe the other times or the times where you didn't come in? Yeah, making sense of that. Acknowledging how difficult, whatever it was, has been. Maybe trying not to be blaming and put all the responsibility on them as well. Normalizing and well, rationalizing I guess"

Standalone group interventions

Participants spoke about the importance of group interventions, which could be delivered in a standalone format, i.e. that patients could attend one session and derive benefit. Ad hoc groups were also described as beneficial. This was due to high patient turnover and the likelihood of patients' being discharged before attending a full course of groups. Managing the dynamics of a group with complex patients was described as a significant challenge.

"I think there are some good groups here that run over a few weeks period, that actually do work quite well as standalone sessions..."

"Sometimes in a group it can be difficult to manage the dynamics. I notice some patients feel uncomfortable [door bangs unclear-25:22] some of the patients that are kind of more obviously unwell"

Stepped care inpatient psychology

A stepped-care approach to psychological interventions was deemed important to meet the demands of a rapidly changing complex client population. The assistant psychologists were important to the integration of psychology into the multi-disciplinary team (MDT) as they worked full-time on the ward and were able to promote psychological ways of thinking.

“Having an assistant there makes a difference; because you’ve got somebody... there is somebody who can hold onto what you are doing. You can at least hand things over to them at the end of the shift...Because otherwise it just gets lost”

Working with complexity and high risk

The next subtheme related to conducting psychological therapy with patients who present with complex mental health difficulties. Acute mental health experiences usually were intertwined with risk issues. Participants spoke about actively trying to work with those who have complex presentations to prevent repeat admissions.

“What I’m trying to do is actively pick out people who are high risk or repeat admission to try and make sure that we get access to those people and do some thinking and planning...what are you doing extra for that person to prove that everything possible is done. Their risk behavior, it’s not just their risk behavior, people don’t just stab themselves there’s good reasons for it and its trying to understand that”

It was noted that a different approach was required to working with those who are experiencing their first episode and first hospital admission compared to those who have had several admissions. For those with a first episode it was essential to offer a space and information on hospital whereas those with multiple admissions the priority was targeting factors causing readmission.

“I’m sure there were lots of people who were kind of more kind of repeat admissions that are also really scared as well but I guess it felt slightly different [with people experiencing a first episode]. It feels like a lot more shocking I think for the people who have never been to hospital”

Addressing distressing ward experiences

Participants spoke about the importance of giving inpatients the space to discuss the impact that admission and inpatient care has had on their well-being and mental health. Admission and ward treatment was often described as traumatic for patients.

“Often people’s experience of admission [is an important topic for conversation], for some people it’s been really traumatic and for some people they were quite happy to come in and then sometimes it’s kind of gone on to being traumatic”

Working with and supporting the wider system

The second superordinate theme identified the importance of working with the system around the client. This included both social networks and mental health teams (inpatient and community) to facilitate effective psychological care.

Formulation-informed team working

Participants discussed the vital role of formulation-informed formal and informal contributions within the MDT. It was an essential means to communicate effectively in a variety of team settings including ward round, handover, professionals’ meetings and care planning meetings.

“being able to come and provide a formulation around what may be going on for the client, but also maybe what’s going with the team”

“And it’s really valuable being integrated in the team, because being on the floor and being around and seeing the dynamics, you can help people think about that”

Communication and feedback

Communication and feedback to the MDT (inpatient and community) was deemed essential for psychological input to be effective. Psychological therapies could not be offered in isolation. Communication and feedback came in many forms including email summaries, report writing, informal conversations and in formal meetings.

“I communicate to whole team so if I’m running a group or doing one-to-ones I always give feedback to the nursing team then to the qualified psychologist and then this morning to the MDT handover... on my ward they are very medical, so I think have a different perspective is very helpful”

Formal and informal staff support

A crucial role to the delivery of inpatient psychology was supporting the staff in their roles to help them support patients. Supporting staff reflective practice was important to the delivery of a more integrative approach to service delivery.

“you always have to consider, is there something you can do to support the staff to enable them to manage this behavior”

“I would usually be running a staff reflective practice group I’d try and check in with all of the staff. Remind them that it was on when it was on. Check in with how they were doing”

Discharge planning and community care

Participants outlined continuity of care and clear discharge plans for the patient as imperative to sustain improvements made from inpatient care. This involved developing clear plans and liaising with key members of the community teams and family to facilitate discharge.

“we equally need to be thinking about what’s happening during outside, which is where they’re going home to and we also need to be thinking about transition arrangements”

Supporting the family system

Working with the family system was an integral part of the delivery of psychological therapies. This included carers support, family-based interventions, psychoeducation for families on crisis management and navigating a hospital admission.

“I think basically one of the most important things is the families. It’s how we can support families when they don’t really have an understanding or when they don’t know how to help in times of crisis and they don’t know resources”

Psychologists played an important role in acknowledging and addressing the long-standing social problems that many inpatients faced alongside their mental health crisis. This included history of trauma, housing difficulties or homelessness, stigma and discrimination, and financial problems. Psychologists felt it was important to offer a space for people to talk about these issues and advocate for patients where they could.

“It’s not to be discriminated against. There’s a lot of racism and stigma around, as you know, and I think that people talk about those kinds of things a little bit as well. Proper decent housing, you can’t do anything if you’ve not got the basics”

Environmental adaptations

Participants spoke about the environmental adaptations required to deliver psychological therapies in the inpatient setting.

Inclusive engagement and advocacy

Participants explained the importance of having an all-inclusive approach to engagement. This involved a flexible process of both informal and formal approaches in a variety of contexts and settings.

“I’m also a great believer that actually every referral should be discussed with the view that there might be something that we can do as psychologists”

In addition, all participants saw an important part of their role was aligning themselves with the patient, being an advocate, and voicing patient needs.

Working alongside the medical model

Delivering psychology within the medical model was a significant challenge. Participants spoke about finding ways to integrate psychological thinking within this approach in order to offer a more psychosocial model of care to patients.

“I think something about being like a champion for the psychological way of thinking. You know, for this person there’s more than just a diagnosis or label or somebody who needs to be medicated. Something about them being a real human being. So, I think that’s probably one of the interventions that is helpful.”

Brief interventions for brief admissions

Participants spoke about having to adapt their interventions to deliver psychology within the context of brief admissions. It was not possible to offer patients a pre-defined number of sessions as discharge was unpredictable. Moreover, therapy was likely to focus on the immediate risk with longer-term therapy being conducted in the community.

“I mean in the community I would usually say to people that we would start with 4-6 sessions but then extend if we need to, and kind of in mind having that the NICE guidelines say at least 16... Whereas I haven’t been saying that to people on the ward because I guess it doesn’t feel as clear whether that work would be kind of organic. I guess it’s also that I see the work on the ward as being more focused on the risk but then handing over to the community team to potentially do the full CBT for psychosis”

Flexible sessions

Participants described the importance of having flexible sessions responsive to the needs and presentation of the patients. This was in relation to session frequency, duration, and timing. Ideally sessions should be offered when the patient required it.

“People come into the ward at different stages of crisis, and it’s ... I suppose, for me, it’s about finding a window of opportunity – as I often call it – about how to engage with these inpatients...”

Delivering psychology in a restrictive environment

Participants discussed the importance of delivering psychological therapies which are adapted to the restricted environment. This meant psychologists being flexible with many therapy processes such as timing of sessions, homework setting, behavioral experiments, and having the same therapy room.

“In terms of the work and the environment itself, it seems definitely being quite flexible helps and so being able to work around some of the structure that’s on the ward already, being able to have sessions around other things and adjusting a bit to where the sessions are going to be. If a particular room is in use then going somewhere else. Those are all kind of part of the work”

Creative psychological provision with minimal resources

All participants described the challenge of delivering psychological therapies in a highly pressured environment with minimal resources. One of the main challenges was being able to be fully integrated and impact on the team culture.

“you need people [psychologists] that are full-time and able to really influence what goes on, on the ward. Because it’s just impossible to do very much in the time that we’ve got. We could do so much more if we had full-time placements”

Discussion

This qualitative study aimed to understand the adaptations required for psychological therapies to be delivered within the acute psychiatric inpatient settings from the perspective of psychological practitioners. The analysis identified three superordinate themes “crisis-focused psychological approaches”, “working with and supporting the social system”, and “environmental adaptations”.

The first theme highlighted the importance of delivering interventions which were focused on the current crisis and risk to facilitate discharge. This involved specific adaptations to the traditional competencies required to deliver psychological therapies (NICE, 2014; Roth & Pilling, 2012). It was imperative that the psychologists focused on the precipitating and maintenance factors for the current admission and offered brief intervention which focused on managing the current crisis factors. Change mechanisms were also crisis specific with psychoeducation, mindfulness, normalization and behavioral strategies being dominant. The delivery of psychological therapies was of equal priority to developing the therapeutic relationship hence a more informal approach to an initial assessment was required. This is line with previous research which identified the importance of inpatient psychological therapy being delivered within the context of a human relationship (Small et al., 2018). All adaptations to therapy reflected the need for psychological work to be responsive, delivered in a time-limited manner, and delivered to a population with complex needs. To date, there are no available evidenced-based interventions which have been developed to respond in this way (Jacobsen et al., 2018).

Integration of the patient’s social and mental health care system was another important finding from the research. Participants believed that the delivery of psychological therapy could not be done in isolation from the inpatient and community environment. Psychological therapies recommended by NICE (CBT and FI) traditionally do not take an inclusive approach to the involvement of the patients broader social system (only family members are

routinely included in FI) (Garety et al., 2008; Morrison et al., 2011), and therefore may be minimized in their effectiveness for an inpatient population. Importantly the inclusion of the family was highlighted, not only to support the patient but to ensure the family feel supported in managing the impacts of the hospitalization on themselves. Previous literature has demonstrated that family members can find inpatient admissions equally distressing, but also that they are often key to the identification and resolution to a mental health crisis (Jankovic et al., 2011) . Staff support, formulation sharing and working closely with the MDT in both formal and informal contexts were identified as important supporting previous research (Christofides, Johnstone, & Musa, 2012).

The final theme related to the adaptations required to deliver psychological therapies in an inpatient environment. An inclusive approach was taken to engagement with everybody having access to psychology who wanted it. However, this was done where possible given the scarce psychological resources in inpatient settings. This is at conflict with usual approaches to psychological therapy where “readiness” for psychological therapy is assessed (Krampe et al., 2017). The remainder of the themes required psychology to be adapted to the environmental restrictions of the inpatient ward and the necessary flexibility required to deliver psychology effectively. These are key differences to how traditional psychology is recommended to be delivered. Briefer ad hoc sessions, creative responses and working alongside the medical model were required. This is supported by previous evidence (Clarke & Wilson, 2008).

This research has important clinical implications for the practice of psychological therapies within the psychiatric inpatient setting. There are key competencies described by participants which are essential to the delivery of psychological therapies in inpatient settings. Firstly, all psychological work had to focus on the short-term goals such as crisis and risk management. Psychologists working in this field need to ensure that their interventions are adapted in this manner. This can be contrasted to routine psychological therapy which would incorporate more longer-term recovery goals (Morrison & Barratt,

2010). Moreover, flexibility was crucial in regard to session time, frequency, duration and length. It was also essential that therapy was patient-led and occurred at a mutually convenient time. Again, this differs from routine provision where there is less flexibility and more likelihood of scheduling weekly hour-long session at a consistent time. For psychological therapy to be at its optimum effectiveness, support and involvement of the MDT was essential. Positive staff attitudes and management support appears crucial to the delivery of psychological therapy in this settings, supporting previous research which has identified these as key to successful implementation of psychological therapy (Ince et al., 2015). Collectively, this demonstrates a number of strengths to the delivery of inpatient psychological therapy, as being flexible, short-term goal focused and involving the system meets many of the best-practice guidelines for delivering psychological therapies for this population (Roth & Pilling, 2012).

A strength of this research was that it was able to explore the inpatient adaptations required for psychiatric inpatient settings which has not been explored previously. Moreover, this research took a rigorous approach to qualitative data collection and analysis maximizing the reliability and validity of research findings (Tracy, 2010). A limitation to this study was that all participants were recruited from the same NHS trust which means their experiences are specific to inpatient teams within this trust and therefore limiting the generalizability of findings to other inpatient settings. Moreover, the researcher was a member of the psychology team of where participants were recruited. This undoubtedly brings bias to the analysis process. However, this was minimized through the involvement of two researchers external to the clinical team where participants were recruited (JB and SJ).

Findings demonstrated that delivering traditional therapeutic interventions is a significant challenge within the current acute psychiatric inpatient context and adaptations are required. As stated in the introduction, the majority of the evidence base which informs NICE guidelines (2014) has been conducted in outpatient settings and therefore recommendations do not relate to the current inpatient context. This research demonstrates that there are

potentially key ingredients for effective and acceptable brief psychological interventions for inpatient settings, but further intervention development and evaluation is required.

Table 1 – Participant Demographics

Participant demographics		
	Mean (Standard Deviation)	
Age (years)	33.58 (6.22)	
Length of inpatient experience (years)	4.88 (6.20)	
Length of experience working with people experiencing psychosis (years)	7.54 (7.50)	
		N (%)
Gender	Male	3 (25)
	Female	9 (75)
Ethnicity	White British	9 (75)
	Asian	2 (16.67)
	Mixed heritage	1 (8.33)
Professional Role	Clinical Psychologist	6 (50)
	Counselling Psychologist	2 (16.67)
	Assistant Psychologist	2 (16.67)
	Trainee Clinical Psychologist	1 (8.33)
	Trainee Clinical Psychologist and CBT therapist	1 (8.33)

Table 2 – Superordinate and subordinate themes

Crisis-focused psychological approaches	Working with and supporting the wider system	Environmental adaptations
Discharge goals, distress reduction and crisis planning Developing a crisis narrative Crisis and risk formulation development Crisis-focused change mechanisms Standalone group interventions Stepped care inpatient psychology Working with complexity and high risk Addressing distressing ward experiences.	Formulation-informed team working Communication and feedback Formal and informal staff support Discharge planning and community care Supporting the family system Marginalization, social deprivation and trauma	Inclusive engagement and advocacy Working alongside the medical model Brief interventions for brief admissions Flexible sessions Delivering psychology in a restrictive environment Creative psychological provision with minimal resources

References

- Berry, K., Barrowclough, C., & Wearden, A. (2009). A pilot study investigating the use of psychological formulations to modify psychiatric staff perceptions of service users with psychosis. *Behavioural and Cognitive Psychotherapy*, 37(1), 39-48. doi: 10.1017/S1352465808005018
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77 - 101. <http://dx.doi.org/10.1191/1478088706qp063oa>
- Christofides, S., Johnstone, L., & Musa, M. (2012). 'Chipping in': clinical psychologists' descriptions of their use of formulation in multidisciplinary team working. *Psychology and Psychotherapy: Theory, Research & Practice*, 85(4), 424 - 435. doi: 10.1111/j.2044-8341.2011.02041.x
- Clarke, I., & Wilson, H. (2008). *Cognitive Behaviour Therapy for Acute Inpatient Mental Health Units*. London: Routledge.
- Department of Health. (2017). *Mental Health Act: Independent Review*. London: Department of Health.
- Garety, P., Fowler, D., Freeman, D., Bebbington, P., Dunn, G., & Kuipers, E. (2008). Cognitive-Behavioural Therapy and Family Intervention for relapse prevention and symptom reduction in psychosis: randomised controlled trial. *British Journal of Psychiatry*, 192(6), 412-423. doi: 10.1192/bjp.bp.107.043570
- Ince, P., Haddock, G., & Tai, S. (2015). A systematic review of the implementation of recommended psychological interventions for schizophrenia: Rates, barriers, and improvement strategies. *Psychology and Psychotherapy: Theory, Research & Practice*, 89, 324 - 350. doi: 10.1111/papt.12084.
- Jacobsen, P., Hodkinson, K., Peters, E., Chadwick, P. (2018) A systematic scoping review of psychological therapies for psychosis within acute psychiatric in-patient settings. *British Journal of Psychiatry*, 213, 2, 490 - 497. DOI: 10.1192/bjp.2018.106

- Jankovic, J., Yeeles, K., Ktsakou, C., Amos, T., Morriss, R., Rose, D., . . . Priebe, S. (2011). Family Caregivers' Experiences of Involuntary Psychiatric Hospital Admissions of Their Relatives – a Qualitative Study. *PLOS one*, 6(10), e25425. . doi: 10.1371/journal.pone.0025425
- Krampe, H., Salz, A., Kerper, L. F., Krannich, A., Schnell, T., Wernecke, K., & Spies, C. D. (2017). Readiness to change and therapy outcomes of an innovative psychotherapy program for surgical patients: results from a randomized controlled trial. *BMC Psychiatry*, 17(417). doi: [10.1186/s12888-017-1579-5](https://doi.org/10.1186/s12888-017-1579-5)
- Mangalore, R., & Knapp, M. (2007). Cost of schizophrenia in England. *Journal of Mental Health Policy and Economics*, 10, 23-41.
- Morrison, A., & Barratt, S. (2010). What are the components of CBT for psychosis? A delphi study. *Schizophrenia Bulletin*, 36(1), 136-142. doi: 10.1093/schbul/sbp118.
- Morrison, A., Hutton, P., Wardle, M., Spencer, H., Barratt, S., Brabban, A., . . . Turkington, D. (2011). Cognitive Therapy for people with a schizophrenia spectrum diagnosis not taking antipsychotic medication: an exploratory trial. *Psychological Medicine*, 1-8. doi: 10.1017/S0033291711001899
- NHS Benchmarking. (2016). *2016 Benchmarking of Adult and Older People's Mental Health services*. London: NHS Benchmarking.
- NICE. (2014). *Psychosis and schizophrenia in adults: treatment and management*. London: National Institute of Clinical Excellence.
- NVIVO. (2017). NVivo qualitative data analysis software Version 11: QSR International Pty Ltd.
- Roth, A., & Pilling, S. (2012). *Psychological Interventions for people with psychosis and bipolar disorder*. London: UCL.
- Small, C., Pistrang, N., Huddy, V., & Williams, C. (2018). Individual psychological therapy in an acute inpatient setting: Service user and psychologist perspectives. *Psychology and Psychotherapy: Theory, Research & Practice*, DOI:10.1111/papt.12169.
- The Kings Fund. (2017). *NHS Hospital beds numbers: past, present, future*. London: The Kings Fund.

Tracy, S. J. (2010). Qualitative Quality: Eight “Big-Tent” Criteria for Excellent Qualitative Research
Qualitative Enquiry, 16(10), 837-851.

Wykes, T., Steel, C., Everitt, B., & Tarrier, N. (2008). Cognitive Behavior Therapy for Schizophrenia:
Effect Sizes, Clinical Models, and Methodological Rigor. *Schizophrenia Bulletin*, 34, 523-537.
<https://doi.org/10.1093/schbul/sbm114>

Appendix 1 – Interview schedule

Interview questions

1. *Can you tell me about your experiences of working as a psychology practitioner in the psychiatric inpatient setting? Prompt: What does your role look like? Day to day tasks?*

2. *Can you tell me about the therapeutic work you have done with people with psychosis? What therapeutic models have you used?*

Prompt: how many sessions do you usually have? What are the format of your sessions?

3. *From your experience, what do you think the therapeutic needs or priorities are of people with psychosis are during a psychiatric inpatient admission?*

Prompt: what have been your goals in past therapeutic sessions? What presenting issues have service users with psychosis discussed with you? What are the focus of your sessions?

Prompt. Suicidality, symptoms, social factors, other psychological factors

4. *What needs or priorities of people with psychosis go unmet during a psychiatric inpatient admission? How do you think we can address these therapeutically?*

ⁱ LW is a clinical psychologist and lecturer in clinical psychology. She has worked as a practicing clinical psychologist in acute mental health inpatient settings in NELFT for almost five years. CW is the strategic lead for acute and inpatient psychology and has also worked clinically in NELFT for over six years. JB is a senior lecturer and Sonia Johnson is a professor of social and community psychiatry, both at the at the Division of Psychiatry, UCL. JB and SJ do not have any involvement with NELFT and are independent to the research site.