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A systematic review of the implementation of psychological therapies in acute mental health inpatient settings

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Abstract

Objectives: Research has demonstrated that psychological therapies are not routinely delivered in acute mental health inpatient settings despite being recommended by the National Institute for Health and Care Excellence (NICE) guidelines. This study aimed to identify the barriers and facilitators to implementing psychological therapies in acute mental health inpatient settings.

Methods: A systematic review and narrative synthesis was undertaken. Primary studies were included if they examined the implementation of a NICE recommended psychological therapy in acute psychiatric inpatient settings and were of any study design. Four databases were searched for eligible studies (MEDLINE, CINAHL Plus, PsycINFO and Embase) and Google Scholar.

Results: A total of 16 studies (a mixture of both qualitative and quantitative methodologies) were included in the review, and the majority evaluated the implementation of Cognitive Behaviour Therapy. Overall, the literature was deemed to be of poor to moderate quality. The main barriers to the implementation of psychological therapy were the busy nature of the ward, multi-disciplinary professionals not being suitability trained and the acute nature of service users mental health difficulties. Facilitators to implementation included the adaptation of interventions to be specifically delivered in the acute inpatient setting, training of multi-disciplinary professionals, leadership support with the delivery of psychological therapies and prioritising the therapeutic relationship.

Conclusions: There is a requirement for senior management to prioritise the implementation of psychological therapies and update clinical guidelines to describe modifications necessary to implement psychological therapies in acute inpatient settings. Future research should improve their methodological quality and continue to develop the evidence base of brief psychological therapies in acute inpatient settings.

KEYWORDS
cognitive behavioural therapy, psychiatric inpatient care, psychological therapies, systematic review

1 | INTRODUCTION

Acute psychiatric inpatient units provide intensive care to people in mental health crisis who are high risk to themselves and others (Kings Fund, 2015). In 2018–2019, 100,359 of UK service users (4.79% of all secondary mental health care service users) were admitted to acute mental health inpatient services demonstrating the crucial role they play in caring for service users in acute distress (NHS Digital, 2019). This is reflected across the world with 99.1 service user's being admitted per 100,000 of the population (World Health Organisation [WHO], 2017).

Acute mental health inpatient care should provide holistic care underpinned by a biopsychosocial framework (Bowers, 2014), which includes psychological therapies. The Accreditation for Inpatient Mental Health Services (AIMS) state that all service users should have access to evidence-based psychological therapy from an appropriately trained practitioner (Royal College of Psychiatrists, 2011; Perry et al., 2015; Penfold et al., 2019). The National Institute for Health and Care Excellence (NICE) (2009, 2014a, 2014b) guidelines recommend several structured psychological therapies during the acute phase of schizophrenia, borderline personality disorder and other serious mental health problems. These include Cognitive Behaviour Therapy (CBT), Family Intervention (FI) and Intrapersonal Therapy (IPT). However, the data indicate that standards set by NICE and other professional bodies are rarely met. For example, the Care Quality Commission's (2009) national survey revealed that only 29% of service users received talking therapy while hospitalised and 25% of service users did not receive therapy despite wanting to. It has also been demonstrated that service users are dissatisfied with their experience of psychiatric inpatient care. This is often because psychological therapy is not available, and treatment predominantly consists of medication (Wood & Alsawy, 2016). The evidence base of inpatient psychological therapies is also lacking. Three recent systematic reviews have been conducted examining the efficacy of psychological interventions delivered in this setting (Jacobsen et al., 2018; Paterson et al., 2018; Wood et al., 2020). They demonstrate that the research evidence is small and of moderate to poor quality, and effects were only found on a few outcomes including psychotic symptoms (at the end of therapy but not at longer-term follow-up; Paterson et al., 2018; Wood et al., 2020), readmission, depression and anxiety (Jacobsen et al., 2018). Therefore, understanding why psychological therapies are not routinely available in this setting (i.e., the barriers and facilitators to their implementation) is imperative.

Previous reviews examining the difficulties in implementing psychological therapies in community settings identified organisational, healthcare professional and service user-related factors (Berry & Haddock, 2008; Ince et al., 2016; Rowlands, 2004). Organisational barriers included inadequate support from management and a lack of resources (Berry & Haddock, 2008; Ince et al., 2016). Healthcare professional-related barriers pertained to a lack of practitioner confidence and appropriate training (Berry & Haddock, 2008). Finally, service user-related factors included difficulties engaging due to distressing symptoms, overmedication and feelings of stigma and disempowerment (Berry & Haddock, 2008; Ince et al., 2016). Facilitators included senior management buy in, efficient division of resources, specialist clinical supervision, educational workshops, service user involvement in treatment delivery and tackling wider societal mental health stigma (Berry & Haddock, 2008; Rowlands, 2004). Although these reviews focused on community mental health services, these barriers may also play a role in the delivery on psychological therapies in an inpatient setting.

In regard to the delivery of psychological therapies in acute mental health inpatient settings, there are likely to be a number of additional barriers unique to inpatient settings which may explain consistently poor accessibility. For example, 14 out of 104 wards enrolled in the AIMS project had no access to a psychologist (Raphael et al., 2016). The wards are also overcrowded as records indicated that bed occupancy rates average above the 85% target (Crisp et al., 2016; NHS Benchmarking Network, 2019). This setting is also characterised by short admissions, difficult cases and a high level of risk (Rethink, 2004; Smith et al., 2015). One review has recently been published, which has examined the implementation of broader indirect and direct psychosocial interventions in this setting (Raphael et al., 2021). This review identified that service users should be provided with clear information on the benefits of the psychosocial intervention, that training for staff delivering the interventions is required and organisational support is needed for the delivery of interventions. However, this review did not focus specifically on the implementation of NICE recommended direct psychological therapies and therefore did not identify the nuanced factors required to deliver these specific interventions. Therefore, there is a need to conduct a review in this area. This review aimed to synthesise research that investigated the barriers to implementing NICE recommended interventions and the facilitators that helped overcome these obstacles. The research questions created to meet these aims were the following:

- What are the reported barriers to implementing NICE recommended psychological therapies in acute mental health inpatient settings?

Key Practitioner Message

- To increase the implementation of ward-based psychological therapies, sessions should be delivered more flexibly, for example, be shorter in duration and focus on the current crisis.
- Healthcare professionals require training to develop their therapeutic skills and knowledge of psychological approaches.
- The small and western samples in the primary studies may have limited the generalisability of our findings. Future research should explore factors specific to ethnic minority populations.

- What are the reported facilitators that promote the use of NICE recommended psychological therapies in acute mental health inpatient settings?

2 | METHODS

2.1 | Protocol and registration

This study undertook a systematic review and narrative synthesis adhering to best-practice guidance outlined by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Moher et al., 2009). The study protocol was registered prior to the searches being undertaken (PROSPERO registration: CRD42020175199).

2.2 | Eligibility criteria

Studies were included if they (a) were conducted in acute adult mental health inpatient settings or Psychiatric Intensive Care Units (PICUs), (b) included sample populations of healthcare professionals, or service users with any mental health problem, (c) examined implementation, that is, investigated factors operating as barriers (factors that obstructs implementation) or facilitators (factors that enables implementation), (d) examined a psychological therapy meeting NICE (2009, 2014a, 2014b) definition, which include Behavioural Activation (BA), FI, CBT, Acceptance and Commitment Therapy (ACT), Compassion Focused Therapy (CFT) and Dialectical Behaviour Therapy (DBT) (ACT and CFT are deemed to meet the NICE criteria for CBT, i.e., people can establish links between their thoughts, feelings or actions and their current or past symptoms and functioning the re-evaluation of people's perceptions, beliefs or reasoning relates to the target symptoms), (e) were of any methodological design and (f) published in a peer reviewed journal.

Studies were excluded if they (a) were conducted in specialist inpatient settings (such as forensic inpatient services), (b) non-inpatient crisis services (such as day hospitals and crisis houses) and (c) children and adolescent inpatient services.

2.3 | Search strategy

The search was conducted in April 2020 and updated in January 2021 using four electronic databases (MEDLINE, CINAHL Plus, PsycINFO and Embase) and Google Scholar. The reference list of full-text articles was also screened for any eligible studies. This comprehensive strategy was chosen to identify studies across the disciplines of psychology, psychiatry, nursing and healthcare. The search was restricted to those published between 1990 and 2021 to ensure they were relevant to current acute mental health inpatient settings (as 1990 was when the introduction of the care programme approach and significant deinstitutionalisation took place). The following search terms

were entered across all databases: 'mental health inpatient' OR 'psychiatric inpatient' OR 'psychiatric ward' OR psychiatric unit' OR 'psychiatric hospital' OR 'acute psychiatric' OR 'acute inpatient' OR 'acute mental health' AND 'psychological intervention' OR 'psychological therapy' OR 'talking therapy' OR 'cognitive behavioural therapy' OR 'dialectical behavioural therapy' OR 'compassion focused therapy' OR 'acceptance and commitment therapy' OR 'behavioural therapy' OR 'cognitive therapy' OR 'group therapy'.

2.4 | Study selection and data collection

The first author independently screened the titles and abstracts of studies retrieved using the search strategy. Twenty per cent of articles were randomly selected and screened by an independent reviewer and an adequate inter-rater reliability rate of (kappa = 0.89) was calculated. The first author also independently screened the full-text articles and identified those to be included in the systematic review. The first author independently extracted and recorded information into predetermined tables. The study characteristics included the author(s), location of study, method, sample and interventions. The reported barriers and facilitators were inputted into a second table. The corresponding author of each study was emailed to request any missing information. The reference lists of all included studies were examined for any further eligible studies.

2.5 | Quality assessment

The Mixed Methods Appraisal Tool (MMAT) (Hong et al., 2018) was used to assess the quality of eligible studies due to diverse study methodologies. The first stage of the MMAT includes two screening questions ('are there clear research questions' and 'do the collected data allow to address the research questions'). The second stage uses one of five checklists, which is chosen based on the study methodology (qualitative research, quantitative randomised controlled trials, quantitative non-randomised trials, quantitative descriptive and mixed method designs). Each checklist has five criteria to be scored as 'Yes', 'Cannot Tell' or 'No'. For example, the Randomised Controlled Trial (RCT) checklist evaluates randomisation, blinding and adherence to the intervention and the non-randomised checklist examines whether subjects are representative of the target population, whether confounders were accounted for and whether outcome data were complete. It is discouraged to use the MMAT (Hong et al., 2018) to calculate an overall score and exclude low quality studies. Therefore, this information was used to assess the quality of the included studies.

2.6 | Synthesis of results

A narrative synthesis was conducted using Popay et al.'s (2006) best-practice guidelines. First, the studies were grouped by methodology, and the study characteristics were tabulated to compare data across

studies. Furthermore, a coding reliability thematic analysis (Braun & Clarke, 2006) was undertaken on the primary studies' results and discussion sections by the first author to identify the reported barriers and facilitators to implementation. The barriers and facilitators to implementation were extracted and synthesised independently in order to directly answer the review question. The first phase involved reading and re-reading the articles to become familiar with the content. The implementation data were then highlighted and coded. The third phase involved analysing the codes for patterns and grouping them into superordinate themes. For example, 'other appointments', 'a lack of time' and 'disruptions on the ward' were grouped into ward environment-related factors. The themes were reviewed and used to form the reported barriers and facilitators.

3 | RESULTS

3.1 | Study selection

After the removal of duplicates, a total of 1167 studies were initially identified. After screening titles and abstracts against the eligibility

criteria, 994 articles were excluded. The full text of the remaining 101 studies was examined, and a further 85 were excluded as they did not meet the eligibility criteria. The remaining 16 studies were included in the review. The study selection process is outlined in Figure 1.

3.2 | Study characteristics

The 16 articles included six qualitative papers (Awenat et al., 2018, 2019; Donaghay-Spire et al., 2016; Small et al., 2018; Tyrberg et al., 2017; Wood et al., 2019), one RCT (Wood et al., 2018), four non-randomised trials (Chang et al., 2014; Fife et al., 2019; Gaudiano et al., 2020; Paterson et al., 2019), one mixed methods design (Heriot-Maitland et al., 2014) and four case series (Davidson et al., 2009; Folke et al., 2015; Jacobsen & Clark, 2016; Moore et al., 2019).

The majority of the studies examined CBT informed approaches ($k = 10$; Awenat et al., 2018, 2019; Chang et al., 2014; Davidson et al., 2009; Donaghay-Spire et al., 2016; Jacobsen & Clark, 2016; Paterson et al., 2019; Wood et al., 2018, 2019). Three papers explored ACT (Gaudiano et al., 2020; Moore et al., 2019; Tyrberg et al., 2017), two investigated DBT informed approaches
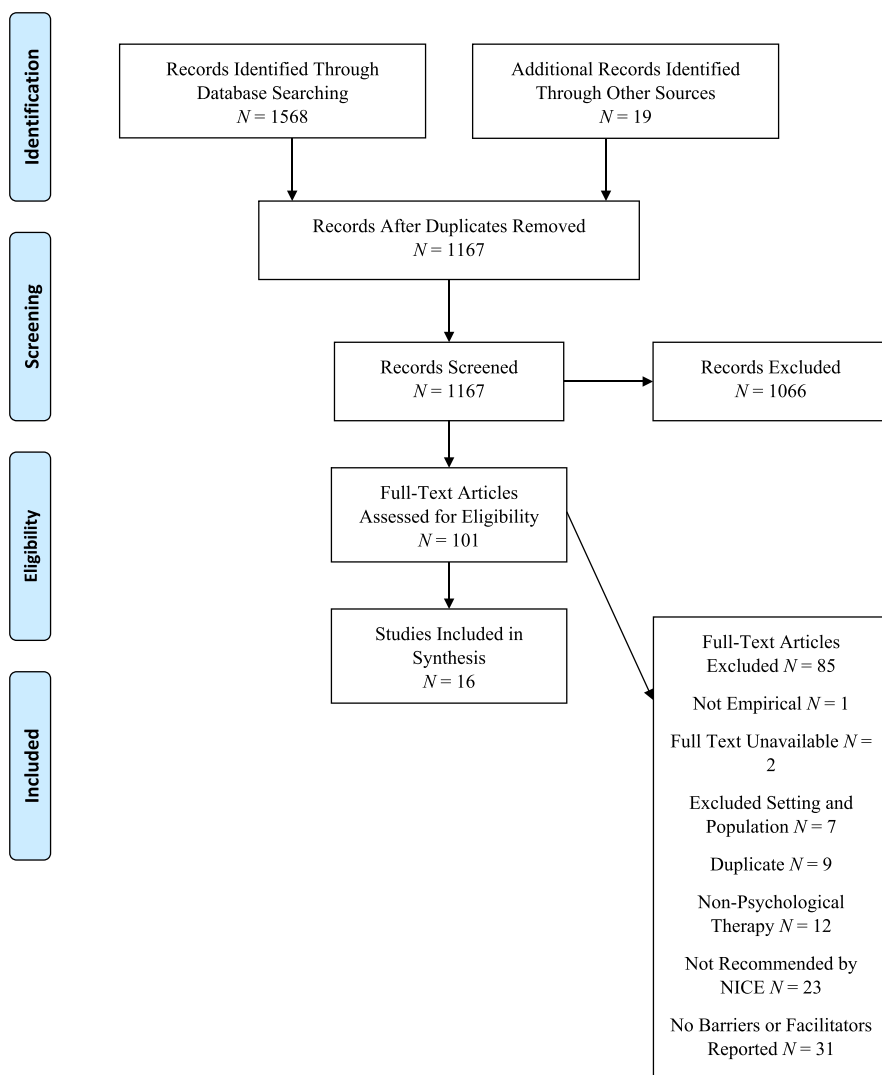

Identification

Records Identified Through Database Searching
$N = 1568$

Additional Records Identified Through Other Sources
$N = 19$

Records After Duplicates Removed
$N = 1167$

Screening

Records Screened
$N = 1167$

Records Excluded
$N = 1066$

Eligibility

Full-Text Articles Assessed for Eligibility
$N = 101$

Studies Included in Synthesis
$N = 16$

Included

Full-Text Articles Excluded $N = 85$

Not Empirical $N = 1$

Full Text Unavailable $N = 2$

Excluded Setting and Population $N = 7$

Duplicate $N = 9$

Non-Psychological Therapy $N = 12$

Not Recommended by NICE $N = 23$

No Barriers or Facilitators Reported $N = 31$

FIGURE 1 PRISMA Flowchart [Colour figure can be viewed at wileyonlinelibrary.com]

TABLE 1 Summary of study characteristics

Study and location	Aims	Method	Setting	N	Demographics	Staff members profession	Service users diagnosis	Intervention	Control
Small et al. (2018), United Kingdom	To explore service users' and psychologists' experiences of individual therapy in acute inpatient settings	Semi-structured interviews thematic analysis	Four acute mental health inpatient wards	14	Service users: Males (N = 5); females (N = 3); 21–55 years; white-British (N = 6); Asian-British (N = 2) Staff members: NR	Psychologist (N = 6); counselling psychologist (N = 1); assistant psychologist (N = 2)	PD (N = 3); psychosis (N = 2); anxiety (N = 1); depression (N = 1); ASD (N = 1)	CBT; ACT; CFT and BA	N/A
Awenat et al. (2018), United Kingdom	To understand patient acceptability of suicide-focused cognitive behavioural psychological therapy	Semi-structured interviews thematic analysis	Five acute mental health inpatient wards	20	Service users: Males (N = 14); females (N = 6); 22–65 years	N/A	Alcoholism (N = 1); anxiety (N = 1); BD (N = 2); depression (N = 2); EUPD (N = 2); MDD (N = 1); SCZ (N = 4); unavailable (N = 7)	CBSP	N/A
Donaghay-Spire et al. (2016), United Kingdom	To explore how people experienced psychological input in inpatient settings	Semi-structured interviews narrative analysis	Three mental health hospitals	10	Service users: Males (N = 1); females (N = 3); white-British (N = 4) Staff members: Males (N = 4) females (N = 4); white-British (N = 2); white-Irish (N = 3); black African British (N = 1); black Caribbean (N = 1)	Consultant psychiatrist (N = 1); social worker (N = 1); Ward manager (N = 1); occupational therapist (N = 1); mental health nurse (N = 2)	NR	CBT	N/A
Awenat et al. (2019), United Kingdom	To investigate staff acceptability of cognitive Behavioural suicide prevention therapy for psychiatric inpatients	Semi-structured interviews thematic analysis	Eight mental health wards	19	Staff members: Males (N = 3); females (N = 16); 22–56 years	Mental health nurse (N = 13); nursing assistant (N = 2); Ward administrator (N = 3); psychiatrist (N = 1)	N/A	CBSP	N/A

(Continues)

TABLE 1 (Continued)

Study and location	Aims	Method	Setting	N	Demographics	Staff members profession	Service users diagnosis	Intervention	Control
Wood et al. (2019), United Kingdom	To explore the adaptations required to deliver psychological therapies from the perspective of inpatient psychological practitioners	Semi-structured interviews thematic analysis	Mental health inpatient services	12	Staff members: Males (N = 3); females (N = 9); 33.58 M years; white-British (N = 9); Asian (N = 2); mixed heritage (N = 1)	Clinical psychologist (N = 6); Counselling psychologist (N = 2); assistant psychologist (N = 2); trainee clinical psychologist (N = 1); trainee clinical psychologist and CBT therapist (N = 1)	N/A	CBT	N/A
Tyrberg et al. (2017), Sweden	To investigate how the ACT model might be useful for nurses in psychiatric inpatient care	Qualitative description	Mental health inpatient ward	20	Staff members: Males (N = 6); females (N = 14); 26–65 years	Assistant nurse (N = 12); registered nurse (N = 8)	N/A	ACT	N/A
Wood et al. (2018), United Kingdom	To examine the feasibility and acceptability of CBT	RCT	Five acutemental health inpatient wards	30	Service users: Males (N = 23); females (N = 7); 33.63 M years; white-British (N = 6); Asian (N = 11); black (N = 1); other (N = 2)	N/A	SCZ (N = 18); first episode psychosis (N = 4); schizoaffective disorder (N = 2); psychotic episode (N = 6)	CBT	Psychoeducation
Gaudiano et al. (2020), United States	To adapt ACT for delivery in a hospital setting to prepare for a larger clinical trial	Open trial	Private mental health hospital	26	Service users: Males (38%); females (62%); 38 M years; 15% Hispanic; 69% Caucasian; 19% multiple races; 12% other	N/A	SCZ 12%; schizoaffective 35%; MDD with psychotic features 15%; unspecified psychotic disorder 38%	ACT	N/A
Paterson et al. (2019), United Kingdom	To evaluate the Edinburgh-acute psychological inpatient therapy service compared to acute psychiatric care alone	Non-randomised parallel cluster feasibility trial	Two mental health inpatient wards	96	Service users: Males (N = 47); females (N = 49); 43.38 M years	N/A	Bipolar manic (N = 23); bipolar depression (N = 6); PD (N = 11); depression (N = 19); SCZ (N = 37)	CBT-informed 'EDAPTS' and TAU	TAU

TABLE 1 (Continued)

Study and location	Aims	Method	Setting	N	Demographics	Staff members profession	Service users diagnosis	Intervention	Control
Fife et al. (2019), United Kingdom	To evaluate the feasibility and acceptability of a DBT-informed skills group for adults who self-harm in a psychiatric inpatient setting	Single arm feasibility trial	Five mental health inpatient wards	24	Service users: Males (N = 17); females (N = 24); 21–55 years; white British (N = 17); mixed (N = 2); black British (N = 1); Pakistani (N = 1); white European (N = 1); Jamaican (N = 1); polish (N = 1)	N/A	BPD (N = 6); psychosis (N = 5); depression (N = 5); anxiety (N = 1) ASD (N = 1); not known (N = 4); no diagnosis (N = 2)	DBT-informed 'coping with crisis'	N/A
Chang et al. (2014), United States	To investigate the feasibility of implementing a cognitive therapy training programme in an acute psychiatric inpatient unit.	Uncontrolled feasibility study	Mental health inpatient unit	29	Staff members: Males (N = 12); females (N = 17); 47.9 M years; Caucasian (N = 17); African American (N = 8)	Nurse (N=NR); mental health technician (N=NR); social worker (N=NR); occupational therapist (N = 1); psychologist (N = 1); psychiatrists (N=NR)	N/A	CBT	N/A
Davidson et al. (2009), United Kingdom	To present the delivery and adaptation of a group for people who hear voices in a psychiatric intensive care unit	Case series	Psychiatric intensive care unit	23	Service users: Males (N = 21); females (N = 2); white British (N = 19); Irish (N = 1); afro Caribbean (N = 1); British Asian (N-1); afghan (N = 1)	N/A	Paranoid schizophrenia (N = 15); schizoaffective disorder (N = 3); BD (N = 4); PTS; psychotic depression (N = 1)	CBT informed 'living with voices' group	N/A
Jacobsen and Clark (2016), United Kingdom	To reflect on the challenges and opportunities experienced in running an MDT therapy group programme at a psychiatric ward	Case series	Inpatient mental health ward	NR	NR	NR	NR	CBT and DBT	N/A

TABLE 1 (Continued)

Study and location	Aims	Method	Setting	N	Demographics	Staff members profession	Service users diagnosis	Intervention	Control
Folke et al. (2015), Sweden	To investigate the mechanisms and efficacy of inpatient BA for depressive symptoms in patients with different psychiatric disorders	Single case experimental design	Three acute mental health inpatient wards	6	*Service users:* Males (N = 2); females (N = 4); 20–64 years	N/A	OCD (N = 1); MDD and PDA (N = 1); BD and ALC (N = 1); MDD and BD (N = 1); BPD and PTSD (N = 1); MDD and SCZ (N = 1)	BA	N/A
Moore et al. (2019), United States	To implement groups that were consistent with an ACT framework	Quality improvement project	Inpatient mental health unit	NR	NR	NR	NR	ACT	N/A
Heriot-Maitland et al. (2014), United Kingdom	To examine the feasibility of running and evaluating a CFT group adapted for acute inpatient settings	Mixed methods	Acute mental health inpatient ward	93	NR	N/A	SCZ; schizoaffective disorder; BD PD; depression; anxiety	CFT	N/A

Abbreviations. ACT, Acceptance and Commitment Therapy; ALC, Alcohol Dependence; ASD, Autism Spectrum Disorder; BA, Behavioural Activation; BD, Bipolar Disorder; BPD, Borderline Personality Disorder; CBSP, Cognitive Behaviour Suicide Prevention Therapy; CBT, Cognitive Behaviour Therapy; CFT, Compassion Focused Therapy; DBT, Dialectical Behaviour Therapy; EDAPTS, Edinburgh-Acute Psychological Inpatient Therapy Service; EUPD, Emotionally Unstable Personality Disorder; MDD, Major Depressive Disorder; N/A, not applicable; NR, not reported; OCD, Obsessive Compulsive Disorder; PD, Personality Disorder; PDA, Panic Disorder with Agoraphobia; PTSD, Post Traumatic Stress Disorder; RCT, Randomised Controlled Trial; SCZ, schizophrenia. TAU = Treatment as Usual.

(Fife et al., 2019; Jacobsen & Clark, 2016), one paper examined CFT (Heriot-Maitland et al., 2014) and one examined BA (Folke et al., 2015). One study focused on multiple therapies (with a primary focus CBT, ACT, and CFT, Small et al., 2018). The study characteristics are summarised in Table 1.

3.3 | Quality assessment

The full quality assessment ratings for each study can be found in the supporting information. The qualitative studies were of good methodological quality. The data collection methods were adequate as semi-structured interviews were audio-recorded and transcribed verbatim (Awenat et al., 2018, 2019; Donaghay-Spire et al., 2016; Small et al., 2018; Tyrberg et al., 2017; Wood et al., 2019). The single RCT was of low methodological quality because the assessors were not blinded to intervention status and there were incomplete outcome measures (Wood et al., 2018). Three out of four quantitative non-randomised studies showed moderate evidence of bias. Two studies did not clearly report whether confounders were accounted for (Fife et al., 2019; Gaudiano et al., 2020). In addition to this, only 38% of Fife et al.'s (2019) participants completed post-therapy measures. Paterson et al. (2019) also had incomplete outcome data as only 52% of subjects in the intervention arm completed the follow-up assessment. The CBT-informed intervention was also not delivered as intended because of limited therapy resources (Paterson et al., 2019). All four quantitative descriptive studies were unclear because the sampling strategies and procedures were inadequately reported (Davidson et al., 2009; Folke et al., 2015; Jacobsen & Clark, 2016; Moore et al., 2019). There was insufficient information to determine whether the sample was representative of the target population and whether nonresponse bias was present. The final study used a mixed-methods design, but it was not possible to tell whether the qualitative and quantitative components were effectively integrated. There were no inconsistences between the quantitative and qualitative findings (Heriot-Maitland et al., 2014).

Overall, these findings suggest that the included studies were of a poor and moderate quality. However, the studies were not excluded from analysis because the MMAT (Hong et al., 2018) discourages doing so. Furthermore, methodological limitations, such as a high drop-out rate, may also reflect challenges to implementing psychological studies and therapies in inpatient settings and therefore excluding such studies may remove important study data.

3.4 | Barriers and facilitators to the implementation of psychological therapy

The barriers and facilitators to implementation of psychological therapies are outlined below and also summarised in Table 2. The contributions of each primary paper to the barriers and facilitators can be found in the supporting information.

TABLE 2 Summary of the barriers and facilitators to delivering psychological therapies in acute mental health inpatient settings

Barriers	Facilitators
The hospital environment	*Adapting psychological therapy*
A lack of time to deliver psychological therapy	Shorten length and cover less material
A lack of appropriate resources	Be flexible with the location and timing of sessions
A lack of private therapeutic space	Target the immediate crisis
An unpredictable, disruptive and noisy environment	Standalone sessions
A restrictive ward environment	Integrate psychological approaches into day to day interactions (e.g., during morning check-ups)
Short-term nature of inpatient care	Provide written therapeutic material
Multidisciplinary staff factors	*Education and workshops*
Lack of appropriate training	Training/workshops on psychological therapies
Operational challenges (e.g., staff sickness, unplanned leave and unpredictable rotas)	Opportunities to observe and cofacilitate psychological therapy
Delivering therapy not an appropriate part of staff roles	*Building the therapeutic relationship*
Concerns that talking about suicide increases suicide	Prioritise the therapeutic relationship
Poor therapeutic relationship	Build the relationship quickly
Service user acute mental health	Collaborative treatment planning and goal setting
Acute levels of distress and psychosis	
Cognitive difficulties and drowsiness due to medication	
Concerns that talking about difficulties will make them deteriorate	

3.5 | Reported barriers

The most frequently reported barrier related to the nature of the inpatient environment and care delivery, which was highlighted in 14 out of 16 studies. The most common obstacle was a lack of time that staff had to deliver psychological therapy, which was most frequent when psychological therapies were being delivered by non-psychological staff (Chang et al., 2014; Folke et al., 2015; Jacobsen & Clark, 2016). The wards are inherently busy, staff members have other responsibilities to attend to and service users have other appointments (Fife et al., 2019; Tyrberg et al., 2017). There are also limited resources available and a lack of private space available to meet with service users (Paterson et al., 2019; Wood et al., 2019). The studies described the wards as unpredictable and disruptive. The wards were too noisy to conduct psychological therapy and sessions occasionally ended abruptly because of ward crises (Heriot-Maitland et al., 2014; Moore et al., 2019; Wood et al., 2018). One article also described it being difficult to implement certain therapeutic intervention strategies because services users detained under the Mental Health Act are restricted to the ward. For example, graded exposure and BA could not always be used to challenge the service users' appraisals due to a lack of Section 17 leave (Small et al., 2018). One other common factor was the short-term nature of inpatient care. The service users were unable

to attend a full course of therapy because their length of stay was short and they were unexpectedly discharged (Chang et al., 2014; Fife et al., 2019; Paterson et al., 2019).

Twelve articles reported barriers relating to the multidisciplinary inpatient staff, including psychological professionals. The studies outlined that not all multidisciplinary team members were appropriately trained or had the confidence to use therapeutic approaches (Folke et al., 2015; Jacobsen & Clark, 2016; Small et al., 2018). The sessions were also not delivered routinely because of persistent operational challenges such as staff sickness, unplanned leave and unpredictable rotas (Jacobsen & Clark, 2016; Paterson et al., 2019; Gaudiano et al., 2020). The articles also suggested that some nursing staff did not feel running therapeutic groups was appropriate for their role (Moore et al., 2019). It was also difficult to challenge the multidisciplinary team's pre-existing beliefs about therapeutically intervening with high risk behaviours. For example, they believed talking about suicide could increase suicidal behaviour (Awenat et al., 2019). Furthermore, service users described some staff members as uncompassionate and passive and that the therapists' style was incompatible with the service user's needs, which reduced engagement (Awenat et al., 2018; Donaghay-Spire et al., 2016).

Finally, 11 studies reported barriers related to the service user's acute mental health presentation. The studies suggested that service users were too acutely distressed to converse with therapists (Gaudiano et al., 2020; Small et al., 2018). Chang et al. (2014) also suggested delivering therapy was more challenging because service users experienced active psychotic symptoms, including thought disorder and delusions, which impeded their ability to focus in session. The healthcare professionals described traditional approaches, including CBT, as unrealistic because acutely distressed service users cannot analyse their appraisals (Small et al., 2018). It was also described as a challenge to deliver therapy when service users displayed cognitive deficits and drowsiness as a side effect of medication (Gaudiano et al., 2020; Small et al., 2018; Wood et al., 2018). One final article revealed that service users were reluctant to engage in psychological therapy because they feared it would further deteriorate their mental state (Awenat et al., 2019). This assumption was amplified when service users had past negative experiences of psychological therapy (Awenat et al., 2018).

3.6 | Reported facilitators to implementing psychological therapies

The most frequently reported facilitators to delivering psychological therapies were adaptations made to the psychological therapy itself. These modifications were mentioned in 10 out of 16 studies. The sessions were shorter in length and covered less material because of time pressures (Davidson et al., 2009; Folke et al., 2015; Heriot-Maitland et al., 2014; Wood et al., 2018). The location and time of sessions were also flexible depending on the ward routine and availability of space (Wood et al., 2019). Furthermore, interventions targeted the immediate crisis rather than longer term recovery goals

(Folke et al., 2015; Wood et al., 2018). Numerous articles described designing the sessions to stand alone (Davidson et al., 2009; Heriot-Maitland et al., 2014; Small et al., 2018). These stand-alone sessions, and their content, were self-contained so if service users could not or did not want to attend further sessions, they would still derive therapeutic benefit. These one-off sessions helped the service users learn useful exercises without being excluded because of their previous non-attendance (Davidson et al., 2009). Furthermore, Tyrberg et al. (2017) outlined that integrating psychological concepts and language into day to day conversation on the ward could increase therapeutic practice. For example, service users were encouraged to embrace their feelings and identify their core values during morning check-ups (drawing on ACT). Gaudiano et al. (2020) suggested that this method was more efficient than forming new groups or training occupational therapists to become ACT specialists. Three articles also emphasised the importance of written therapeutic materials (Heriot-Maitland et al., 2014; Jacobsen & Clark, 2016; Wood et al., 2018). These handouts helped service users recall information when their mental state improved.

Six articles also suggested that additional training on using therapeutic approaches was useful. For example, healthcare professionals in Moore et al.'s (2019) study attended a workshop that outlined the six principles of ACT and their application in inpatient settings. Training programmes alleviated the staff member's uncertainties, increased their knowledge and confidence to facilitate psychology groups (Awenat et al., 2019; Chang et al., 2014). One article also mentioned the advantage of observing and co-facilitating groups with clinical psychologists before taking on a larger therapeutic role (Jacobsen & Clark, 2016).

Finally, three studies highlighted the importance of improving the therapeutic relationship (Donaghay-Spire et al., 2016; Small et al., 2018; Wood et al., 2019). This alliance had to be established quickly and service users described feeling comfortable opening-up to warm and attentive therapists who made time for them (Donaghay-Spire et al., 2016; Wood et al., 2019). There was also an increased sense of trust when service users and clinicians collaborated on the treatment plan and goals (Small et al., 2018). This finding demonstrated the merit of service user involvement.

4 | DISCUSSION

The narrative synthesis identified that it is a challenge to implement psychological therapy in acute mental health inpatient settings because of three main factors, the hospital environment, multidisciplinary staff issues and service user's acute presentations. The hospital environment and staff-related factors are the primary barriers. It was outlined that the main strategy to overcome this is adapting the delivery of psychological therapies, including making sessions shorter, reducing the content and delivering standalone sessions (i.e., having a therapy specific goal that is addressed in a single session, which may include a brief assessment, simple formulation and brief change strategy), and for staff to have appropriate training and

protective time to deliver the intervention (Davidson et al., 2009; Folke et al., 2015; Small et al., 2018). Some services users were reluctant to attend psychological therapy. The studies highlight the importance of establishing trust and building a strong therapeutic relationship to help engagement (Awenat et al., 2018). This can be achieved by staff meaningfully collaborating with service users on therapy plans and for all multidisciplinary staff to have skills in developing therapeutic relationships (Small et al., 2018). Delivering psychological therapy can also be challenging because the service users are in an acute mental health crisis when on an inpatient ward (Chang et al., 2014; Gaudiano et al., 2020). Strategies to overcome this were offering handouts, having written instructions and adapting interventions to target crisis, reduce risk, and support a safe discharge (Heriot-Maitland et al., 2014; Wood et al., 2018).

A number of the findings overlapped with prior implementation reviews conducted in the community. The common barriers include limited resources, busy caseloads, lack of training and the overmedication of service users (Berry & Haddock, 2008; Ince et al., 2016). The findings suggested that psychological approaches are secondary to medication in both community and inpatient settings. The barriers specific to inpatient wards are associated with the acute nature of service user's difficulties and the physical environment that service users are restricted to. Some barriers and facilitators overlapped with those found in the broader psychosocial interventions delivered in inpatient settings systematic review (Raphael et al., 2021) including staff needing protected or dedicated time, and organisational support being required, to deliver psychological therapies. However, additional factors were identified specific to NICE recommended psychological interventions specifically focusing on the adaptations required to delivery therapy for the acute population and brief admissions (Heriot-Maitland et al., 2014; Paterson et al., 2019; Wood et al., 2019).

The NICE guidelines (2014) for psychosis recommend starting CBT in the acute phase and continuing the full course of treatment post-discharge. However, these guidelines offer no direction on how to deliver psychological therapy in inpatient settings. Given the aforementioned barriers to delivering psychological therapies in the ward setting, it would be helpful for future guidelines to consider including details of how these therapies should be applied in inpatient settings. One approach would be to adapt the psychological models in line with the facilitating factors outlined in this review; however, further research would be required to ensure they are feasible, acceptable and effective as they would be deviating from evidenced-based protocols. Alternatively, it may be that other psychological therapies, which are already underpinned by process better suited to the inpatient environment (e.g., a flexible psychotherapeutic model), may be more suitable to this setting and their evidence base needs further exploration (Jenkins et al., 2020). The implementation of therapy must also be supported on an organisational level. This is particularly important for non-psychologists who deliver therapy in addition to their other professional responsibilities. Fadden (2006) recommended enlisting management to reduce caseloads, prioritise, and create a protected time for delivering psychological therapies.

To the authors' knowledge, this is the first systematic review to synthesise barriers and facilitators to implementing NICE recommended psychological therapy for acute mental health inpatient service users. The protocol, search strategy and aims were registered in advance on PROSPERO and best practice systematic review guidelines were adhered to. A limitation was that the search strategy did not included forward searching, which may have meant that potentially eligible studies may have been missed. Another limitation was the lack of implementation framework (e.g., Peters et al., 2013) used to guide the synthesis of results which reduced transparency and rigour. It should also be noted that systematic reviews are only as reliable as the primary studies included. The quality assessment conducted using the MMAT (2018) identified weaknesses in several studies. For example, the single RCT's (Wood et al., 2018) assessors were not blinded to the intervention. The RCT and two non-randomised studies (Fife et al., 2019; Paterson et al., 2019) also had incomplete outcome data. Plus, a group in Paterson et al.'s (2019) study was not conducted as intended because of limited therapy resources. These biases suggest that validity was threatened, and the findings should be interpreted with caution. However, as this review was examining implementation, the mixed quality of studies is of interest because it highlighted further challenges with conducting research in inpatient settings. For example, incomplete outcome data and difficulties following up participants were due to sudden discharge. This western sample and exclusion of non-English publications could also be considered a limitation. For example, the majority of studies that reported ethnicity had a White-British majority sample (Davidson et al., 2009; Donaghay-Spire et al., 2016; Fife et al., 2019; Small et al., 2018; Wood et al., 2019). There may be barriers and facilitators specific to Black, Asian and Minority Ethnic (BAME) groups that this review was unable to identify. This is important because it has been established that ethnic minorities are unable to access psychological therapy frequently because of long waiting times, poor communication and discrimination (Memon et al., 2016). It is important to understand barriers to implementation in inpatient care and facilitators to delivering culturally sensitive care. Future research should rectify these limitations by reducing biases and recruiting large samples of diverse participants. The studies should also continue to investigate the facilitators to implementation because fewer facilitators than barriers were reported. There is also a need for qualitative studies to discover service users' experience of brief psychological therapies in inpatient wards and clinical trials to evaluate its effectiveness.

5 | CONCLUSIONS

In conclusion, the literature identified barriers to implementation associated with the ward environment, mental health professionals and service users. The articles reviewed suggested that the wards are inherently busy, non-psychologist healthcare professionals are often not appropriately trained and service users can be too symptomatic to engage. These obstacles can be overcome by tailoring therapies to the inpatient setting and offering further training. There is a need for

researchers to conduct more RCTs and feasibility studies to develop and evaluate the provision of brief psychological therapies in inpatient settings.

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