ADAPTED EVIDENCED-BASED PSYCHOLOGICAL INTERVENTIONS

Delivering evidenced-based psychological interventions requires specialist training. The competences outlined in this section are for professionally registered practitioners who are trained to deliver psychological interventions, such as, a clinical psychologist, counselling psychologist or psychological therapist.

Knowledge

An ability to draw on knowledge that national guidance recommends that a number of evidenced-based psychological interventions (individual, family, and group) should be initiated in the acute phase of the patient's mental health difficulties
An ability to draw on knowledge that psychological therapies should focus on crisis management and reduce behaviours that threaten the patient's safety, while also identifying and incorporating the patient's priorities for therapy and promoting their strengths, values, and resources
An ability to draw on knowledge that psychological therapies delivered to patients in crisis assume that the patient may be struggling to implement their usual means of coping and may need additional support to manage the crisis
An ability to draw on knowledge of research evidence that suggests that it is feasible, acceptable, and efficacious to deliver brief and targeted psychological interventions for those in crisis

Establishing the therapeutic framework for patients in acute mental health crisis

An ability to draw on knowledge that any intervention rests upon a good therapeutic alliance, in which the therapist's stance is warm, empathetic, collaborative, non-judgemental and honest	
An ability to draw on knowledge that the therapist will need to maintain a consistent and constructive stance even when the patient finds it difficult to engage	
An ability to manage discussions about the limitations of confidentiality sensitively and directly, holding in mind the particular issues facing this population and the information-sharing issues that may arise	
An ability to convey hope for therapy by:	
	conveying a sense of hope about the potential benefits of therapy (based upon the evidence base and previous successes)
	engaging in 'Socratic dialogue' around negative and hopeless thoughts about their situation (for example, how have you managed to keep going? What has helped? How have you been getting through?)
	examining the costs and benefits of trying out a more hopeful approach (for example, the potential benefit of more active problem-solving versus apathy and inaction)
An ability to offer sessions in flexible locations, particularly outdoors or off the ward, as this may help facilitate engagement	

Ability to manage barriers to engagement in patients in acute mental health crisis

An ability to draw on knowledge that having multidisciplinary colleagues actively assist the patient in therapy sessions (for example, getting to sessions, practising skills) can support engagement
An ability to draw on knowledge of common barriers to engagement (for example negative attitudes towards treatment, negative beliefs about mental health services, receiving forced treatment under the Mental Health Act, experiences of restrictive practices)
An ability to address the patient's concerns about adverse consequences of disclosing their difficulties in therapy (for example, that it could delay their discharge)

An ability to make use of a range of clinical strategies to address barriers to engagement, such as:
working with the patient to identify, and so plan for, obstacles to engagement
identifying and addressing negative beliefs that may interfere with engagement
problem-solving practical issues, such as being too tired in the mornings to attend

Adapting the therapeutic offer

An ability to adapt session structure to reflect the constraints of a brief admission, such as:
flexibility in the way sessions are delivered and scheduled, for example:
being able to offer sessions on the same day the patient was referred/identified
offering more frequent sessions (i.e., more than one session a week)
offering sessions off the ward or outdoors if possible
adjusting the session duration to a length that the patient can tolerate
ensuring that agenda-setting prioritises the issues that both therapist and patient agree are the most pertinent to the presenting crisis
adjusting the priorities of the session dependent on:
the patient's presenting risk/needs relating to the crisis
the imminence of discharge (as latter sessions may need to focus on discharge planning)
concerns from the wider staff team
new information about risk

Offering crisis-focused psychological interventions

An ability to prioritise addressing the patient's basic needs (for example, financial problems and homelessness) either directly or by signposting them to appropriate services as without addressing these the benefit of therapy may be compromised
An ability to prioritise the patient's immediate safety on the ward, for example, by:
removing or minimising any ward-based potential triggers that may cause distress or (re)traumatise (i.e., by considering principles of trauma informed care)
putting in place safety plans to manage ongoing risk behaviours
supporting the development of positive therapeutic relationships with the wider staff team
building a routine/schedule of therapeutic activities
An ability to prioritise stabilising distressing emotions and risk behaviours that patients may be experiencing during their crisis by using strategies such as emotional regulation, psychoeducation, problem solving and coping strategies*
An ability to help patients manage the cognitive, behavioural, emotional, interpersonal factors which trigger and maintain the crisis, using evidenced based psychological therapies outlined in the relevant NICE guideline or competency framework**
An ability to work with the patient to develop a relapse prevention plan which incorporates early warning signs, crisis management, and prevention strategies*
An ability to work with the patient to identify any sleeping difficulties and utilise strategies such as sleep hygiene, sleep diaries, and developing a sleep routine (by identifying sleep restriction or extension targets)

*detailed in other relevant sections of the framework
** all NICE guidance can be found here https://www.nice.org.uk/guidance and competency frameworks can be found here https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/core/competence-frameworks

ADAPTED FAMILY/CARER INTERVENTIONS

Delivering evidenced-based family/carer interventions requires specialist training. The competences outlined in this section are for those with a core profession who are trained to deliver such interventions.

Further detail on the competences for family intervention can be found here (Family Interventions for psychosis and for bd web version.pdf (ucl.ac.uk)). This section will focus on the specific priorities for inpatient settings. The term "family and carers" will be used to refer to any key people in the patient's social network.

Knowledge

An ability to draw on knowledge that because an acute mental health crisis can be a very distressing time for the patient's family and carers, they should be offered support	
An ability to draw on knowledge that family/carer interventions have been demonstrated to have:	
	positive outcomes for the family/carer themselves, such as improvements in carer burden, depression, general health, and quality of life
	positive impacts on patient quality of life, functioning outcomes, and reduction of relapse and readmission
An ability to draw on knowledge that national guidance recommend evidenced-based family/carer interventions for patients in crisis	
An ability to draw on knowledge that communication skills development, problem solving, and relapse prevention are components of family/carer intervention that can be helpful when a patient is experiencing a mental health crisis	

An ability to adapt the delivery of family/carer intervention for the inpatient setting

An ability to support the patient to consider family/carer involvement in their treatment/therapy by:	
	outlining the benefits of family/carer involvement in treatment/therapy
	allowing the patients to weigh up the pros and cons of their involvement
	if relevant, collaboratively deciding when and how they might be involved
An ability to collaboratively deliver family/carer interventions which specifically focus on helping all parties cope and manage the acute mental health crisis, and include components such as:	
	sharing of information (psychoeducation and normalisation) on inpatient care and crisis (for example, the Mental Health Act and sectioning, ward processes/procedures, understanding the development and maintenance of a mental health crisis)
	staying well or relapse prevention strategies
	communication skills
	problem-solving skills specifically for managing the crisis
	helping family members develop empathy for each other's position/respect for alternative views
	stress management and crisis management techniques
	coping strategy enhancement
	motivational interviewing (for example, where substance/alcohol misuse is part of the presentation)
An ability to adapt the delivery of family/carer interventions to maximise engagement by considering:	
	a flexible structure (for example, shorter/longer sessions)
	frequency (for example, having more than one session per week)

timing (for example, offering flexible appointment times to work around family/carer availability, such as evenings and weekends)

Enhancing family communication

An ability to ensure that the delivery of communication skills is tailored to the crisis-focused formulation (i.e., mapped to the family and patient's current needs):
an ability to ensure that the family understand the rationale for a focus on communications skills and why it is important to manage crises
An ability to help the family develop positive communication, characterised by constructiveness and behavioural specificity, and including:
developing skills in active listening
attending to the positives (for example, ensuring that positive feelings are expressed explicitly)
'asking for what you want' (for example, making positive requests in a clear and explicit manner)
expressing difficult feelings (for example, disappointment or anger)
An ability to help the family mentalise and understand what is going on in each other's minds and understand each other's perspectives

Problem solving with the family

An ability to draw on knowledge that problem solving with the patient and their family/carers can help manage concerns which contributed to the current crisis
An ability to draw on knowledge that problem solving should be applied to problems that have been collaboratively identified with the patient and their family/carers and relate to the current crisis
An ability to identify problems that require staff intervention (for example, difficulties accessing benefits, housing issues)
An ability to draw on information gained at assessment to understand how concerns are currently discussed and resolved by the family
An ability to reassure the family that developing structured techniques for problem solving will build upon their existing strengths
An ability to provide a rationale for problem solving and its likely impact on family/carer functioning/stress
An ability to help the family develop effective problem-solving and crisis management skills, for example by:
discussing the benefits of the problem-solving approach in a way that is readily acceptable to the family (i.e., as a way of achieving priorities or addressing every-day challenges)
applying the problem-solving approach to crisis situations by modelling each of its elements to current issues
An ability to ensure that solutions usually involve all members of the family making changes rather than it being just one family member (such as the patient) who has to do things differently
An ability to ensure that (as far as is possible and practical) all family members are included in the process and have a voice, achieved by:
ensuring all family members contribute to the identification of possible solutions (for example, everyone makes one suggestion)
ensuring that solutions are found by collaboration amongst the whole family (so as to guard against the imposition of a solution by one family member)
An ability to adopt a staged approach to problem solving, starting with circumscribed, behaviourally specific problems through to more complex or emotionally laden concerns
An ability to help promote the family's proficiency and independence in applying problem solving by shifting from active involvement, modelling, and demonstration towards encouraging its use by the family outside of sessions

an ability to encourage the family to use the problem-solving technique within family meetings as a means of generalising its use outside of clinical sessions, particularly considering how things can be implemented once the patient is discharged

Early warning signs and relapse prevention work

An ability to draw on knowledge of the role that the family can play in supporting the personal recovery and wellbeing of the patient	
An ability to draw on knowledge that the priority of this work is to ensure the patient and their family can manage discharge and prevent further admissions	
An ability to draw on knowledge that both early warning signs work and relapse prevention work can contribute to safe discharge planning and reduce rehospitalisation	
An ability to discuss the patient and family's experiences of hospital admission and early warning signs	
An ability to help the family develop the techniques necessary to identify, monitor and respond to the early signs of relapse by:	
	helping the family to identify specific early signs, for example, by reflecting back on changes in behaviour associated with previous relapses, by using checklists of common prodromal signs helping the family identify a sequence and a "timeline" for early signs
	helping the family reflect on and identify, triggers/ "flash points" to relapse
	helping the family identify and agree the appropriate responses should signs be evident (for example, what the patient can do, what the family can do, what the service will do)
	specifically discussing the potential impact of substance misuse on relapse where appropriate documenting decisions in a way that is helpful to the family (for example, using record sheets or written plans) and agreeing how this information is to be retained
An ability to hold in mind the risk of families becoming over-vigilant for warning signs, and to help the family discuss how they can balance appropriate observance against unhelpful sensitivity (for example, leading to intrusive and over-controlling behaviours)	
An ability to liaise with any services that are included in the agreed relapse strategy, and to communicate their expected roles, for example, liaising with a home treatment team to ensure that the team is aware of its role	
An ability to ensure that the relapse strategy is not seen as a "one off" or static process and is reviewed at regular intervals/at significant events (for example, change of personal circumstances and hospital admission) with the appropriate practitioners	
An ability to deal with the difficult emotions that might be triggered by discussions of relapse, and to reinforce the rationale for engaging in the process (for example, acknowledging reluctance to reflect back on periods of ill health, or fear that the patient will become unwell again)	
An ability to be mindful of the particular issues facing families where there is risk of frequent/recurrent relapse (for example, bipolar disorder). This may include:	
	helping the family come to terms with fluctuations in mood and find ways of coping
	helping the family to understand that a "bad day" is not always a sign of relapse (prevention of excessive vigilance or over-monitoring)

ADAPTED OCCUPATIONAL INTERVENTIONS

Delivering occupational interventions requires specialist training. The competences outlined in this section are for professionally registered practitioners who are trained to deliver occupational interventions such as an occupational therapist.

Knowledge

An ability to draw on knowledge that the health of an individual is fostered through active engagement in one's occupations and that when the patient is experiencing a crisis this may be hindered	
An ability to draw on knowledge that disturbances in occupation usually result in:	
	poor sleep
	difficulties completing personal self-care tasks
	difficulties completing domestic activities of daily living
	a lack of motivation to participate in leisure activities
	poor concentration to attend to tasks
	disrupted social interactions
	disrupted routines
An ability to draw on knowledge of common occupational functioning issues which cause or exacerbate a patient's mental health crisis (for example, problems with employment and completing usual routine tasks)	
An ability to draw on knowledge that during a crisis the patient may have a significant decrease in volition and find it difficult to engage in occupational interventions	
An ability to draw on knowledge of the effects or side effects of psychopharmacological treatment on occupational functioning	

Assessing and delivering occupational interventions

An ability to conduct a thorough assessment of occupational functioning difficulties which have contributed to the patient's crisis, with a particular focus on identifying:	
	what occupational difficulties may pose a risk (for example, a patient being vulnerable due to challenges with budgeting)
	facilitators and barriers to current occupational functioning
	occupational barriers to a safe discharge (for example, self-neglect)
	hopes and goals for current and future meaningful occupational roles
An ability to develop an intervention plan focusing on areas of poor occupational function which have contributed to the current crisis and associated risks, including:	
	patterns of occupation
	communication issues
	interactive skills
	motor skills
	environment
An ability to identify positive routines to support occupational engagement where a lack of routines is an exacerbating factor to the patient's current crisis and risk	
An ability to identify occupations and therapeutic activity that are of interest where lack of activity is an exacerbating factor to the patient's current crisis and risk	

Planning for discharge

An ability to plan for discharge by identifying barriers or facilitators to occupational activities including their ability to:	
	carry out domestic and personal self-care activities at home
	carry out domestic chores in the local neighbourhood, such as shopping or leisure activities

An ability to develop a discharge plan focusing on areas of occupation including:
independent living skills
environmental adaptation of home
exploring future occupational options (employment, education, leisure)

GROUP-BASED INTERVENTIONS

This section outlines competences required by professionals to offer group-based interventions. Not all of the competences will be relevant to all professionals and will be dependent on the type of group intervention being delivered. Practitioners should draw upon the competences relevant to the activity or intervention they are delivering, which should be within the boundaries of their professional role.

Knowledge

- An ability to draw on knowledge of the characteristics of the target group population for whom the group intervention is designed (for example, age/ developmental stage, presenting problems etc.)
- An ability to draw on knowledge that group interventions are integral to inpatient care, should be delivered flexibly seven days a week and out of hours by all professionals, to ensure group activities are available to patients at all times of the day
- An ability to draw on knowledge of the aims, principles or model underpinning a group intervention
- An ability to draw on knowledge that group interventions are beneficial ways for patients to learn from others, gain peer support, and develop interpersonal skills
- An ability to draw on knowledge of national guidance indicating the range of psychosocial group interventions, including:
  - low intensity psychological interventions (for example, guided self-help, psychoeducation)
  - high intensity psychological interventions (for example, Cognitive Behaviour Therapy [CBT] groups)
  - family/carer support groups
  - activity based groups (for example, art groups, newspaper/reading groups, physical activity, and exercise)
  - peer-led groups to promote sharing experiences and peer support
  - process groups aimed at utilising group interpersonal processes for individual benefit

Group planning

- An ability to draw on the evidence base to make an informed choice about the best group intervention plan for patients
- An ability to coproduce a group with patients, which will meet the needs of current patients and, if applicable, their family and carers
- An ability to plan the basic structure and content of the group, such as:
  - practicalities (for example, setting and timing)
  - the content/agenda of each session
  - roles of staff running the group
  - any additional/ specific resources required for group sessions
  - any evaluation procedures

Group set up and engagement

- An ability to specify and apply inclusion and exclusion criteria for the group
- An ability to provide participants with information on the content and purpose of the group
- An ability to explore (and where possible address) any barriers to participation in the group, such as:
  - practical barriers (for example, other concurrent meetings)
  - emotional barriers (for example, social anxiety)
  - historical factors (for example, previous negative experiences of groups)
- An ability to help each group member identify what they would like to gain from the group

An ability to consider the most appropriate location for the group and the pros and cons (for example, on the ward or off the ward)

Group delivery

An ability to develop a therapeutic relationship with all group attendees by conveying warmth, genuineness, empathy, and respect	
An ability to adapt communication skills to deliver a group with patients who may have varying acute mental health needs including:	
	adjusting verbal communication in response to the needs of individual group members
	providing written and visual aids to support the communication of group content
	making written communication more accessible by using simple language
An ability to structure sessions so they meet the needs of patients in crisis by ensuring:	
	clear and collaboratively set group rules
	the group content is focused on issues relating to their presenting needs
	appropriate pacing of the group (for example, not covering too much information in a single session)
	regular opportunities for group discussion and peer interaction
	regular summaries and feedback to ensure patients understand the content
An ability to implement components of the group intervention including:	
	specific intervention techniques
	management of group and change processes
An ability to ensure the group is appropriate for inpatients by considering adaptations to the:	
	length (for example, potentially shorter with more breaks to allow for memory and concentration difficulties and fewer overall sessions)
	structure (for example, having group sessions which can be accessible as standalone sessions so that patients can still derive benefit from the group even if they can only attend one session or join mid-way through)
	frequency (for example, multiple, short group sessions per week)
	attendance (for example, allowing more flexibility for patients to come in and out of the group)
	facilitators (for example, having two facilitators to ensure the needs of the group can be managed)
	location (for example, in the communal area or outdoors)
An ability to manage the ending of the group, keeping in mind that the longer the patient has attended the group, the more likely ending the group programme may lead to some difficult emotions such as anxiety, or disappointment that group has ended	
An ability to help the patient reflect on their overall experience of group participation	

Managing group processes

An ability to apply basic knowledge of group processes to establish an environment which is physically and emotionally safe, by:	
	discussing the ‘ground rules’ of the group (for example, taking turns to speak, starting, and ending the group on time) in a manner that is appropriate to the group members
	“safeguarding” the ground rules by drawing attention to any occasions on which they are breached
	helping all group members to participate by monitoring and attending to their emotional state
	monitoring and regulating self-disclosure by both members and group leaders in order to maintain an environment where members can share

An ability to identify and manage any emotional or physical risk to group leaders and group participants
An ability to manage any emotional distress or behaviours that challenge within the group context by:
ensuring, if possible, that updated information on any potential emotional distress/ behaviours which challenge is gathered prior to the group (for example, by attending morning handover, checking the updated clinical notes/risk assessment) so a management plan can be considered
using skills such as active listening, and adopting a calming tone and body language throughout
knowing when it is appropriate to seek support from colleagues (i.e., when the behaviour/emotional distress is imminently going to result in harm, or is causing significant disruption to the facilitation of the group)
reporting and recording any risk behaviours which have been identified
An ability to manage any emotional distress or behaviours which may challenge within the group context by:
ensuring, if possible, that updated information on any potential emotional distress/ behaviours which challenge is gathered prior to the group (for example, by attending morning handover, checking the updated clinical notes/risk assessment) so a management plan can be considered

Ability to evaluate the group

An ability to review the patient's goals for the group
An ability to draw on knowledge of appropriate strategies and tools for evaluation, based on the resources available, and:
to provide a rationale for the evaluation strategy to patients
to feedback evaluation in a sensitive and meaningful manner

Ability to use supervision

An ability to use supervision to reflect on group processes
An ability for group leaders to reflect on their own impact on group processes

POSITIVE BEHAVIOURAL SUPPORT (PBS) INTERVENTIONS

Delivering positive behavioural support (PBS) interventions requires specialist training. The competences outlined in this section are for those who have received specific training in delivering PBS interventions.

Knowledge

- An ability to draw on knowledge that PBS interventions are a person-centred approach for providing long-term support to patients who have, or may be at risk of developing behaviours that challenge, and that:
  - it is often employed to help people with a learning disability and/or autism, including those with mental health conditions
  - it is based on an assessment of the social and physical context in which the behaviour occurs, and used to construct socially valid interventions that enhance quality of life for the person and their family and carers
- An ability to draw on knowledge that PBS can be used to understand and manage behaviours that challenge in order to reduce the behaviour, increase the patient's safety, and facilitate a safe discharge
- An ability to draw on knowledge that behaviours that challenge are a form of communication whose meaning and function need to be understood in order to reduce them
- An ability to draw on knowledge that understanding behaviours that challenge requires identification of its antecedents, the behaviour itself, and its consequences (ABC model), and should be underpinned by a specialist assessment of the functions of the behaviour*
- An ability to draw on knowledge that a PBS plan should incorporate three types of behavioural strategies which fall into one of three key areas:
  - primary strategies, which are strategies that aim to prevent the behaviour from escalating
  - secondary strategies, which manage the behaviour at the early stages of escalation
  - reactive strategies, which manage the behaviour when it reaches crisis and no other strategies have worked

PBS Intervention

- An ability to undertake a detailed assessment and formulation of the behaviours that challenge* which draws upon:
  - collaborative stakeholder involvement for example, patients, their family and carers, multidisciplinary colleagues
  - information on the behaviour from multiple sources, for example, patient, family and carers, and staff feedback, clinical notes, and a clinical assessment
  - the patient's strengths and resources
  - appropriate adaptations for the inpatient environment
- An ability to regularly review and revise the plan to ensure it reflects the current needs, interests, health, and well-being and risks of the patient by:
  - regularly seeking out further assessment information about the behaviour
  - updating the formulation/re-formulating the behaviours that challenge
- An ability to develop a comprehensive PBS plan which clearly outlines the primary, secondary, and reactive strategies
- An ability to review and adapt the plan if the environment changes or the patient is discharged from the ward

PBS Intervention

- An ability to implement a PBS plan which draws upon, primary, secondary, and reactive strategies to manage behaviours that challenge:

an ability to implement primary strategies which aim to prevent the behaviours that challenge from escalating, including:	
	minimising the triggers of the behaviour (for example, minimising noises through noise cancelling headphones if the main trigger is poor sleep)
	modifying the environment (for example, changing rooms to a quiet room is noise is the main issue for the poor sleep)
	proving opportunities for skill acquirement (for example, sleep hygiene strategies)
an ability to implement secondary strategies to manage the behaviours that challenge when it starts to escalate, including:	
	calming approaches (for example, calming talk, active listening about the issue)
	environmental modifications (for example, finding a quieter spot away from loud noises or big groups)
	coping strategies (for example, supporting the patient to undertake a breathing exercise)
an ability to implement reactive strategies, which are only used as a last resort, when the behaviours that challenge has not reduced despite the implementation of primary and secondary strategies, including:	
	non-aversive reactive strategies (for example, diversion/distraction strategies)
	crisis management (for example, restrictive practices*)

An ability to systematically monitor the implementation and effectiveness of the support plan and to review and adapt it in the light of this evaluation

*See relevant section (*Ability to undertake an assessment of the function of behaviours* and *Collaborative safety (risk) planning and intervention*)

SPIRITUAL AND RELIGIOUS SUPPORT

This section outlines competences required by professionals to offer appropriate spiritual and religious support to patients. Not all of the competences will be relevant to all professionals and will be dependent on the type of activity or intervention being conducted. Therefore, practitioners should draw upon the competences relevant to the activity or intervention they are delivering, which should be within the boundaries of their professional role.

Knowledge

An ability to draw on knowledge that religious beliefs and spirituality:
- can shape the ways that patients make sense of and cope with their crisis
- can help patients through crises by acting as a source of hope, meaning, and comfort
An ability to draw on knowledge that staff can invalidate, offend, or contribute to the disengagement of a patient if they do not incorporate the patient's spiritual/religious belief systems and practice into their inpatient care
An ability to draw on knowledge that some patients may experience self-blame, guilt, and a sense of alienation from their religious community if they feel that they are not meeting expected standards due to their current crisis
An ability to draw on knowledge that being admitted to hospital can hinder opportunity to practice religious or spiritual rituals, which can lead to a loss of connection and guilt
An ability to draw on knowledge that in some cases, religious and spiritual beliefs and practice may become altered in a state of crisis and may act to maintain the crisis if they are, for example:
- believing that they are being punished by God
- believing they are hearing the voice of God/the devil

Integrating religion/spirituality into interventions

An ability to assess the patient's religious or spiritual beliefs and understand how they relate to the current mental health crisis
An ability to integrate the patient's religious or spiritual beliefs into the formulation of their current mental health crisis
An ability to integrate the patient's spiritual and religious practices into interventions, as a means of understanding and coping with their crisis, such as:
- prayer
- reading religious scripture
- religious support groups
- chaplaincy
An ability to facilitate access to religious/spiritual practices during an inpatient stay (for example, access to religious scripture, multi-faith prayer/worship room, leave to visit faith services)
An ability to signpost patients to local religious/cultural groups
An ability to deliver an intervention which, when appropriate, is collaboratively delivered with chaplaincy, such as:
- psychoeducation and normalisation of religious/spiritual beliefs/practices
- prayer and reading of religious scripture