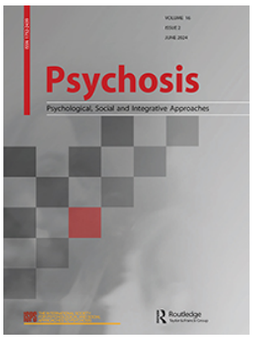

Routledge
Taylor & Francis Group

Psychosis

Psychological, Social and Integrative Approaches

ISSN: (Print) (Online) Journal homepage: www.tandfonline.com/journals/rpsy20

Delivering a Cognitive Behaviour Therapy for psychosis (CBTp) informed crisis intervention in acute mental health inpatient settings: a therapy protocol

Lisa Wood, Anthony P. Morrison, Barbara Lay, Claire Williams & Sonia Johnson

To cite this article: Lisa Wood, Anthony P. Morrison, Barbara Lay, Claire Williams & Sonia Johnson (11 Sep 2024): Delivering a Cognitive Behaviour Therapy for psychosis (CBTp) informed crisis intervention in acute mental health inpatient settings: a therapy protocol, Psychosis, DOI: 10.1080/17522439.2024.2386176

To link to this article: https://doi.org/10.1080/17522439.2024.2386176

Published online: 11 Sep 2024.

PSYCHOSIS
https://doi.org/10.1080/17522439.2024.2386176

Routledge
Taylor & Francis Group

Delivering a Cognitive Behaviour Therapy for psychosis (CBTp) informed crisis intervention in acute mental health inpatient settings: a therapy protocol

Lisa Wood[a,b], Anthony P. Morrison[c], Barbara Lay[d*], Claire Williams[b] and Sonia Johnson[a]

[a]Division of Psychiatry, University College London, London, UK; [b]Acute and Rehabilitation Directorate, North East London NHS Foundation Trust, Rainham, UK; [c]Psychosis Research Unit, Greater Manchester Mental Health NHS Foundation Trust, Manchester, UK; [d]Psychiatrische Dienste Aargau, Aargau, Switzerland

ABSTRACT

Background: People experiencing psychosis in acute crisis should be offered Cognitive Behavioural Therapy for psychosis (CBTp) however there are no protocols developed to inform delivery specifically for people in acute crisis receiving inpatient mental health care. This paper narratively describes a CBTp-informed crisis-focused therapy protocol to inform the delivery of therapy in inpatient settings.

Method: This study draws on relevant systematic reviews, qualitative interview studies with stakeholders, Delphi studies, and coproduction to develop the protocol. It draws upon crisis theories and CBTp theories to underpin it.

Results: This paper outlines a modularised approach to working with people with psychosis and in crisis. It outlines the key values underpinning the protocol, and the key modules of: engagement, assessment and identifying priorities; formulation of the crisis, stabilisation, safety, and problem solving, crisis plans and crisis cards, change strategy work focusing on crisis appraisals, and discharge and relapse planning.

Discussion: A crisis-focused cognitive behavioural therapy protocol is presented which can be used to inform therapy for people experiencing psychosis and in crisis. More research is required to explore the efficacy of such therapies.

ARTICLE HISTORY
Received 2 February 2024
Accepted 23 July 2024

KEYWORDS
Cognitive behaviour therapy; psychiatric inpatient; therapy protocol; schizophrenia; psychosis

Background and rationale

Cognitive Behavioural Therapy for psychosis (CBTp) is a talking therapy which aims to help people cope with their experiences of psychosis by looking at how they make sense and respond to them. The National Institute for Health and Care Excellence (NICE, 2014) outline that patients with psychosis should be offered CBTp during the acute phase following a protocol-driven approach. There is substantial evidence that CBTp is an effective intervention for improving outcomes for people experiencing psychosis, such as positive symptoms and prevention of relapse, with small-to-medium effect sizes (Bighelli et al., 2021; Wykes et al., 2008). Large definitive trials have been conducted with a variety of psychosis populations such as people with at risk mental states, first episode psychosis and severe and enduring psychosis, largely demonstrating effectiveness (Lewis et al., 2000; A. P. Morrison et al.,

CONTACT Lisa Wood l.wood@ucl.ac.uk Division of Psychiatry, University College London, Maple House, 149 Tottenham Court Road, London W1T 7NF, UK

*Present Affiliation: Lucerne Psychiatry, Lucerne, Switzerland.

2011, 2018); however, patients in acute crisis settings have been relatively overlooked in recent decades. Some early CBTp studies have been conducted in inpatient settings, and demonstrated benefits on negative symptoms, total symptoms, functioning and readmission, however few trials have been conducted to specifically deliver CBTp interventions in acute crisis, particularly the current contemporary context of brief admissions, acute levels of risk (e.g. self-harm and suicidality), and involuntary hospitalisation (Wood et al., 2020). There are several challenges to the delivery of CBTp in current inpatient settings, which have resulted in less than a quarter of patients having access to it (Ince et al., 2015; Jacobsen et al., 2018). These challenges include complex patient needs (e.g. acute distress, memory, and concentration difficulties), and structural barriers (e.g. receiving care in a restrictive environment and limited leave due to involuntary admissions). Therefore, a protocol to help inform the delivery of CBTp interventions in this complex setting is essential.

There is emerging evidence that briefer (6–8 sessions) targeted CBTp-informed interventions are effective for those experiencing psychosis, which is promising for inpatient environments where brief interventions are generally, only possible. These interventions have targeted symptoms such as insomnia, anxiety, paranoia, and auditory hallucinations, including one which targeted insomnia in inpatient settings, demonstrating the potential for a brief targeted protocol-driven approach in this setting to be effective (Craig et al., 2018; Freeman, Dunn, et al., 2015; Freeman, Waite, et al., 2015; Sheaves et al., 2017). These approaches target specific causal mechanisms of psychosis, which is how they can bring about change in a time-limited manner. Moreover, there is an emerging literature from outpatient contexts indicating that more frequent sessions (i.e. more than once a week) may improve outcomes, which is yet to be implemented in inpatient settings. Taking this evidence into account, the aim of this paper is to give an overview of a protocol-driven approach to deliver a CBTp-informed crisis intervention for people with psychosis in inpatient settings.

Ethics statement

This protocol does not draw on any data from human participants, and therefore ethical approval was not required.

Overview of the protocol and delivery

This intervention protocol is currently being examined as part of a feasibility randomised controlled trial to determine usefulness and acceptability (Wood, Williams, et al., 2022). Within this intervention protocol, the components of a CBTp model are applied alongside components of stabilisation and establishing safety, crisis and discharge planning. The intervention is underpinned by existing CBTp protocols and theoretical models (A. Morrison, 2017), competency frameworks (Roth & Pilling, 2012; Wood, Jacobsen, et al., 2022), systematic reviews (Jacobsen et al., 2018; Wood et al., 2020), Delphi studies (A. Morrison & Barratt, 2010; Wood, Jacobsen, et al., 2022), relevant qualitative work (Wood et al., 2019a, 2019b, 2019c, 2021) and literature on crisis and discharge planning (Dass-Brailsford, 2007). The content of this protocol were developed in partnership with a stakeholder group of experts by experience (personal lived experience of psychosis and inpatient care, and family/carers) and clinicians (Wood et al., 2023).

The intervention offers an average of 6–8 sessions (up to two sessions a week), including at least one follow-up session post-discharge, but ideally more, to follow people through their crisis care pathway journey (i.e. via inpatient and Home Treatment Teams). The protocol has been designed to be delivered in a contemporary psychiatric inpatient context of brief admissions (current average 39 days, (NHS Benchmarking Network, 2024)). The number of proposed sessions is based on the average length of time people are likely to be under crisis service, however if more sessions are possible, then they should be offered in line with NICE (2014) guidelines. It is acknowledged that the number of sessions offered will depend on a variety of factors including the length of admission, willingness to engage in sessions post-discharge, and presenting difficulties, to name a few. The number of

sessions offered should be flexible and based on patient need. A single session intervention can be offered, but the therapist should aim to offer more sessions where possible to ensure therapeutic benefit (Jacobsen et al., 2018). Collaborative goal setting can be a challenge in this context due to patients often being involuntarily hospitalised (HM Government, 2007), which they may not agree to. However, the intervention should focus on a collaborative crisis-focused goal with the aim of helping the patient manage the crisis, their admission, move towards a safe discharge back home, and prevent future admissions.

A. Morrison (2017) outlines the importance of adhering to protocols and fidelity scales such as the Cognitive Therapy Rating Scale (CTSR (Blackburn et al., 2001)) to ensure that the outcomes found in research trials can be replicated in clinical practice, which is also key to this protocol delivery. It will be more challenging to deliver an intervention that will meet all the requirements of the CTSR (Blackburn et al., 2001) in inpatient settings, but the CTSR should still be followed, where possible. However, for example, it may only be possible to set one agenda item, and a formulation may be simplified.

Values underpinning the delivery of the manual

The values underpinning this protocol build on established CBTp values outlined in two key papers (Brabban et al., 2016; A. Morrison, 2017). These are values such as prioritising personal recovery, optimism, a good therapeutic relationship, person centred practice, active listening, and validation of experiences. There are also process-oriented values such as having a shared goal, collaboration, normalisation, evaluating how accurate and helpful appraisals are, active involvement and choice, undertaking between session tasks, understanding thinking processes, basing therapy on an empirically tested cognitive model, and bridging between sessions. This section will expand on the values required for this intervention protocol.

A trusting therapeutic relationship based on *professionalism and advocacy* is crucial due to the high level of distress patients may be experiencing in relation to their psychotic symptoms and the challenging, restrictive, and potentially traumatising context that therapy is being delivered in. For example, patients experiencing psychosis are more likely to be involuntarily hospitalised (Akther et al., 2019) and have previous negative experiences with services (Halvorsrud et al., 2018), so prioritising the therapeutic relationship, being professional and advocating for the patient with the wider care team is crucial. The therapist should be transparent about the limitations of their role in the team (e.g. limits of confidentiality, limits in facilitating significant changes in care plans and leave entitlement). The relationship should be built through both formal and informal interactions, e.g. having a chat in the corridor as opportunities to build rapport outside of sessions.

It is vital that the intervention is *culturally competent and incorporates an understanding of the person's cultural needs*. It is imperative to acknowledge that inpatient admissions disproportionately affect people from racially marginalised backgrounds and that inpatient stays can be traumatising (Halvorsrud et al., 2018). Rathod et al. (2019) outlines key cultural considerations to ensure CBTp is delivered in a culturally competent way including, assessing racism, discrimination, and negative experiences of health services, developing an understanding of the person's cultural and religious beliefs, seeing people in a place of safety (e.g. a quiet room or outdoors), using an interpreter, and involving family and extended community in therapy. Culturally adapted CBTp has been applied in psychiatric inpatient settings demonstrating that such adaptations can help facilitate the delivery of effective CBTp (Habib et al., 2015).

Flexibility is incredibly important to the success of this intervention due to patients' acute experiences of psychosis and the restrictive environment (Wood et al., 2019a). Patients may be experiencing distressing psychotic symptoms, drowsiness from medication, or be subject to restrictive practices which is understandably going to impact on engagement. Therefore, flexibility should be considered in terms of session time, duration, frequency, pacing, attendance, and location. Sessions should be offered in a quiet space, off the unit or outdoors if leave is allowed (due to room noise and interruptions; Jacobsen et al., 2018).

The weeks following discharge from hospital are when patients feel most vulnerable and are at highest risk of suicidality, self-harm and continuity between hospital and community care can reduce this risk (Meehan et al., 2006). Therefore, if possible, therapy should continue beyond admission and support the person throughout their crisis care pathway journey. If this is not possible, a comprehensive plan should be put in place to manage inpatient discharge with at least one follow-up session, handover meetings, and referral to community psychology services.

The delivery of the therapy should ensure the patient feels in *control, empowered and hopeful* given that (a) lack of control, disempowerment, and hopelessness are precipitating factors of crisis and risk behaviours such as self-harm and suicidality (Tobitt & Kamboj, 2011); (b) that therapy is being delivered in a disempowering and restricted environment (Akther et al., 2019); and (c) it is a key priority to those experiencing psychosis (Pitt et al., 2007). The therapist should give patients as much ownership over the therapeutic process as possible and ensure therapy instils messages of hope and that overcoming crisis and distressing experiences of psychosis is possible. This can be achieved through processes such as validation, normalisation, and psychoeducation, and the delivery of crisis-focused change strategies (A. Morrison, 2017). Control, empowerment, and instilling hope should also be goals for therapy, for example, the patient could work towards taking more control over their inpatient care plan, their experiences of psychosis (e.g. command hallucinations), or interpersonal relationships.

Finally, the therapist should be *well-informed about the acute mental health inpatient care* the patient is receiving. This requires therapists to have a good knowledge of mental health legislation, anti-psychotic medication and their side effects, and other pertinent unit processes and procedures. This is to ensure the therapist can deliver interventions within this context and have informed discussions with the patient about their inpatient care. Moreover, the therapist can pass this knowledge onto the patient further empowering them about their care.

Process issues when working with people in acute mental health crisis in inpatient settings

There are many implementation challenges to consider when delivering this therapeutic protocol to patients in an acute mental health inpatient setting. A recent review outlined the barriers to implementing psychological therapy in inpatient settings related to the patient and the environment, which will be outlined further below (Evlat et al., 2021).

Some patients may have difficulties with their memory and concentration due to factors such as high levels of medication use and related side effects, drugs and alcohol use, and distressing experiences of psychosis, to name a few (Kuipers et al., 2006; Moncrieff et al., 2009). Therefore, appropriate adaptations will be required to manage this including shorter sessions, offering breaks, written summaries, and resources, recapping previous sessions, summarising key points at the end of every session, fewer agenda items, using simplified/lay language, use of images and visual aids, and simplified thought records and behavioural experiment sheets. Moreover, regular check-ins throughout the session where the person has understood what had been discussed, and recapping of previous sessions at further sessions could help the person retain information.

Many patients will also be experiencing ongoing acute experiences of psychosis. This may be a valuable opportunity to assess and find ways to help the patient manage these experiences, but this would need to be carefully navigated due to potential distress. If these experiences are highly distressing it may be important to allow for pauses, time, and space within the session; however, it can be a good opportunity to try and understand the phenomenology of the psychosis experience (e.g. voice hearing) and its impacts. Moreover, patients may be experiencing disorganised thinking or thought disorder, which is common in crisis (Byrne, 2007). Thought disorder is when a patient is making sense of their experiences but may have skipped explanatory steps which make it less obvious to the listener how their speech may link together (Palmier-Claus et al., 2017), and is likely to be meaningful communication to the individual. Therefore, it is important for the therapist to try and

Table 1. Modules of therapy.

	Modles
1	Engagement, assessment and identifying priorities
2	Formulation of the crisis
3	Stabilisation, safety, and problem solving
4	Crisis plans and crisis cards
5	Change strategy work focusing on crisis appraisals
6	Discharge and relapse (recovery) planning

adopt a slower pace and ask clarification questions to allow space for the person to describe their experiences, even when it seems unclear. The therapist should hold in mind that real meaning can be made from such communications.

There are many barriers which relate to the inpatient environment itself. As outlined, several patients may be compulsorily admitted and therefore undertaking activities such as behavioural activation may be difficult. In addition, the wider multi-disciplinary team (MDT) may contradict the work undertaken in the sessions in some way (e.g. telling them that their voices are a symptom of Schizophrenia rather than a spiritual voice). Therefore, it is important that the therapist works closely with staff to share formulations, develop a shared narrative of the patient's presenting difficulties, and negotiate the use of leave for intervention sessions. It has been indicated that therapists who are embedded in the MDT, working collaboratively, and communicate effectively with the inpatient MDT improves the quality of inpatient care, particularly for those with psychosis whose symptoms are often medicalised (Berry & Barrowclough, 2009).

Therapy modules

This protocol outlines six key modules for the delivery of the intervention, which are outlined below. Not all these modules will be required and should be considered based on the priorities and goals of the patient. The modules of therapy are outlined in Table 1.

Engagement, assessment and identifying priorities

As stated, the therapeutic relationship is a priority, and therefore engagement should be the focus of the first meeting(s). The therapist should clearly explain their role and how they fit into the team, confidentiality (i.e. that confidentiality is usually at a team level and that session content is generally fed back to the team), duration of the session, length of input, and how the patient will be followed up if they are unexpectedly discharged, to build trust. A brief explanation of what the intervention entails should be given at the start, with further description being expanded upon as the session progress and opportunity for the patients to ask questions. Issues of confidentiality and consent should be reviewed regularly throughout the sessions as the person's wellness and practical circumstances (e.g. being involuntarily hospitalised) may fluctuate, which may impact this. The assessment session is an opportunity for the therapist to demonstrate allyship for the patient in terms of working together to communicate their needs to the wider team and supporting them to input into their wider care plan.

The assessment should have a collaborative focus and aim to develop an understanding of the patient's presenting needs in relation to the current crisis, risk behaviours, and experiences of psychosis. The assessment should explore the factors outlined in the theoretical model (Figure 1) and broadly cover the precipitating factors for admission (i.e. stressful life events and environmental factors) including internal triggers/changes (e.g. anomalous experiences, intrusions into awareness), admission experiences, cognitive, behavioural, emotional, and physiological components of the crisis experience, protective factors, personal identity, culture and religious beliefs, interpersonal relationships, current levels of functioning and traumatic experiences. A particular

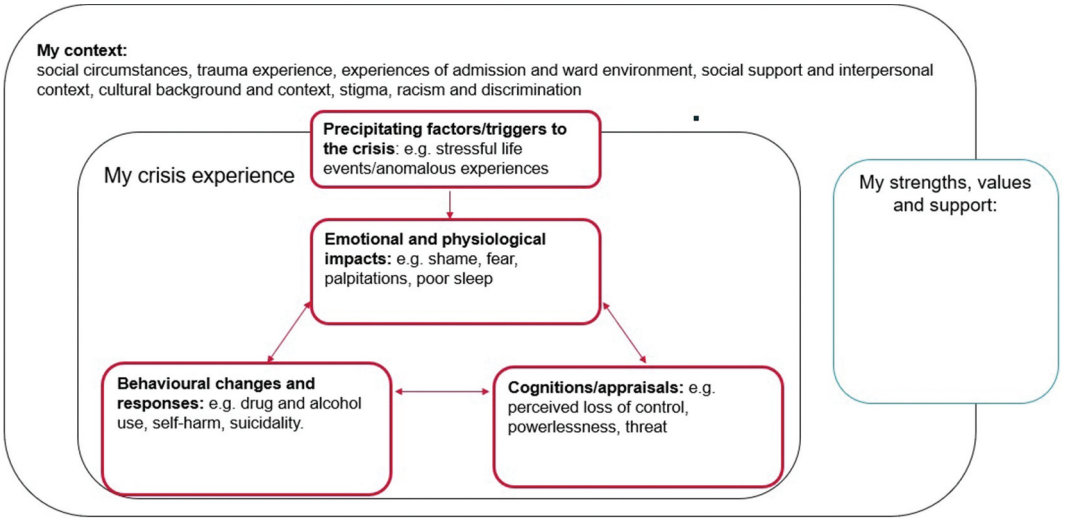

Figure 1. Formulation model of crisis.

focus should be on understanding the changes in characteristics of the experiences of psychosis, including the conviction, belief inflexibility, frequency, intensity, levels of associated distress, negative content, perceived malevolence, control, identity and power, and compliance with any auditory hallucinations as these can intensify when in crisis (Birchwood et al., 2000; Byrne, 2007). Moreover, time should be spent understanding the patient's perspectives on the nature and extent of their problems as patients who have a lower perceived sense of control, perceive their problems to be biologically caused, and who believe their problems will not last long are less likely to engage and benefit from therapy, and work might need to be undertaken to explore these beliefs (Freeman et al., 2013).

A thorough risk assessment of the individual's presenting and historical risk should also be undertaken including understanding the relationship between experiences of psychosis and risk behaviours (e.g. command hallucinations telling the individual to harm themselves or others (Royal College of Psychiatrists, 2021)). The therapist should also explore the specific psychological factors associated with the development and maintenance of risk behaviours and draw on relevant psychological research of suicidal behaviour to do so (e.g. R. O'Connor & Kirtley, 2018).

Due to the limited nature of inpatient stays, if possible, a basic understanding of the presenting crisis, therapy goals and safety needs in relation to the unit should be established by the first session. However, assessment can continue throughout the sessions as new information is presented. By the end of the first session(s) a crisis-focused problem list, which should include distressing experiences of psychosis and risk behaviours such as self-harm and suicide, should be identified and a goal explicitly identified from these. This goal may be working toward discharge and returning to normal life, increasing safe behaviours and reducing risk behaviours, improving day-to-day functioning, or being able to better communicate their needs to the care team. Using Q-sort cards may help if the patient is struggling to identify a goal (Douglas et al., 2022).

Formulation of the crisis

A collaborative formulation should be developed based on the model outlined in Figure 1. The formulation should focus on the current crisis, related experiences of psychosis and risk behaviours, and be directly related to the goal of the therapy. Therefore, the formulation may focus on the crisis

episode, or have more explicit focus on specific behaviours relating to the crisis (e.g. suicidality and self-harm) or focus on ongoing distress relating to the unit environment. A brief formulation should always be shared with the patient before intervention work is undertaken, even if this is verbally or very simplified, for example, by linking the trigger of hospital admission to current experiences of psychosis and related feelings, thoughts, and behaviours. However, if there are reasons this is not possible, the therapist should retain the formulation and use it to guide the work until it can be collaboratively shared. Like the assessment, a formulation can be built upon as sessions continue, but having a basic formulation by the end of the first couple of sessions allows for the commencement of brief intervention work. The therapist should aim for a comprehensive formulation but a basic formulation is sufficient to begin intervention work.

Intervention work

Once a crisis formulation has been developed and a goal has been agreed, strategies can be utilised to help the patient with their crisis-focused goal. Given that patients may only want brief sessions or be experiencing acute distressing experiences of psychosis, it may only be possible to undertake one basic strategy with them per session. Strategies should be tried in collaboration with the patient as the usefulness of the strategies outlined below are very individual. If one strategy does not work or is not helpful, the therapist should move onto another.

Stabilisation, safety, and problem solving

The first module of the intervention is to prioritise the promotion of the patient's safety and basic stabilisation. This is indicated as an important stage in therapy for those, experiencing complex trauma, distressing experiences of psychosis, suicidality, and self-harm (Berk et al., 2004) and therefore imperative for those in crisis experiencing psychosis. This module should incorporate consideration of the direct issues causing significant threat to the patient's psychological and physical safety.

As outlined, many patients will come with social problems, such as housing and financial difficulties, and the therapist should support stabilisation of these issues by signposting and contributing to a multidisciplinary care management plan as indicated in the NHS Long Term Plan (NHS England, 2019). Environmental stabilisation is also a priority. Trauma-informed care approaches have been demonstrated to have benefits for patients in inpatient settings and are integral to the care of people experiencing psychosis (Hardy, 2017; Muskett, 2013). Such strategies may include removal of key triggers of distress where possible, providing a calming environment (e.g. safe/quiet rooms), identifying safe staff members, and clear communication from the team about care planning and treatment. This is in line with a CBTp approach where environmental modifications are key to reducing distress in people experiencing psychosis (A. Morrison, 2017).

Psychological stabilisation and safety should include supporting patients with high emotional arousal and related physiological symptoms, which are often the primary difficulty for patients in crisis (Tobitt & Kamboj, 2011). Therefore, developing coping and self-management strategies is crucial (Johnson et al., 2018). This work should aim to help the patient cope with the current crisis by giving them strategies to manage the triggers and cognitive, behavioural, emotional, and physiological components of the crisis. Evidenced based strategies that can be helpful are general coping work/distraction strategies (e.g. coping with voices work; Hearing Voices Network, 2015) grounding strategies, prayer and religious comfort, anxiety management (including progressive muscle relaxation and breathing exercises), safe place imagery, mindfulness, compassionate words/imagery, distraction techniques, emotion regulation strategies (such as TIPP and IMPROVE; Linehan, 2015) (Berk et al., 2004). A hope box, which is a collection of such strategies stored in a box, has been demonstrated to be helpful for people who are feeling suicidal, and may be a helpful way of collecting strategies that a patient can use in a time of crisis (Berk et al., 2004).

An important component of coping and self-management is psychoeducation and therefore sharing information on the management of crisis, risk behaviours, and inpatient care may be beneficial to patients. For example, topics for psychoeducation may include the reasons why psychotic crises occur, prevalence rates of psychotic crises, social and psychological factors which influence psychotic crisis development (including experiences such as trauma, racism, discrimination), the role of our thoughts, feelings, and behaviours in keeping the psychotic crisis going, and the importance of developing ways of coping. These areas of psychoeducation can also be applied to specific behaviours relating to the crises such as suicidality or self-harm. Moreover, education on mental health legislation, treatments, and unit procedures may be equally important to empower the patient.

Addressing insomnia and sleep disruption is also of importance as it is often reported as a precipitating factor in admissions and exacerbates experiences of psychosis (Koyanagi & Stickley, 2015). Sleep interventions that focus on sleep hygiene and developing healthy sleep routines have been shown to be beneficial for those with psychosis, including those within inpatient settings (Sheaves et al., 2017).

As outlined, when people are in heightened emotional distress, experiencing acute psychosis, highly aroused or suicidal, they may struggle more than usual to problem solve key issues that may have contributed to the cause or maintenance of their crisis (Dass-Brailsford, 2007). Therefore, crisis work may include supporting the person with problem solving. Problem solving can occur in six key stages; identify the key problem(s) that contributed to the crisis, identify potential problem solving strategies, consider their pros and cons, set out a step-by-step plan, carry out the plan, review and, if required, revise/adjust the plan (Roth & Pilling, 2012).

Crisis plans and crisis cards

Crisis plans are plans which aim to promote safety and outline key strategies that may be helpful to the patient in managing the crisis as it happens. They have been shown to be useful in managing acute crisis, and related risk behaviours such as self-harm and suicidality (R. C. O'Connor et al., 2022). Crisis cards have the same aim but are designed to be carried around by the patient in their wallet or pocket. These are helpful for patients on the unit in case they become acutely distressed during their admission. It is important to ensure that the MDT knows about their crisis plans and can encourage them to use them. Drawing on Birchwood et al. (2000) relapse prevention work, crisis plans should include information on things that prevent the patients from becoming distressed, triggers (internal and external) of distress, early warning signs, self-management strategies, strengths and resources, things that friends and family can do, and things that staff can do. The crisis card can include these areas but may need to focus on the specific patient priority areas due to its size. Crisis plans and cards should be adapted for the patient when they are ready for discharge, so they are tailored to managing crises when back at home.

Change strategy work focusing on crisis appraisals

The change strategies used in this module draw upon strategies commonly used in CBTp (A. Morrison, 2017) but adapted specifically for crisis-related appraisals and behaviours. These strategies are described in more detail in A. Morrison's (2017) paper and include normalisation, examining advantages and disadvantages of events, appraisals and responses (including those related to hearing voices, unusual beliefs and paranoia), role play/skills practice, evidential analysis, generating alternative explanations, survey planning/review, beliefs/expectations about success and pleasure, reducing social isolation/graded activity scheduling/mastery and pleasure/schedule success, safety seeking behaviours/behavioural experiments/exposure, metacognitive beliefs/strategies, and attentional strategies. An example of how to adapt these would be developing a behavioural activation

plan that incorporates unit-based activities and graded leave from the unit, or undertaking a behavioural experiment that tests the belief "If I talk to others, they will ignore me" by talking to fellow patients in the communal area or during meal times.

Discharge and relapse (recovery) planning

Discharge should be kept in mind from the outset of inpatient care (NICE, 2016), and therefore should be on the agenda of any psychological input. Discharge planning should also include an agreement on any follow-up sessions being undertaken post-discharge. The priority of psychological input when the patient is planning for discharge is to revisit the triggers for admission and explore whether they are likely to be present upon discharge as well as identify and new or emerging triggers, and develop a prospective formulation of potential cognitive, behavioural, emotional, and physiological consequences of these, with a particular focus on risk behaviours such as suicide. The discharge plan should outline what the patient needs or should do to cope with these potential experiences, drawing upon strategies already outlined above. This process may involve adapting the crisis plan to focus more on coping once discharged.

All stages should include the involvement of the person's social networks, such as family, carers, and community care coordinators, but this is particularly important when discharge planning where possible. Having social network involvement in discharge planning can help improve outcomes for patients and reduce readmission (Eassom et al., 2014). If the patient has limited social networks, efforts should be made to consider services that can support them and/or help them develop social networks (if important to them). Moreover, any discharge planning undertaken in the therapeutic work should also be shared with the team to inform the wider care plan.

Conclusions and future directions

This paper outlines a CBTp-informed crisis intervention for inpatients, drawing upon crisis literature and relevant CBTp theories and approaches. It has been developed in collaboration with patients with lived experiences of inpatient care and psychosis. It outlines adaptations to the assessment, formulation, and intervention phases. There is emphasis on prioritising the therapeutic relationship, working on the current crisis presentation, and working flexibly. It is currently being tested in a feasibility randomised control trial for acceptability (Wood, Williams, et al., 2022) and undergoing qualitative evaluation from those who have delivered and received the intervention and, if found acceptable, further definitive trials may be required to examine its effectiveness.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

This study was undertaken as part of the lead author's National Institute of Health Research (NIHR) Health Education England Integrated Clinical Academic Clinical Lectureship [ICA-CL-2018-04-ST2-013].

Data availability statement

No data was generated by this study.

References

Akther, S., Molyneaux, E., Sturat, R., Johnson, S., Simpson, A., & Oram, S. (2019). Patients' experiences of assessment and detention under mental health legislation: Systematic review and qualitative meta-synthesis. *British Journal of Psychiatry Open*, *5*(e37), 1–10. https://doi.org/10.1192/bjo.2019.19

Berk, M., Henriques, G. R., Warman, D. M., Brown, G. K., & Beck, A. T. (2004). A cognitive therapy intervention for suicide attempters: An overview of the treatment and case examples. *Cognitive and Behavioural Practice*, *11*(3), 265–277. https://doi.org/10.1016/S1077-7229(04)80041-5

Berry, K., & Barrowclough, C. (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*(39). https://doi.org/10.1017/S1352465808005018

Bighelli, I., Rodolico, A., García-Mieres, H., Pitschel-Walz, G., Hansen, W. P., Schneider-Thoma, J., Siafis, S., Wu, H., Wang, D., Salanti, G., Furukawa, T. A., Barbui, C., & Leucht, S. (2021). Psychosocial and psychological interventions for relapse prevention in schizophrenia: A systematic review and network meta-analysis. *The Lancet Psychiatry*, *8*(11), 969–980. https://doi.org/10.1016/s2215-0366(21)00243-1

Birchwood, M., Spencer, E., & McGovern, D. (2000). Schizophrenia: Early warning signs. *Advances in Psychiatric Treatment*, *6*(2), 93–101. https://doi.org/10.1192/apt.6.2.93

Blackburn, I. M., James, I. A., Milne, D. L., & Reichelt, F. K. (2001). *Cognitive therapy scale - revised (CTS-R) manual*. Univeristy of Newcastle.

Brabban, A., Byrne, R., Longden, E., & Morrison, A. (2016). The importance of human relationships, ethics and recovery-orientated values in the delivery of CBT for people with psychosis. *Psychosis: Psychological, Social and Integrative Approaches*, *9*(2), 157–166. https://doi.org/10.1080/17522439.2016.1259648

Byrne, P. (2007). Managing the acute psychotic episode. *BMJ*, *334*(7595), 686–692. https://doi.org/10.1136/bmj.39148.668160.80

Craig, T. K. J., Rus-Calafell, M., Ward, T., Leff, J. P., Huckvale, M., Howarth, E., Emsley, R., & Garety, P. A. (2018). AVATAR therapy for auditory verbal hallucinations in people with psychosis: A single-blind, randomised controlled trial. *The Lancet Psychiatry*, *5*(1), 31–40. https://doi.org/10.1016/S2215-0366(17)30427-3

Dass-Brailsford, P. (2007). Crisis intervention (Chapter 5). In P. Dass-Brailsford (Ed.), *A practical approach to trauma: Empowering interventions* (pp. 93–112). Sage Publications.

Douglas, C., Wood, L., & Taggart, D. (2022). Recovery priorities of people with psychosis in acute mental health in-patient settings: A Q-methodology study. *Behavioural and Cognitive Psychotherapy*, *50*(1), 1–14. https://doi.org/10.1017/s1352465820000892

Eassom, E., Giacco, D., Dirik, A., & Priebe, S. (2014). Implementing family involvement in the treatment of patients with psychosis: A systematic review of facilitating and hindering factors. *British Medical Journal Open*, *4*(10), 1–11. https://doi.org/10.1136/bmjopen-2014-006108

Evlat, G., Wood, L., & Glover, N. (2021). A systematic review of the implementation of psychological therapies in acute mental health inpatient settings. *Clinical Psychology & Psychotherapy*, *28*(6), 1574–1586. https://doi.org/10.1002/cpp.2600

Freeman, D., Dunn, G., Garety, P., Weinman, J., Kuipers, E., Fowler, D., Jolley, S., & Bebbington, P. (2013). Patients' beliefs about the causes, persistence and control of psychotic experiences predict take-up of effective cognitive behaviour therapy for psychosis. *Psychological Medicine*, *43*(2), 269–277. https://doi.org/10.1017/S0033291712001225

Freeman, D., Dunn, G., Startup, H., Pugh, K., Cordwell, J., Mander, H., Cernis, E., Wingham, G., Shirvell, K., & Kingdon, D. (2015). Effects of cognitive behaviour therapy for worry on persecutory delusions in patients with psychosis (WIT): A parallel, single-blind, randomised controlled trial with a mediation analysis. *The Lancet Psychiatry*, *2*(4), 305–313. https://doi.org/10.1016/S2215-0366(15)00039-5

Freeman, D., Waite, F., Startup, H., Myers, B., Lister, R., Mdnerney, J., Harvey, A. G., Geddes, J., Zaiwalla, Z., Luengo-Fernandez, R., Foster, R., Clifton, L., & Yu, L. (2015). Effi cacy of cognitive behavioural therapy for sleep improvement in patients with persistent delusions and hallucinations (BEST): A prospective, assessor-blind, randomised controlled pilot trial. *The Lancet Psychiatry*, *2*(11), 975–983. https://doi.org/10.1016/S2215-0366(15)00314-4

Habib, N., Dawood, S., Kingdon, D., & Naeem, F. (2015). Preliminary evaluation of culturally adapted CBT for psychosis (CA-CBTp): Findings from developing culturally-sensitive CBT project (DCCP). *Behaviour and Cognitive Psychotherapy*, *43*(2), 200–208. https://doi.org/10.1017/S1352465813000829

Halvorsrud, K., Nazroo, J., Otis, M., Hajdukova, E., & Bhui, K. (2018). Ethnic inequalities and pathways to care in psychosis in England: A systematic review and meta-analysis. *BMC Medicine*, *16*(1), 1–17. https://doi.org/10.1186/s12916-018-1201-9

Hardy, A. (2017). Pathways from trauma to psychotic experiences: A theoretically informed model of posttraumatic stress in psychosis. *Frontiers in Psychology*, *8*, 697. https://doi.org/10.3389/fpsyg.2017.00697

Hearing Voices Network. (2015). *Hearing voices coping*. https://www.hearing-voices.org/wp-content/uploads/2012/05/Hearing_Voices_Coping_Strategies_web.pdf

HM Government. (2007). *Mental health act 2007*. HM Government.

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 & Psychotherapy: Theory, Research & Practice*, *89*, 324–350. https://doi.org/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. https://doi.org/10.1192/bjp.2018.106

Johnson, S., Lamb, D., Marston, L., Osborn, D., Mason, O., Henderson, C., Ambler, G., Milton, A., Davidson, M., Christoforou, M., Sullivan, S., Hunter, R., Hindle, D., Paterson, B., Kelly, K., Lean, M., Pilling, S., Morant, N., & Lloyd-Evans, B. (2018). Peer-supported self-management for people discharged from a mental health crisis team: A randomised controlled trial. *Lancet*, *392*(10145), 409–418. https://doi.org/10.1016/S0140-6736(18)31470-3

Koyanagi, A., & Stickley, A. (2015). The association between sleep problems and psychotic symptoms in the General population: A global perspective. *Sleep*, *38*(12), 1875–1885. https://doi.org/10.5665/sleep.5232

Kuipers, E., Garety, P., HFowler, D., Freeman, D., Dunn, G., & Bebbington, P. (2006). Cognitive, emotional, and social processes in psychosis: Refining cognitive behavioral therapy for persistent positive symptoms. *Schizophrenia Bulletin*, *32*(Supplement 1), 24–31. https://doi.org/10.1093/schbul/sbl014

Lewis, S. W., Tarrier, N., Haddock, G., Bentall, R., Kinderman, P., Kingdon, D., Siddle, R., Leadley, K., Grazebrook, K., Everitt, J., Benn, A., & Faragher, B. (2000). The Socrates trial: A multicentre, randomised, controlled trial of cognitive-behaviour therapy in early schizophrenia. *Schizophrenia Research*, *41*(1), 9. https://doi.org/10.1016/S0920-9964(00)90327-X

Linehan, M. (2015). *DBT skills training manual*. The Guildford Press.

Meehan, J., Kapur, N., Hunt, I., Turnbull, P., Robinson, J., Bickley, H., Parsons, R., Flynn, S., Burns, J., Amos, T., Shaw, J., & Appleby, L. (2006). Suicide in mental health inpatients and within 3 months of discharge. *British Journal of Psychiatry*, *188*(2), 129–134. https://doi.org/10.1192/bjp.188.2.129

Moncrieff, J., Cohen, D., & Mason, J. P. (2009). The subjective experience of taking antipsychotic medication: A content analysis of internet data. *Acta Psychiatrica Scandinavica*, *120*(2), 102–111. https://doi.org/10.1111/j.1600-0447.2009.01356.x

Morrison, A. (2017). A manualised treatment protocol to guide delivery of evidence-based cognitive therapy for people with distressing psychosis: Learning from clinical trials. *Psychosis: Psychological, Social and Integrative Approaches*, *9*(3), 271–281. http://dx.doi.org/10.1080/17522439.2017.1295098

Morrison, A., & Barratt, S. (2010). What are the components of CBT for psychosis? A delphi study. *Schizophrenia Bulletin*, *36*(1), 136–142. https://doi.org/10.1093/schbul/sbp118

Morrison, A. P., Pyle, M., Gumley, A., Schwannauer, M., Turkington, D., MacLennan, G., Norrie, J., Hudson, J., Bowe, S. E., French, P., Byrne, R., Syrett, S., Dudley, R., McLeod, H. J., Griffiths, H., Barnes, T. R. E., Davies, L., Kingdon, D., Aydinlar, S., … Tully, S. (2018). Cognitive behavioural therapy in clozapine-resistant schizophrenia (FOCUS): An assessor-blinded, randomised controlled trial. *The Lancet Psychiatry*, *5*(8), 633–643. https://doi.org/10.1016/S2215-0366(18)30184-6

Morrison, A. P., Stewart, S., French, P., Bentall, R. P., Birchwood, M., Byrne, R. E., Davies, L., Fowler, D., Gumley, A. I., Jones, P. B., Lewis, S. W., Murray, G., Patterson, P., & Dunn, G. (2011). Early detection and intervention evaluation for people at high-risk of psychosis-2 (EDIE-2): Trial rationale, design and baseline characteristics. *Early Intervention in Psychiatry*, *5*(1), 24–32. https://doi.org/10.1111/j.1751-7893.2010.00254.x

Muskett, C. (2013). Trauma informed care in inpatient mental health settings: A review of the literature. *International Journal of Mental Health Nursing*, 1–9. https://doi.org/10.1111/inm.12012

National Institute for Health and Care Excellence. (2014). *Psychosis and schizophrenia in adults: Treatment and management*. National Institute of Clinical Excellence.

National Institute for Health and Care Excellence. (2016). *Transition between inpatient mental health settings and community or care home settings*.

NHS Benchmarking Network. (2024). *Mental health benchmarking report 2024*. NHS Benchmarking Network.

NHS England. (2019). *NHS long-term plan*.

O'Connor, R., & Kirtley, O. (2018). The integrated motivational–volitional model of suicidal behaviour. *Philosophical Transactions of the Royal Society B: Biological Sciences*, *373*(1754), 20170268. https://doi.org/10.1098/rstb.2017.0268

O'Connor, R. C., Smillie, S., McClelland, H., Lundy, J.-M., Stewart, C., Syrett, S., Gavigan, M., McConnachie, A., Stanley, B., Smith, M., Brown, G. K., Stanley, B., & Simpson, S. A. (2022). SAFETEL: A pilot randomised controlled trial to assess the feasibility and acceptability of a safety planning and telephone follow-up intervention to reduce suicidal behaviour. *Pilot and Feasibility Studies*, *8*(1), 156. https://doi.org/10.1186/s40814-022-01081-5

Palmier-Claus, J., Griffiths, R., Murphy, E., Parker, S., Longden, E., Bowe, S., Steele, A., French, P., Morrison, A., & Tai, S. (2017). Cognitive behavioural therapy for thought disorder in psychosis. *Psychosis: Psychological, Social and Integrative Approaches*, *9*(4), 347–357. https://doi.org/10.1080/17522439.2017.1363276

Pitt, L., Kilbride, M., Nothard, S., Welford, M., & Morrison, A. P. (2007). Researching recovery from psychosis: A user-led project. *Psychiatric Bulletin*, *31*(2), 55–60. https://doi.org/10.1192/pb.bp.105.008532

Rathod, S., Phiri, P., & Naeem, F. (2019). An evidence-based framework to culturally adapt cognitive behaviour therapy. *The Cognitive Behaviour Therapist*, *12*, 1–15. https://doi.org/10.1017/S1754470X18000247

Roth, A., & Pilling, S. (2012). *Psychological interventions for people with psychosis and bipolar disorder*. UCL.

Royal College of Psychiatrists. (2021). *Assessment and management of risk to others*.

Sheaves, B., Freeman, D., Isham, L., & McInerney, J. (2017). Stabilising sleep for patients admitted at acute crisis to a psychiatric hospital (OWLS): An assessor-blind pilot randomised controlled trial. *Psychological Medicine*. https://doi.org/10.1017/S0033291717003191

Tobitt, S., & Kamboj, S. (2011). Crisis resolution/home treatment team workers' understandings of the concept of crisis. *Social Psychiatry & Psychiatric Epidemiology*, *46*(8), 671–683. https://doi.org/10.1007/s00127-010-0234-y

Wood L., Constant C., Byrne A. (2021). Exploring the experience of acute inpatient mental health care from the perspective of family and carers of people experiencing psychosis: A qualitative thematic analysis study conducted during the COVID-19 pandemic. *International Journal of Mental Health Nursing*, *30*(6), 1620–1629. https://doi.org/10.1111/inm.12915

Wood, L., Jacobsen, P., Ovin, F., & Morrison, A. P. (2022). Key components for the delivery of cognitive behavioral therapies for psychosis in acute psychiatric inpatient settings: A delphi study of therapists views. *Schizophrenia Bulletin Open*, *3*(1), sgac005. https://doi.org/10.1093/schizbullopen/sgac005

Wood, L., Rowe, A., Persaud, K., Nyikavaranda, P., Malde Shah, N., Guerin, E., Dare, C., Constant, C., & Birken, M. (2023). Reflections on the coproduction of a crisis-focused intervention for inpatient settings underpinned by a cognitive behavioural therapy for psychosis (CBTp) model. *Psychosis*, 1–12. https://doi.org/10.1080/17522439.2023.2220373

Wood, L., Williams, C., Billings, J., & Johnson, S. (2019a). Psychologists' perspectives on the implementation of psychological therapy for psychosis in the acute psychiatric inpatient setting. *Qualitative Health Research*, *29*(14), 2048–2056. https://doi.org/10.1177/1049732319843499

Wood, L., Williams, C., Billings, J., & Johnson, S. (2019b). The role of psychology in a multidisciplinary psychiatric inpatient setting: Perspective from the multidisciplinary team. *Psychology & Psychotherapy: Theory, Research & Practice*, *92*, 554–564. https://doi.org/10.1111/papt.12199

Wood, L., Williams, C., Billings, J., & Johnson, S. (2019c). The therapeutic needs of psychiatric in-patients with psychosis: A qualitative exploration of patient and staff perspectives. *British Journal of Psychiatry Open*, *5*(3), e45. https://doi.org/10.1192/bjo.2019.33

Wood, L., Williams, C., Billings, J., & Johnson, S. (2020). A systematic review and meta-analysis of cognitive behavioural informed psychological interventions for psychiatric inpatients with psychosis. *Schizophrenia Research*, *222*, 133–144. https://doi.org/10.1016/j.schres.2020.03.041

Wood, L., Williams, C., Pinfold, V., Nolan, F., Morrison, A. P., Morant, N., Lloyd-Evans, B., Lewis, G., Lay, B., Jones, R., & Greenwood, K. (2022). Crisis-focused cognitive behavioural therapy for psychosis (CBTp) in acute mental health inpatient settings (the CRISIS study): Protocol for a pilot randomised controlled trial. *Pilot and Feasibility Studies*, *8*, 205. https://doi.org/10.1186/s40814-022-01160-7

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