**Key competencies for the delivery of cognitive behavioural therapies for psychosis in acute psychiatric inpatient settings: A Delphi study of therapists' views**

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**Abstract**

Cognitive Behaviour Therapy for psychosis (CBTp) is the psychological therapy recommended for people with psychosis and can start in the acute phase. However, there is not consensus on how CBTp should be delivered in an acute mental health inpatient setting. This study aimed to gain consensus from therapists on how CBTp should be delivered in this context. A two stage Delphi study was conducted to establish consensus on what the core components are of inpatient CBTp from the perspective of therapists who are experts in the field. Forty-five therapists took part in two rounds of rating statements on the areas of engagement and feedback, assessment and model, formulation, change strategies, homework and principles and values. A final list of 114 statements were included, which were rated as essential or important by ≥80% of respondents. The delivery of inpatient CBTp is dependent on several adaptations to traditional CBTp including indirect work, being more flexible with session content and delivery, and making adaptations to the restrictive environment. These recommendations could inform training, competency frameworks, and delivery of CBTp in inpatient settings.

Key words: Cognitive Behaviour Therapy for psychosis, delphi method, inpatient, acute mental health

## Introduction

Acute mental health inpatient settings care for those who are in crisis, experiencing high levels of distress, and are often at risk of harm to themselves, from or to others [1]. Moreover, over half of current inpatients are detained under section of the Mental Health Act [2] demonstrating the high level of need within this population [3]. Inpatient wards should be providing a comprehensive and holistic care package to each service user to help them manage their mental health crisis and facilitate a safe discharge [4], and part of this package of care should be psychological therapy [5]. Cognitive Behavioural Therapy for psychosis (CBTp) is the first line recommended psychological intervention for people with psychosis outlined by the National Institute for Health and Care Excellence [6]. NICE guidelines state that CBTp should be offered to people during the acute phase of their psychosis [6]. Service users should be offered 16 to 24 sessions of CBTp underpinned by a treatment manual which supports people to establish links between their thoughts, feelings, or actions and their current or past symptoms and/or function [6]. However, it is well documented that service users in inpatient settings report not receiving adequate access to psychological interventions [7]. This is often due to a lack of resources, hectic and restrictive ward environment, brief duration of admission and a lack of appropriately trained practitioners to deliver such interventions [8, 9].

There are specific challenges to the delivery of CBTp. Firstly, the average length of stay on acute inpatient wards is usually 32 days [10] making 16 to 24 sessions extremely difficult to deliver [11]. Although NICE guidelines state that CBTp be started within an admission and carried on without interruption after discharge, in practice this rarely happens due to a lack of continuous care pathways from inpatient-community settings, and long waiting lists in the community for therapy [12]. Thus, undertaking elements of therapy such as behavioural experiments and behavioural activation outside of the ward environment may be limited [13]. Moreover, service users are often in mental health crises, experiencing acute distress, and can be at risk of harm to themselves and others [14]. They are also often experiencing several social difficulties such loneliness, interpersonal trauma, housing, and financial insecurity [15]. Thus, CBTp needs to be delivered considering a multitude of potentially complex factors.

Several recent systematic reviews have been conducted to examine the efficacy of psychological intervention for psychosis delivered in inpatient settings [16-18]. These reviews demonstrated that the current quality of the evidence base of CBTp is low to moderate [16] and effects were only found on a few outcomes including psychotic symptoms (at the end of therapy but not at longer-term follow-up; [17, 18], readmission, depression, and anxiety [16]. These reviews also identified that none of the interventions had been explicitly adjusted to meet the needs of service users in the inpatient setting. Some emerging evidence has demonstrated how CBTp should be adapted for its delivery in inpatient

settings [19]. One study demonstrated that it is important to offer brief and targeted interventions which focus on supporting the service user to manage their current crisis [17]. It also suggests adaptations such as sharing formulations with the multidisciplinary team, having sessions with family members and carers, utilising leave allowances to do therapeutic work and being an advocate for the service user. However, there is still uncertainty about how CBTp should be applied in inpatient settings to meet the needs of service users.

A previous Delphi study has been conducted in order to identify the key competencies required to deliver on-model CBTp in community context [20]. This study arose due to debates about what elements truly comprise CBTp and what distinguishes it from CBT for other presentations. This study was able to inform a protocol for delivery of CBTp in research trials and clinical practice [21] as well as a key competencies framework of CBTp [22]. This study was valuable in guiding clinicians in delivering CBTp in a community context. However, no such research has been undertaken for the delivery of CBTp for the acute mental health inpatient setting. There has been no exploration of experts' opinions on how CBTp should be delivered in inpatient settings. Therefore, the aim of this study is to conduct a Delphi study of psychological therapists' perspectives on the key competencies required to deliver CBTp in the psychiatric inpatient setting.

## Methodology

### *Study design*

A Delphi study was undertaken to synthesise experts' opinions on the core competencies regarding the delivery of Cognitive Behaviour Therapy for psychosis (CBTp) in the acute mental health inpatient setting. The Delphi approach outlined by Langlands and colleagues underpinned the research design [23]. We undertook the Delphi process in three stages. Firstly, we developed initial Delphi statements utilising qualitative literature, a competency framework, an existing Delphi study, and systematic review data16, 17, 19, 20, 24 We the proceeded to undertake a two-round Delphi process where statements were rated by experts in the field. We deviated from the Langlands process as we did not include expert stakeholder input in the initial Delphi statements development phase23. However, we conducted qualitative interviews with stakeholders instead to ensure stakeholder opinion was included. We report our study in line with the Conducting and REporting DElphi Studies (CREDES) guidelines [25].

### Ethical approval

This study was submitted for Health Research Authority (HRA) approval but was deemed not to require approval by the HRA as it was a study with staff that has no impact on their work in the NHS. Therefore, local approval and sponsorship was gained from North East London NHS Foundation Trust's Research and Development (R&D) department. The study gained local approval from twenty-one NHS organisation in order to approach the contacts in the authors' professional networks (See Supplementary material for full list).

*Participant inclusion and exclusion criteria*

Participants were eligible to take part in the study if they were experts in the delivery of CBTp in the acute mental health inpatient setting, We defined this as therapists who:- (a) had a relevant British Psychological Society (BPS)/Health Care Professions Council (HCPC)/British Association of Behavioural and Cognitive Psychotherapies (BABCP) accredited qualification in psychology/psychological therapy, (b) were either a clinical psychologist, counselling psychologist, psychological therapist, or a practitioner with specialist training in CBT (such as a post-graduate diploma), (c) had at least six months clinical experience working in a psychiatric inpatient setting, (d) had at least six months experience of working therapeutically with people who experience psychosis (e) worked at agenda for change band 7 and above. No exclusion criteria were specified. All participants were recruited from the United Kingdom.

*Recruitment and Participants*

Participants were recruited through convenience sampling through the authors' networks of inpatient psychologists and other professionals who are experienced in working in inpatient settings and who are qualified to deliver CBTp. Initially a working group of clinicians who were contributing to the development of the British Psychological Society's (BPS) and Association of Clinical Psychologists UK (ACP-UK) Psychological Services within the 'Acute Adult Mental Health Care Pathway: Guidelines for Commissioners and Managers' were contacted. Further contact was then made with psychologists working on postgraduate CBTp training courses. A snowballing approach was then adopted with participants recommending further eligible participants. We aimed to recruit a minimum sample of n=15 – 20 participants which is considered adequate when sampling a homogenous group of expert participants in a Delphi study[26].

*Procedure and analysis*

Item generation: Elements pertinent to the delivery of Cognitive Behaviour Therapy for psychosis (CBTp) were identified through examination of relevant literature. A literature search was undertaken to examine relevant policy documents, research papers, outcome measures and fidelity scales. Relevant literature was initially gathered together by authors based on their knowledge of the area. Key papers were identified by the authors by reviewing the relevant literature including an already published Delphi study [20] and a competency framework for the delivery of psychological therapies for psychosis [22]. A further google search was undertaken using variations of the terms "CBTp" and "inpatient" to identify further resources. In addition, the lead author conducted qualitative interviews with psychologists who have expertise of delivering cognitive behavioural interventions for psychosis in inpatient settings who outlined their priorities for the delivery of psychological therapies in this setting[19]. This also helped identify items that were specific to the delivery of CBTp in inpatient

settings. The information gathered from these sources were collated and sorted into groups based on common themes[23]. Statements were refined and decided upon by the authors who have expertise in delivering inpatient CBTp. A previous Delphi study in the field was used to help structure the statements[20]. From this a final list of statements were generated. A total of 104 statements were generated. A 5-point Likert scale was then generated (1 essential; 2 important; 3 don't know; 4 unimportant; 5 should not be included) for participants to rate each item on.

Stage 1 and 2 was hosted on Qualtrics and all participants were emailed the link to the study when approached to take part. The research was conducted in two stages:

Stage 1: At the first stage participants rated all the statements on a 5-point Likert scale to indicate whether they think the statement reflects an important component of inpatient CBTp (1 essential; 2 important; 3 don't know; 4 unimportant; 5 should not be included). If ≥80% of participants members rated an item as essential or important it was included as a standard; if 70-79% of panel members rated an item essential or important, panel members were asked to rerate the item in a second round. All statements below 70% were excluded. There was also a free-text option at the end of each category for participants to contribute their thoughts on possible other statements.

Stage 2: At the second stage, participants were invited back to rerate items which were previously rated as extremely important or important by 70 – 79% of participants, as well as to rate newly generated statements which had been identified from the free text contributions in Stage 1. The second stage was held to try and achieve consensus and form a final list of items for inclusion. The statements were then judged by the same criteria outlined above again. If ≥80% of participants members rated an item as essential or important it was included. All other statements were excluded. Once all statements were identified, the research team screened the statements to identify ones which were common to delivery of CBTp in all settings, one which were modified and are of particular importance in inpatient settings, and ones which were unique to the inpatient setting.

**Results**

*Participant demographics*

166 people were contacted to take part in the study of which 27 identified as not eligible, 94 did not respond, opted out or only submitted a partial response. 45 participants took part in Stage 1 of the study and 37 participants (82%) took part in Stage 2 of the study. 44 participants completed the demographics section. Participant demographics are outlined in table 1.

[INSERT TABLE 1 HERE]

Stage 1

The flow of each stage can be seen in figure 1. A total of 104 statements were reviewed in Stage 1. 75 statements were deemed as essential or important by 80% or more of participants. 14 statements were excluded as they were deemed as essential or important by less than 70% of participants. 15 statements were deemed as essential or important by 70% - 79% of participants and therefore did not reach consensus and needed to be reviewed in a Stage 2. An additional 45 statements were formed from free text responses/suggestions contributed by the Stage 1 participants.

Stage 2

A total of 60 statements were reviewed by 37 participants in Stage 2 of the study. 39 statements were deemed as essential or important by 80% or more of participants. 21 statements were deemed as essential or important by less than 80% of participants excluded as a result of Stage 2 responses. A final sum of 114 statements reached consensus across Stage 1 and 2 of the study (table 2). Out of the 114 statements, 59 (51.75%) were common statements which would apply to all CBTp delivery across service contexts, 37 (32.46%) were modified statements which have more applicability to inpatient settings, and 18 (15.80%) were unique to the inpatient setting.

[INSERT FIGURE 1 HERE]

**Discussion**

This study aimed to identify the core components important to the delivery of Cognitive Behaviour Therapy for psychosis (CBTp) in inpatient settings. To our knowledge, this is the first study which has attempted to do so. We were able to identify 114 items which have been deemed central to the delivery of inpatient CBTp. Compared to the previous Delphi study [20], which identified the core competences of traditionally delivered CBTp, we have identified several additional competences which are specific to the inpatient setting. In relation to the engagement and feedback components, a number of additional items were identified including being flexible (for example, tolerating non-attendance of sessions), ensuring that the patient feels empowered and in control (especially important due to the disempowering nature of acute mental health inpatient care) and the therapist being clear with the patient on how they fit within the wider team. The importance of building therapeutic relationships, empowerment and control when delivering inpatient based psychosocial interventions has been highlighted in previous inpatient research, which this current study supports[9, 14].

In terms of structure and principles, there was several items which related specifically to the inpatient context. It was highlighted that the therapist should feedback CBTp outcomes and risk issues to the

multi-disciplinary team. It is widely acknowledged that all inpatient interventions and treatments should be multi-disciplinary and contribute to wider care plans[4], which is demonstrated here. In addition, it has also been highlighted that multi-disciplinary staff value psychological feedback as this can help inform wider treatment planning[27]. The components also highlighted the importance of being flexible and patient-led in the delivery of sessions and ensure that sessions can standalone as further sessions are not guaranteed (as sometimes patients can be discharged abruptly). Having flexible, standalone sessions has been identified in previous inpatient psychological therapy trials as important to therapy delivery[28]. Importantly the items also included the incorporation of a patient's cultural and ethnic background, as well as spiritual and religious beliefs, in the delivery of CBTp. This supports previous research which outlines the importance of culturally adapting CBTp for ethnic minority groups[29], which is particularly pertinent in an inpatient context given over-representation of such groups in inpatients settings and the excessive use of the mental health act in populations experiencing racial inequality.

There was consensus that the assessment, formulation, and intervention should focus on the current crisis and risk as well as address the potentially detrimental impacts of hospitalisation, which is a clear difference from traditional CBTp[20]. In addition, there was consensus that the formulation and intervention should not be undertaken in isolation and should inform the wider team's approach to care, which has been highlighted in previous research[19]. Between session tasks were also approached more flexibly and were not seen as vital in the inpatient setting which contradicts traditional approaches of CBT which outlines this as essential[30]. Novel change strategies included stabilising the crisis, increasing a patient's sense of safety, involving the multi-disciplinary team in change strategy delivery when possible, and adapting them to the restrictive environment.

A total of 114 statements were agreed as essential or important by the experts, which is quite a large number of core competencies for the delivery of CBTp in inpatient settings. The original CBTp Delphi study identified only 77 items demonstrating that a further 37 items were important in this study. This is likely to reflect the flexible nature of CBTp delivery in inpatient settings as outlined by our experts. Moreover, a number of the competences identified related to indirect work, and working with the service user's network which are additional competences to the traditional CBTp model[21].

To the authors' knowledge, this is the first study which has attempted to gain consensus on the core components of CBTp delivered in inpatient settings and provides important insight for psychological therapists in a field that is lacking evidence. Moreover, we were able to include experts who were from academic, clinical and research backgrounds which ensured that experts from a broad range of settings were included. A limitation was that our inclusion criteria was quite broad which may have meant some less experienced staff taking part. Moreover, out recruitment only took place within the UK and therefore may not be representative to other countries or contexts. A further limitation was

the small sample size as some Delphi studies can have quite significantly larger samples [23, 31]. However, given the specialist topic area and a limited number of experts in the field we managed to recruit an adequate sample which is in line with other previous Delphi studies[20]. Another limitation was not having external experts in the development of the initial statements, which is a deviation from Langland et al's[23] original approach. This stage mainly depended on existing literature; however, the first author had conducted qualitative interview on the topic area to inform statement development[19]. The literature search was also not done systematically which may have led to key literature being missed. Collectively, this led to a further 45 statements being suggested by the experts in stage 1 which suggests that all key competences were not captured in the initial statements. We did not ask the experts if they thought statements were unique to the inpatient setting or generic and instead identified these ourselves. This again is a missed opportunity to gather expert opinion on the relevance of the statements to this setting. Finally, it is important that the findings are understood within the UK context in which the research was conducted. In other non-UK contexts the length of stay may be shorter or longer, which will impact on how CBTp is delivered. For example, some stays in the United States can be as short as 10-days which may make implementing some of the recommendations in this paper more of a challenge [32].

This study has several important implications. Firstly, these items will be useful to professionals responsible for training CBTp for use in acute settings. There were clear adaptations which deviated from how traditional CBTp is delivered. They could be used to underpin a competency framework, like the previous one which has already been developed for working with psychosis[22]. They could also be used to inform the evaluation of adherence and fidelity to inpatient CBTp clinical trials and could help inform the basis of an adherence measure that would be based on expert consensus. The items could also help clinicians in practice as the items outline how they should be delivering CBTp in the inpatient setting. Finally, if this information was shared with patients and carers, it could allow them to understand what should be delivered in inpatient CBTp which may be empowering.

Future research should include examination of whether these components are important for the outcome of therapy in a large clinical trial. This will identify what the effective components and mechanisms of inpatient CBTp are. A more formal competency framework could be developed from this study to inform how inpatient CBTp is delivered. Further research would be needed to undertake this. Finally, it would be important to conduct research examining patients' perspectives on what they consider to be the important principles, components and outcomes of delivering CBTp in inpatient settings; such research could utilise Delphi methodology or qualitative interviews or focus groups.

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**Table 1 – Participant demographics**

| Demographic | | Mean | SD | Range |
|---|---|---|---|---|
| **Length of experience (years)** | In inpatient services | 8.2 | 6.9 | 0.5 - 30 |
| | In working with people with psychosis | 10.6 | 6.8 | 1.5 - 30 |
| | **Category** | | **N** | **%** |
| **Gender** | Female | | 31 | 70 |
| | Male | | 12 | 27 |
| | Did not report | | 1 | 2 |
| **Professional title** | Qualified Psychologist | | 15 | 34 |
| | Consultant Psychologist or Lead/Head of Service | | 14 | 32 |
| | Senior, Specialist or Principal Psychologist | | 9 | 20 |
| | Therapist (CBT or Psychotherapy) | | 3 | 7 |
| | Lecturer | | 2 | 5 |
| | Professor | | 1 | 2 |
| **Ethnicity** | White – British | | 31 | 70 |
| | White – Irish | | 5 | 11 |
| | White – Any other background | | 4 | 9 |
| | Asian/Asian British – Indian | | 3 | 7 |
| | Mixed – White & Asian | | 1 | 2 |

**Table 2 – Final list of Delphi Statements**

| Included Delphi Statements | Round | % | Statement type |
|---|---|---|---|
| **Engagement and feedback** | | | |
| 1. Normalizing of psychotic symptoms should be used to reduce stigma and improve engagement | 1 | 93.3 | C |
| 2. Patient feedback should be sought frequently, including at the end of each session, including eliciting both positive and negative feedback | 1 | 95.6 | C |
| 3. Inpatient CBTp should be implemented using a collaborative approach at all times, keeping in mind the inherent power imbalance the patient experiences (e.g., patient being on section of the Mental Health Act or compulsorily detained) in the inpatient setting | 1 | 100 | M |
| 4. Inpatient CBTp should take into account the patients' perspective and ''world view'' including culture and ethnicity | 1 | 100 | C |
| 5. The therapist should take into account the patient's presenting symptomatology, past experiences of services, and cultural/ family beliefs and expectations in engagement | 1 | 97.8 | C |
| 6. The rationale of inpatient CBTp should be explained and demonstrated to the patient | 1 | 95.6 | C |
| 7. Engagement should be prioritised in inpatient CBTp | 1 | 100 | C |
| 8. A more flexible approach to engagement should be undertaken keeping in mind that inpatients may be weary and untrusting of professionals | 1 | 100 | M |
| 9. Allowance should be made for non-attendance and refusal | 1 | 95.6 | M |
| 10. The therapist should ensure that the pace of the therapy is appropriately matched to the patients | 2 | 97.3 | C |
| 11. The priority of inpatient CBTp is to focus on engagement and collaboration, which should be done flexibly and creatively | 2 | 100 | M |
| 12. The therapist should be transparent about their role in the wider team and their power to influence wider decisions about the patient's care | 2 | 100 | M |
| 13. The therapist should have a good understanding of the psychosis care pathways/services and potential adverse experiences patients may have had | 2 | 100 | M |
| 14. The therapist should be aware of inpatient factors that may impact engagement and attempt to overcome these (e.g., sedation, lack of privacy) | 2 | 100 | U |

| | | | |
|---|---|---|---|
| 15. The therapist should make it very clear to the patient that engaging in inpatient CBTp is not compulsory | 2 | 100 | M |
| 16. The therapist should avoid the use of jargon and use simplified language | 2 | 100 | C |
| 17. The therapist should be skilled at managing a patient's fear that discussing their mental health will have detrimental impacts, e.g., unwanted increases in medication, or loss of leave, or lengthened admission | 2 | 100 | U |
| 18. The therapist should offer a therapeutic space for patients to talk freely and openly and for their perspectives to be valued | 2 | 97.3 | C |
| 19. The therapist should have good therapeutic skills such as curiosity, openness, honestly, empathy, genuineness, and non-judgment | 2 | 100 | C |
| **Structure and principles** | | | |
| 20. Inpatient CBTp should aim to reduce distress and improve quality of life | 1 | 97.8 | C |
| 21. Inpatient CBTp should be culturally sensitive and should consider the person's cultural and ethnic background | 1 | 97.8 | C |
| 22. Inpatient CBTp should include involvement from family members and/or the patient's social network where possible (and if the patient agrees) | 1 | 84.4 | M |
| 23. The therapist should summarise and feedback the outcomes of therapy and risk issues to the inpatient multi-disciplinary team | 1 | 100 | M |
| 24. The therapist should summarise and feedback the outcomes of therapy and risk issues to the community multi-disciplinary team | 1 | 97.8 | M |
| 25. Sessions should be offered flexibly, and patient led (e.g., time of therapy, length of session, number of sessions) | 1 | 97.8 | M |
| 26. Sessions should be offered as "standalone" as further sessions are not guaranteed | 1 | 84.5 | U |
| 27. Inpatient CBTp should include exploration of spiritual and religious aspects of a patient's difficulties if they seem pertinent to the presenting crisis | 1 | 91.1 | M |
| 28. Summaries and feedback should be used to structure the session | 1 | 82.2 | C |
| 29. Inpatient CBTp sessions should always be accommodated to the patient's abilities and levels of cognitive functioning (e.g., memory and concentration difficulties). | 1 | 97.8 | M |
| 30. Inpatient CBTp should include a focus on relapse prevention | 1 | 86.7 | U |

| | | | |
|---|---|---|---|
| once the patient is near discharge/recovered from the crisis | | | |
| 31. Inpatient CBTp should explore the potentially traumatic impact of admission and hospital care | 1 | 86.7 | U |
| 32. Inpatient CBTp should aim to elicit hope for recovery | 1 | 97.8 | C |
| 33. Inpatient CBTp should consult the patient regarding the terminology used to explain their experiences | 1 | 100 | C |
| 34. Inpatient CBT should include acknowledgment of, and attempts to address social issues (e.g., financial, homelessness, stigma, racism/discrimination) with support from the multi-disciplinary team | 1 | 91.1 | M |
| 35. Inpatient CBTp should end in a planned manner, wherever possible, and plan for long-term maintenance of gains after treatment or further therapy | 1 | 84.5 | M |
| 36. The patient should make choices and take appropriate ownership for the CBTp sessions (i.e., there should be a shared responsibility between therapist and patient) | 1 | 91.1 | C |
| 37. Inpatient CBTp should assist the maintenance of a patient's capacity to make informed decisions about their lives | 1 | 84.5 | M |
| 38. The patient and therapist should jointly agree a problem list | 1 | 88.9 | C |
| 39. Agreed short- and long-term goals should underpin the intervention | 1 | 86.7 | C |
| 40. Agreed goals which relate to a safe discharge should be considered | 1 | 97.8 | U |
| 41. Agreed goals which relate to tackling the current crisis should be established | 1 | 97.8 | U |
| 42. Agreed goals which relate to reducing risk (to self and others) should be established | 1 | 95.6 | M |
| 43. A collaborative agenda should be set at the start of every session | 1 | 82.2 | C |
| 44. Goals should be SMART (specific, measurable, achievable, realistic and time limited) | 1 | 82.2 | C |
| 45. Inpatient CBTp should help the patient consider a range of perspectives regarding his/her experience | 1 | 88.9 | C |
| 46. Inpatient CBTp for inpatient settings should be founded upon the principles of evidence-based practice and value-based practice | 1 | 91.1 | C |
| 47. Inpatient CBTp should help the patient develop hypotheses regarding their current situation and to generate potential solutions | 1 | 95.6 | C |

| | | | |
|---|---|---|---|
| 48. Brief summaries should occur at the beginning and end of each session | 1 | 84.4 | C |
| 49. Inpatient CBTp therapists should be realistic in what they can offer, i.e., cannot stop all symptoms but may be able to help with e.g. distress, increased understanding | 2 | 97.3 | M |
| 50. Inpatient CBTp should include brief summaries and feedback (giving and receiving) throughout sessions. | 2 | 91.9 | C |
| 51. Patients should feel they have autonomy, choice and control over their therapy, which is particularly important within the context of restrictive inpatient environments and compulsory admissions | 2 | 100 | M |
| 52. Inpatient CBTp should be tailored to the patient's cognitive ability (e.g., use written material if they have memory difficulties) | 2 | 97.3 | M |
| 53. Inpatient CBTp therapists should keep the admission duration in mind when collaboratively planning therapy and should take a stepped approach (e.g., for a three-day admission do something that doesn't need a formulation, and if longer time a basic here & now maintenance cycle) | 2 | 97.3 | U |
| 54. Inpatient CBTp should take into account issues of social inequality (e.g., racial trauma and institutional racism) which may have impacted on the patient's mental health, access to services, and experiences of hospital admission | 2 | 91.9 | M |
| 55. Inpatient CBTp should prioritise a patient's immediate safety on the ward by addressing key environmental triggers (e.g., things that could trigger trauma memories such as restrictive practices) | 2 | 89.2 | U |
| **Assessment and model** | | | |
| 56. A more informal approach to assessment should be taken to simultaneously assess and engage the person. | 1 | 91.1 | M |
| 57. Inpatient CBTp assessment should prioritise the reasons for admission and current crisis | 1 | 91.1 | U |
| 58. An inpatient CBTp assessment should include a thorough risk assessment of harm to self (e.g., suicide and self-harm) and others (e.g., violence and aggression) | 1 | 84.4 | M |
| 59. Inpatient CBTp assessment should explore the person's experiences of inpatient care and relationships with staff | 1 | 95.6 | U |
| 60. Inpatient CBTp must identify the needs of the patient and competency of the therapist before undertaking in-depth therapeutic work | 1 | 84.5 | C |

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| 61. Inpatient CBTp should be idiosyncratic to the individual patient | 1 | 95.6 | C |
| 62. Inpatient CBTp should examine the role that behaviours have in triggering and maintaining the patients' difficulties | 1 | 91.1 | C |
| 63. Inpatient CBTp should help a patient to identify and elicit those thoughts, images, and beliefs that are fundamental to their distress (i.e., the key cognitions) | 1 | 97.8 | C |
| 64. Inpatient CBTp should elicit any behavioural features that contribute to the maintenance of the patient's problems | 1 | 95.6 | C |
| 65. Inpatient CBTp ought to elicit and examine behavioural patterns such as ''safety seeking behaviours'' in relation to the relevant emotions associated with them | 1 | 88.9 | C |
| 66. Inpatient CBTp should elicit and assess the intensity of emotions associated with a particular situation or cognition | 1 | 97.8 | C |
| 67. Inpatient CBTp should identify emotional issues that interfere with effective change (e.g., hostility, anxiety, excessive anger) | 1 | 86.7 | C |
| 68. Inpatient CBTp should value the expertise that patients bring about their own lived experiences | 2 | 100 | C |
| 69. Inpatient CBTp should always incorporate the wider systemic and cultural context of a patient | 2 | 86.5 | M |
| 70. Inpatient CBTp should consider the detrimental impacts of the mental health services, admission, and the inpatient environment on patient's thoughts, feelings, and behaviours | 2 | 97.3 | U |
| 71. An inpatient CBTp assessment should draw upon multiple sources of information such as information from the multi-disciplinary team and clinical notes | 2 | 94.6 | M |
| 72. An inpatient CBTp assessment should identify a patient's strengths, values, and protective factors | 2 | 97.3 | C |
| 73. An inpatient CBTp assessment should examine the benefits and risk in engaging in CBTp for the patient | 2 | 86.5 | C |
| **Formulation** | | | |
| 74. A good collaborative relationship must be formed to help develop a comprehensive formulation | 1 | 95.6 | C |
| 75. A balanced formulation should highlight the patient's strengths as well as difficulties | 1 | 95.6 | C |
| 76. The therapist must avoid overcomplex 'kitchen sink' formulation and intervention | 1 | 88.9 | C |
| 77. Inpatient CBTp should develop a formulation of the patient's difficulties and use psychological mechanisms to target the | 1 | 95.6 | M |

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| processes that are controllable in relapse | | | |
| 78. A formulation should be developed and used to outline a treatment plan | 1 | 93.3 | C |
| 79. A formulation should draw together current concerns, risks, vulnerabilities, strengths, precipitating and perpetuating factors | 1 | 95.6 | C |
| 80. A formulation of the current crisis should be devised and used to set targets for intervention | 1 | 88.9 | M |
| 81. A formulation should be used to inform the multi-disciplinary team's care plan/discharge plan when possible | 1 | 91.1 | U |
| 82. Information about the patient from the multi-disciplinary team should be used to inform the formulation when possible | 1 | 88.9 | M |
| 83. Information from the family/social network should be used to inform the formulation when appropriate | 1 | 86.7 | M |
| 84. Guided discovery and Socratic questioning should be used to elicit key cognitions/images/behaviours and emotions to inform the formulation | 1 | 95.6 | C |
| 85. Inpatient CBTp can include a reflective practice component to inform a wider inpatient care plan and increase staff compassion | 2 | 91.9 | U |
| 86. A formulation can be completed outside of session with the wider multi-disciplinary team to inform the patient's care plan | 2 | 83.8 | M |
| 87. The therapist should be able to reflect upon interpersonal factors that may have influenced the session and use these to inform the formulation | 2 | 89.2 | C |
| **Between session tasks "Homework"** | | | |
| 88. Between session tasks should be used flexibly and be dependent on the needs and usefulness to the patient | 1 | 97.8 | C |
| 89. Practical plans (i.e., practical between session tasks) should be developed with the patient to facilitate effective change | 1 | 84.4 | C |
| 90. Between session tasks should only be set up when it is appropriate and manageable for the patient | 2 | 94.6 | C |
| 91. Between session tasks can be completed by the therapist as well as the patient, for example when doing behavioural experiments | 2 | 81.1 | C |
| 92. Between session tasks should be described as an opportunity to learn and test things out | 2 | 89.2 | C |
| 93. Between session tasks must be adapted to the restrictions of an inpatient environment to ensure they are manageable for the patient | 2 | 94.6 | U |

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| 94. Between session tasks may need to be smaller and more manageable tasks (e.g., agreement for ongoing monitoring/observation) rather than changed focused | 2 | 83.8 | M |
| **Change strategies** | | | |
| 95. Socratic questioning, diaries, and monitoring procedures should help the patient reflect upon and explore new meanings about their thinking, behaviour, and context, when possible | 1 | 84.5 | C |
| 96. Psychoeducation which includes understanding and managing the current crisis and inpatient admission | 1 | 91.1 | C |
| 97. The patient should be supported to explore alternative explanations of experiences that may be more adaptive and less distressing | 1 | 97.8 | C |
| 98. Inpatient CBTp should identify and work with safety seeking behaviours | 1 | 82.2 | C |
| 99. Inpatient CBTp should enhance existing coping strategies and develop new coping strategies to manage the crisis | 1 | 97.8 | M |
| 100. Inpatient CBTp should focus on stabilisation and safety through the use of appropriate means (e.g., grounding strategies and emotion regulation) | 1 | 95.6 | M |
| 101. Inpatient CBT should recognize and manage obstacles that a patient brings to therapy | 1 | 100 | C |
| 102. The therapist should consider the potential impacts of team dynamics/the ward environment on the effectiveness of the CBTp intervention when planning the intervention | 2 | 97.3 | U |
| 103. Inpatient CBTp should focus on reducing self-criticism and self-attacking beliefs in the patient's crisis | 2 | 81.1 | C |
| 104. Change strategies should only be chosen based on an agreed collaborative formulation and goals | 2 | 86.5 | C |
| 105. Inpatient CBTp should involve the multidisciplinary team when possible, e.g., with supporting behavioural activation and self-monitoring of symptoms | 2 | 81.1 | M |
| 106. Inpatient CBTp change strategies should be delivered flexibly based on the patient's needs and ward environment (e.g., restrictions based on the ward environment) | 2 | 100 | U |
| **Therapist assumptions and beliefs** | | | |
| 107. Therapists should believe that recovery in psychosis is possible | 1 | 95.6 | C |

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| 108. Therapists should work within a model that it is not the hallucination or the delusion per se that is clinically relevant, but the amount of distress or disability associated with it | 1 | 91.1 | C |
| 109. Therapists ought to believe that hallucinations or thought disorder can happen to anyone if they are very stressed | 1 | 93.3 | C |
| 110. Therapists ought to view most symptoms of psychosis as quite common in the normal population | 1 | 86.7 | C |
| 111. Therapists should believe that all inpatients, despite severity of symptoms or length of time in mental health services, should be offered the opportunity for psychological therapy as they may be able to benefit. | 1 | 95.6 | U |
| 112. Therapists should not assume that being hospitalised is a negative event for patient | 2 | 91.9 | M |
| 113. Therapists need to work alongside and communicate effectively with their multi-disciplinary inpatient colleagues in order to deliver effective CBTp | 2 | 94.6 | M |
| 114. The therapist should promote a wider understanding of CBTp principles and strategies to the wider inpatient team | 2 | 97.3 | M |

% = percentage of participants who endorsed the item as essential or important; C = Common statements which would apply to CBTp delivered in any setting; M = Modified statements which are particularly pertinent to inpatient settings; U = Statements which are unique to the inpatient setting.

Figure 1. Item flow