TULIPS

Talk, Understand, Listen for In-Patient Settings

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Brief Name

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WHY?

Between April 2017 and March 2018, 103,952 people who were in contact with mental health services spent time on mental health wards (NHS Digital, 2018). On average, it costs the NHS over £12,000 per acute inpatient ADMISSION (Andrews et al., 2012). Despite extremely high costs associated with inpatient care, inquiries highlight poor quality of care in these settings (Mind, 2011; Schizophrenia Commission, 2012; CQC, 2018). In particular, patients do not have access to evidenced-based psychological therapies, which are strongly advocated by NICE guidance for severe mental health problems, including Schizophrenia, Bipolar Disorder, Major Depression and Personality Disorder (NICE, 2009; NICE 2014a, NICE 2014b; NICE, 2015). The Care Quality Commission (CQC) found only 29% of inpatients had been offered talking therapies and nearly a quarter of all respondents had asked for therapy but did not receive it (CQC, 2009). Lack of access to therapy either prolongs admissions, or means that if patients are discharged due to pressure on beds, their needs are not met, resulting in high rates of readmission or suicide following discharge (Mental Health Task Force, 2016).

The Mental Health Task Force (2016) advocates a 'referral to treatment access' standard for psychological therapy in acute inpatient care, meaning that NHS Mental Health Trusts will need to deliver timely, evidence-based psychological treatments in these settings. The Task Force equally recommends investment to increase access to psychological therapies for people with severe mental health problems across the healthcare system. Previous reviews demonstrate the benefits of psychological therapies for severe mental health problems, in terms of improvements in symptoms and reduced costs to the NHS (Andrews et al., 2012; Jones et al., 2012; Wykes et al., 2008). However, recent systematic searches have found that very few trials of psychological therapies target inpatient wards (Paterson et al., 2018; Jacobsen et al., 2018). Although there is good evidence for psychological therapies from high quality trials with outpatients (e.g. Wykes et al., 2008), we propose that existing evidenced-based psychological therapies need to be adapted for inpatient settings. The process of delivering therapy in inpatient settings is also likely to present unique challenges which require empirical investigation.

We have therefore undertaken a programme of research over the past 18 months to develop an inpatient psychology services that can be trialled on acute mental health wards in the NHS. This research has involved a review of the literature to identify barriers and facilitators to delivering psychosocial interventions in inpatient settings, semi-structured interviews with key stakeholders (including patients, inpatient clinicians and carers), a pilot study to deliver the proposed intervention across two case study wards and a consensus conference with 22 experts to refine the intervention model we piloted.

The intervention aims to deliver a stepped model of care. All patients will receive step one which is a psychological formulation developed in conjunction with at least the psychologist and the named nurse. The formulation will outline the patient's key needs, strengths, factors which led to the development and maintenance of problems and support plans deriving from the information generated. The formulation will be used to determine which patients might benefit from further psychological input at either step two which is nurse-led one-to-one sessions focused on addressing key problem areas or step three which is up to 16 one-to-one therapy sessions with a clinical psychologist focused on assessment, formulation and factors keeping the patient in hospital or triggering future admissions. The intervention aims not only to increase patient access to therapy, but also to create more psychologically-informed ward environment. As such a clinical psychologist (Band 8a, 0.5WTE) will be embedded on the wards to deliver staff training and supervision in psychological approaches, team formulation sessions, reflective practice and adding a psychological perspective to key team meetings.

WHAT?

Materials

1. The intervention providers will be Band 8a clinical psychologists and they will receive two days training by the research team in the intervention. This will include workshop-based training on the intervention model and how to deliver reflective practice groups, training and supervision to others, adapting one-to-one therapy for inpatients, team formulation, practical solutions to implementation challenges and guidance on data collection and reporting requirements for the research. This training will be supported by PowerPoint slides and recordings of clinical material from previous trials undertaken by the research team.

2. The research team will develop PowerPoint slides for the clinical psychologist to refine (in collaboration with the research team) and deliver to ward staff. These slides will include a generic training session for all ward staff on: a) trauma and mental health (including hospital-related trauma); b) the importance of and key components of therapeutic relationship; c) compassion fatigue and the importance of self-care; and d) and formulation. We will also develop nine more focused training slides on delivering one-to-one sessions relating to: anxiety, depression, distressing symptoms of psychosis, healthy living (including exercise, eating well, sleeping well, drug and alcohol use), an introduction to 1-2-1 therapy sessions, problematic anger and aggression, self-esteem, self-harm and introduction to group sessions. In collaboration with senior ward staff, the psychologist will select four of these training sessions, refine them if required (in collaboration with the research team) and deliver them to qualified nursing staff or any other ward-based staff who express an interest in further training and supervision

in psychosocial interventions. The training could be refined to mirror terminology of other psychologically-informed training interventions that have previously been delivered on the wards or adapted to include material from the psychologist's own resources if the research team feel that it is sufficiently consistent with the ethos and aims of the intervention being tested.

3. In collaboration with the PPI group, the research team have developed a guide to the stepped model of care in lay language and this will be given to all patients upon admission. This guide can be refined by the clinical psychologist in collaboration with the research team if required.

4. Following training, nursing staff delivering step two of the intervention will be provided with guided self-help booklets on the key areas they are trained in (which made include the following anxiety, depression, distressing symptoms of psychosis, healthy living (including exercise, eating well, sleeping well, drug and alcohol use), problematic anger and aggression, self-esteem, and self-harm, and they will work through these with patients receiving step two

All materials for the study will be stored on a central online resource and can be downloaded by intervention providers.

Procedures

Intervention preparation and training will involve the following three key procedures.

Ward evaluation and background work

The research team and the clinical psychologist (intervention provider) will develop an understanding of the ward culture and readiness for psychological intervention. This will involve the following processes:

- Speak to any psychologist with relatively recent experience on ward to understand their thoughts on the psychological mindedness of staff on the wards; receptiveness to psychological/psychosocial interventions; any key individuals who may be relevant to implementation e.g. people with previous training in psychology/senior managers who have implemented psychosocial interventions; and any potential barriers specific to the individual ward.

- Meet with senior nursing or medical staff to get their view on the new intervention and anything we need to consider on ward (e.g. current ward routine, any particular

member of staff who they think would be good allies to implementation, key meetings the psychologist should attend). Allow opportunity for questions and concerns to be raised and listen to staff expertise and knowledge. Confirm what support is required from them e.g. releasing staff for away training days, allowing staff to attend formulation and reflective practice groups (explain that this time needs protecting and should form part of their job role).

- Identify if any assistant psychologists, OT's or recovery workers who are based on the ward and understand their potential to be involved in delivering step two interventions.

- Establish where the ward is currently with the rollout of Safewards or similar psychologically informed ward-based interventions, for example, what stage of the rollout are in, how well these have been implemented and how these will work alongside TULIPS.

- Identify appropriate room for therapy to take place (including group formulation and group therapy sessions).

- Identify suitable office/desk space for psychologist, noting that the psychologist needs to be based on the ward, if not directly near it so can attend ward daily.

- On basis of the above discussion use supervision with the research team to tailor the TULIPS model to the specific ward environment. For example, decide approximately how much time can be allocated for delivering each step and attendance to meetings.

Psychologist training and supervision

- The research team will deliver two days training to the psychologist. This will focus on the intervention model, how to deliver reflective practice groups, training and supervision to others, adapting one-to-one therapy for inpatients, team formulation, practical solutions to implementation challenges and guidance on data collection and reporting requirements for the research. The session will be delivered as a workshop and may involve more than one psychologist (if sites are starting at the same time)

- The training will be supplemented by fortnightly hourly supervision with the research team via Skype focused on barriers to implementation and fidelity to model. Telephone or email support from research team regarding fidelity and research data collection will also be available as and when required.

- The psychologist will also receive fortnightly hourly supervision from a more senior psychologist based on site and who ideally has experience of inpatient working. This person will also be receive a condensed training session in the intervention model delivered via Skype, be given copies of the slides from the therapist training and have

telephone and email support from the research team regarding fidelity to the model if required.

- The psychologist may have access to peer supervision if available within the Trust or via a virtual forum organised by the research team if several sites are delivering the intervention at the same time.

Ward staff training

- The psychologist will deliver a half-day training session to all permanent ward staff (this can include bank/agency where they have been working on the wards for an extended period of time) delivered over 2-3 sessions and focused on trauma and mental health (including hospital-related trauma), importance of and key components of therapeutic relationships, compassion fatigue, the importance of self-care and formulation. Ideally, the training sessions should take place on site so that staff can return to work following, or prior to the training session. However, the session should not take place on the ward as inevitability this could lead to staff returning to assist with any incidents that occur. The training session will need to be delivered over a number of days; given the typical number of staff per acute ward we recommend that 3-4 training sessions are delivered. The ward manager can roster on more bank/agency staff to cover the ward (if required). An alternative method would be for the ward manager to roster on permanent staff to cover these time periods and provide them with time in lieu. The ward manager should also attend this training.

- The psychologist will deliver a further four half-day training sessions for all qualified nursing staff and other ward staff with an interest in further training and supervision in psychosocial interventions. The content of these sessions will be determined by the psychologist and the senior nursing staff could will include four of the following (anxiety, depression, distressing symptoms of psychosis, healthy living (including exercise, eating well, sleeping well, drug and alcohol use), problematic anger and aggression, self-esteem, and self-harm) in addition to generic training on how to conduct one to one sessions and groups. These sessions should ideally also be delivered on site but not on the ward and over a number of days, although given there are less qualified nurses, we recommend a maximum of 2 sessions per training package to capture all qualified staff. Where possible, the half training days should be combined into 1 full day to assist the ward manager to cover the shifts accordingly. The ward manager should also attend this training.

Intervention Model

- The core intervention model will involve the following procedures, which are presented as a stepped model of care.

- Upon admission, the named nurse will provide the patient with verbal information about what psychological services are available to them during their admission with the support of the TULIPS information sheet. The nurse will make it clear to patients that TULIPS is not just about providing individual therapy sessions with a psychologist to everyone but that nursing staff are also trained in delivering psychological therapies and psychologists support the nursing staff in their work with patients.

- The psychologist, named nurse and where appropriate the patient decides on whether the persons needs can be met by an intervention with a nurse or psychological therapist themselves, this may change during the process of the psychological intervention.

Level 1 *(For everyone)*

• A formulation will be developed for all patient irrespective of whether or not they want psychological input.

• The psychologist will undertake a formulation session with named nurses and any other staff on shift who are available and able to contribute to the meeting.

• Following the meeting a summary of the formulation will be recorded by psychologist in clinical records but documented as a working hypothesis that is subject to change.

Note: the intervention also includes regular team formulation meetings whereby staff select a patient to discuss but these are separate to level one formulations.

Level 2

(For patients who would like some type of therapy and have a specific need that can be addressed through a relatively structured, circumscribed intervention determined on the basis of the formulation in level one)

- Nurses will be trained in four guided self-help interventions. These can be delivered in one-to-one formats or as groups with both modes of delivering being optimal.

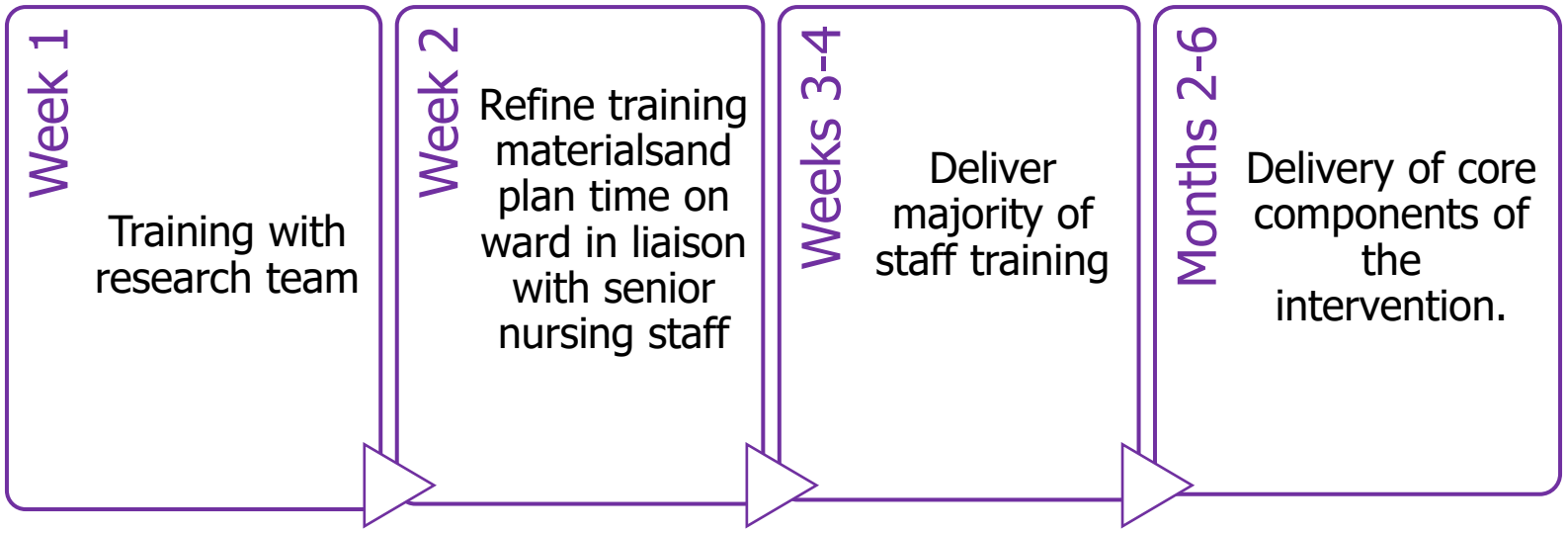
- Nurses will receive individual supervision with psychologist to support the delivery of the interventions. One session of the psychologist's time per week will be dedicated to staff supervision. Shift rotas should allow the opportunity for staff to attend supervision at least fortnightly, this can be managed by stipulating to staff that it is part of their job role, covering the ward with a suitable number of bank/agency staff where required and conducting the supervision sessions across handover time where there is often an increase in the number of staff on shift. Supervision to act as a forum for staff to reflect and discuss any barriers to implementation of groups and one-to-one interventions.

- The psychologist should monitor patient progress throughout the intervention delivery and liaise with their named nurse and MDT to determine if this is an appropriate level.

Level 3

(For patients who have requested therapy and who have more complex needs that cannot be addressed by a level two intervention as determined on the basis of the formulation in level one)

- The psychologist and the patient to determine together the best time of day to have sessions, best duration of sessions, best location of sessions and identify with the patient at least one achievable end goal of the sessions.
- The psychologist to monitor progress throughout and liaise with the patient and MDT to determine if appropriate.
- The psychologist to understand from the patient if they would like to continue the work they have done on the ward within the community and if so to explore community provision and liaise with community services. If not, the psychologist should ensure that the formulation is included at discharge summary with the caveat that this is a working hypothesis.
- When patients are discharged unexpectedly, the psychologist should ensure they still send formulation to community team and any implications for the support plans.



During the 7-month intervention period the psychologist's time will be broken down as follows:

Suggested breakdown of week from months 2-6 based on 18.75 hours per week

- 3 hours patient formulation (level 1)
- 3 hours supervising staff to deliver step two and delivering any outstanding training
- 2 hours one-to-one therapy (level 3)
- 2 hours administration and liaison
- 3 hours team meetings (handovers, ward rounds, other review meeting)
- hours team formulation or reflective practice
- 2.75 hours break/lunch
- hours own supervision

All the above includes travel and preparation time

WHO PROVIDED?

The main intervention provider will be a Band 8a clinical psychologist, ideally although not necessarily, with previous experience in working in acute inpatient settings. They will receive two days training in the intervention and fortnightly supervision from a more senior psychologist (ideally with inpatient experience), in addition to fortnightly supervision from the research team. The on-site supervision will ideally be carried out face-to-face, although this may involve skype or
telephone supervision for up to half of the sessions if the location of the supervisor and supervisee does not permit easily meeting face-to-face. The majority of the supervision with the research team will be carried out via Skype or teleconference.

Step 2 level interventions will be delivered by qualified nursing staff on the ward or other ward-based staff who express an interest in receiving further training and supervision in psychosocial intervention. These staff will be trained and supervised to deliver interventions by the clinical psychologist.

HOW?

Level 1

- A formulation will be developed for all patient irrespective of whether or not they want psychological input. This will be developed in a face-to-face meeting with the psychologist and named nurse, but could also include any other staff on shift who are available to attend and offer input into the meeting. Information for the formulation should be derived from case notes reviewed together during the meeting and the staff and psychologist's own knowledge of and conversations with the patient.

- One session of the psychologist's time per week is to be dedicated to level one work. Although the ideal aim would be to develop formulations for every single patient, this ideal may not be achievable. The psychologist therefore needs to take a pragmatic approach and use their formulation time to co-ordinate between 2-3 formulation meetings per week. At points in the study when there are more patients in need of a

formulation than there is resource (e.g. at the start of the study when no one has a formulation or during high periods of patient turnover) decisions about which patients to focus on should be based on the following factors: longer length of stay, repeated admissions and patients staff perceive as particularly challenging. At later points in the study if the ward has a relatively low turnover, it may be possible to formulate each new admission, however, it is important not to focus solely on new admissions at the start of the study as this runs the risk of research participants who are on the ward at baseline being excluded from a key component of the intervention. It is also important to not solely focus on the patients that staff find challenging as this runs the risk of people with low levels of risk but unmet need being missed.

Level 2

- Nurses will be trained in four guided self-help interventions. These can be delivered in one-one-one formats or as groups with both modes of delivering being optimal.
- Frequency and duration of one-to-one sessions to be determined in collaboration with patients.
- Frequency and duration of group sessions to be determined in collaboration with the psychologist and senior nursing staff.
- One session of the psychologist's time per week to be dedicated to providing 30-minute individual supervision slots to staff in their intervention delivery.

Level 3

- The psychologist will meet with patients for one-to-one therapy delivered face-to-face for up to 16 weeks.
- Frequency, location and duration of sessions to be determined in collaboration with the patient.
- One session of the psychologist's time per week to be dedicated to one-to-one work.

Additional ward-based work undertaken by the psychologist

- Fortnightly reflective practice sessions of one-hour duration facilitated by the psychologist and delivered in group format face-to-face. These meetings need to occur during a regular slot that maximises staff attendance (e.g. at the point of shift cross over) and rotas and staff allocations need to take into account these meetings. These meetings are to be viewed as a compulsory part of staff role's role on the ward and are not optional extra.

- Fortnightly team formulation sessions of one-hour duration facilitated by the psychologist and delivered in group format face-to-face. These meetings need to occur during a regular slot that maximises staff attendance (e.g. at the point of shift cross over) and rotas and staff allocations need to take into account these meetings. These meetings are to be viewed as a compulsory part of staff role's role on the ward and are not optional extra. Note that these team formulation meetings are separate to and in addition to level one formulations and are about a group of staff coming together to reflect on their current and future work with a patient. Information discussed during these meetings may come from case notes and staff and psychologist's knowledge and conversations with the patient. It is important that all levels of staff attend these formulations including support staff and other members of the MDT based on the ward as the purpose of the meeting is to develop a shared understanding of the patient. Decisions about which patients to discuss during these meetings should be based on staff request. However, the psychologist should ensure that meetings do not focus solely on high risk patients as those with lower risk who are less problematic for staff may be excluded.

- Number of MDT meetings attended and frequency to be determined in collaboration with senior nursing and medical staff.

WHERE?

The intervention will be delivered in on acute inpatient wards. The psychologist will be based on the ward and therefore will need access to computers on the ward and a private room to see patients in.

WHEN AND HOW MUCH?

- The intervention will be delivered over a 7-month period including one-month preparation and training and 6 months of core intervention delivery. The number of sessions for each aspect of the psychologist's role are detailed below although the total number of patients that receive each level of intervention is not predetermined as the frequency and dose of each intervention sessions is determined by patient and the MDT request and the number of new patients that will be admitted to and discharged from each ward during each intervention period is not known.
- One hour of psychologist supervision with site-based supervisor per fortnight.
- Up to three hours of team meetings (handovers, ward rounds, other review meeting) per week.
- Up to two hours one-to-one therapy per week (number of patients that can be seen will depend on length of each session, frequency of sessions and dose of sessions delivered), but it estimated that the psychologist will carry a caseload of 2-3 patients and the maximum duration of sessions any person will receive will be 16 hours.
- Up to three hours of level one formulation per week, meaning that the psychologist can generate formulations for between 2-3 new patients per week.
- Up to three hours supervising staff to deliver step two and delivering any outstanding training. It is estimated that this will enable the psychologist to see between 4-6 staff per week.
- One team formulation or reflective practice session per week estimated at one-hour duration with 30 minutes preparation time.

TAILORING

It is anticipated that the intervention will be tailored to each ward in collaboration with the research team.

Training

Core training slides will be produced but these are can be refined by each psychologist on the basis of the ward's needs in collaboration with the research team.

The generic staff training can be modified so the different weight given to the various components covered (trauma, therapeutic relationships, self-care and formulation).

The more specialised 4 half day training sessions will vary from ward to ward but will all be selected from a resource of anxiety, depression, distressing symptoms of psychosis, healthy living (including exercise, eating well, sleeping well, drug and alcohol use), problematic anger and aggression, self-esteem, self-harm training packages, setting up 1-2-1 sessions and setting up groups. The material within each training package can be refined by the psychologist to incorporate their own material and resources or to take into account previous training that ward staff may have undertaken, in collaboration with the research team.

Level one formulations

- Formulations must include key components which include the following (session opening and agenda; description of patient; key problems elicited; reference to patients strengths, resources, goals, values, and significant life events; team coping and patterns of interactions between the patient and staff members; relevant social and cultural aspects of the patient's experiences; support plans, interventions and recommendations), but no specific therapeutic model is specified on the basis that different psychologists may be trained in different approaches and the process of formulating is felt to be more important than the specific methodology (although there is no evidence to support this assertion).

- The focus of these sessions is to be determined by the packages that the staff are trained in and includes any four of the topics listed above.

- The staff will be provided with guided self-help booklets to use with patients and be requested not to use their own material. The level of group versus one-to-one sessions is to be determined on a ward by ward basis but one-to-one are deemed the optimal mode of delivering and should not be replaced completely by group sessions.

Level three interventions

- The focus of these sessions is on assessment, formulation or intervention-based activity which should be based on a clear goal developed by the patients.

- The frequency and duration of each sessions is to be negotiated with individual patients.

- No model of therapy is specified on the basis that the psychologist may be trained in different approaches and the TULIPS intervention is primarily testing the delivering a psychologically-informed environment as opposed to testing a specific form of therapy. However, the sessions should rate highly on non-specific therapeutic factors e.g. interpersonal effectiveness on CTRS and working alliance.

Other aspects of the psychologist's role.

- Reflective practice groups and team formulation sessions can be delivered using the preferred model of the psychologist but the latter need to rare highly on the basis of (session opening and agenda; description of patient; key problems elicited; reference to patients strengths, resources, goals, values, and significant life events; team coping and patterns of interactions between the patient and staff members; relevant social and cultural aspects of the patient's experiences; support plans, interventions and recommendations).

- The exact number of and type of MDT meetings that the psychologist will attend will be determined on a ward by ward basis following discussions with senior members of the ward team.