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SCOPING PSYCHOLOGICAL PROVISION AND NEED AT 'THE LAKES' MENTAL HEALTH UNIT, EAST AREA (COLCHESTER) NEPFT

Introduction
I was asked by Dr Romey Jacobson (Consultant Clinical Psychologist and Associate Director of Applied Psychology & Psychological Therapies) to undertake a scoping exercise of inpatient psychological provision at the 'Lakes' (Mental Health Unit), Colchester. This forms part of a review of the Psychological Therapies Service across the Trust, but also due to a specific request from managers at the Lakes in respect of the current provision of psychological therapies.
I have reviewed non-governmental and governmental guidelines in order to establish what is recommended for inpatient wards.

PART ONE:

BACKGROUND AND CURRENT PROVISION

Current psychological therapy service at the Lakes
Background to the Lakes
'The Lakes' Mental Health Unit is the name for the inpatient service covering the Colchester area of Essex and consisting of two inpatient wards (Gosfield and Ardleigh). These two wards are GP surgery aligned and each 'serviced' by three Consultant Psychiatrists with a Crisis and Home Treatment team across the patch. The inpatient service is integrated with the Crisis and Home Treatment Team and consequently there are three groups of service users under the team: those who are under Home treatment; those who are inpatients (36) ; and those who are known as 'partial' inpatients (5) – who sleep at home but spend their days at the Lakes.

Current Psychological Therapy Service
The current psychological therapies input at the Lakes consists of 8 sessions from a 'Senior Adult Psychotherapist' (K) as well as groups provided by Music, Art and Drama therapists on a weekly basis. K's background profession is mental health nursing, but she has additional specialist training in psychodynamic counselling as well as a group analyst. According to the job description, K is organisationally within the inpatient service (i.e the budget for her full time post is within the Inpatient service); she is responsible to the Lakes Clinical Manager and accountable to the Director of Nursing Services, but is professionally accountable to a Consultant Psychotherapist from the Psychotherapy Service who provides her clinical supervision.

Background to the Inpatient ' Senior Adult Psychotherapist' post
The background to this management arrangement is that K was acting deputy ward manager (nursing) before she undertook her counselling and group analyst training and the funding for her post remains as it did, with the inpatient services. It is my understanding that following her training K's base was the Lakes but her work was diffuse (K described it as psychotherapist for the acute division) including: liaison with A&E and the general hospital; work with the local hospice; consultation to the acute wards (including elderly and PICU); as well as psychotherapy assessments and occasional interventions assessments and telephone work for Crisis Team. I was informed that a change in management led to a review of K's post and a decision to focus the role onto more direct clinical work on the ward. Since then (approximately one year ago), K has spent 8 sessions (4 days) on the wards, her other 2 sessions (1 day) is spent in the outpatient psychotherapy service based at the Northgate Centre, Colchester.

In terms of clinical remit, the job description specifies that the Senior Adult Psychotherapist 'undertake highly specialised assessments for suitability for psychodynamic psychotherapy and makes formulations and care plans for those whom psychodynamic psychotherapy is the treatment of choice'.

To itemise, the current psychological therapy service to the Lakes consists of:

- *K – Psychodynamic Psychotherapist:*
  - Staff consultation (to the CRHT team)
  - Meeting all inpatients
  - Individual assessments (of suitability for psychodynamic psychotherapy)
  - Individual interventions (4-6 sessions – starting in the inpatient services and continuing with CRHT if necessary)
  - Attendance at pre-Care Review Meetings (of which there are 6 for the 6 Consultant Psychiatrists working into the inpatient service)
  - Group interventions:
    - Relationship Group (run twice per week for both inpatients and partial inpatients)
    - Transitions Group (run once per week for both inpatients and partial inpatients)
    - Community Group (I/S co-facilitates with another member of the team)

- *Other psychological input into the Lakes*
  - Music Therapy (run twice per week – once for inpatients, once for partial inpatients) facilitated by TC)
  - Art Therapy (run once per week for both inpatients and partial inpatients) facilitated by DH)
  - Drama Therapy (temporarily not running, facilitated by SD)
  - Anxiety management & relaxation groups facilitated by SB (OT)
  - There were plans to add a Cognitive Behavioural Therapy (CBT) group in the near future.

Review of Current Provision

Although this offers psychodynamic oriented psychotherapy to the Lakes, this input is limited to a psychodynamic/psychoanalytic informed approach and does not provide:

- **broader and more specialist psychological assessments** for example assessments of personality and coping style, assessments to assist in diagnosis and treatment, psychological risk assessments, assessments of severity of symptoms and their impact, cognitive and neuropsychological assessments as well as other psychometric assessments;
- **a range of psychological interventions**, for example solution focused, cognitive behavioural, systemic, DBT, CAT etc
- **consultations & management**.

PART TWO:

MATCHING CURRENT PROVISION TO EXTERNAL & INTERNAL GUIDELINES FOR PSYCHOLOGICAL PROVISION TO INPATIENT SERVCIES

Having established what is offered, I will now look at how this compares to recommendations and guidelines for inpatient services using criteria provided by the Royal College of Psychiatrists (AIMS), Star Wards, British Psychological Society, NICE guideline, Health Care Commission and internal Trust guidelines.[1]

Accreditation for Acute Inpatient Mental Health Services (AIMS)

'AIMS: Standards for Acute Inpatient Wards' (The Royal College of Psychiatrists, 2009) states that within their accreditation system a ward should offer service users access to specialist practitioners of psychological interventions more than one half-day (four hours) per week per ward. An 'excellent' rated ward would offer at least one staff member linked to the ward delivering two or more problem- specific, high intensity psychological interventions (to correspond to two or more diagnostic criteria as per NICE guidance). Most wards participating in reviews by AIMS have struggled to meet basic standards for access to psychological services (Star Wards, 2008). The Lakes provision offers talking therapies (although it is noted this is currently limited to a psychodynamic approach), however it currently does not offer a broader range of interventions and is also missing being able to offer a broad and specialist range of psychological assessments.

[1] To note, the following recommendations and guidelines may be services provided by various mental health professions with additional training in psychological therapies.

Star Wards
The Star Wards criteria for tweaking, turning and transforming Inpatient Wards, is quite detailed about psychological input on wards [a fuller account of these recommendations is included in Appendix D]. In 2008 a review showed that a mere 17% of acute mental health wards have a dedicated clinical psychologist. From Star Wards 1:

"Professionally chartered, applied psychologists who practice psychological therapies after many years of doctoral-level training – are widely recognised as the most capable psychological therapy practitioners in the context of severe, enduring and/or complex and risky distress. They are also the best candidates for training and supervising other mental health professions…"

and Star Wards 2:

"Unfortunately, there is relatively little known about the benefits, or otherwise, of psychotherapy for acute in-patients. It's tempting, almost common sense, to think it can only be a good thing. But there are complex issues about patients' ability to engage in what can be painful or challenging therapy when they are seriously ill, as well as concerns about potential discontinuity of treatment when they leave hospital".

British Psychological Society (BPS):
The BPS recommendation is that Clinical Psychologists offer assessments and formulations, as well as interventions, consultations, supervision and training. Their training in a range of theories and interventions gives both a broad and specialist range of psychological skills to a multidisciplinary team. Assessments should include psychometrics, cognitive and neuropsychological; as well as of personality, symptoms, risk; leading to formulations and recommendations.

The current psychological provision at the Lakes provides only one aspect of what should be a broader psychological role, (as it is limited to a psychodynamic orientation). For example, according to the current Job Description, assessments are of 'suitability for psychodynamic psychotherapy', which means the assessment information may be of limited use to other members of the team who require assistance in other aspects of formulation and intervention/management. Further information on BPS recommendations is provided in the Appendix B, Table 1.

NICE Guidelines
The NICE guidelines highlight the good practice of psychotherapy on inpatient wards but indicate that rather than one orientation, a wide range of interventions should be on offer including: Cognitive Behavioural Therapy (C.B.T.), Dialogical Behaviour Therapy (D.B.T.), Cognitive Analytic Therapy (C.A.T.) and Family Therapy (see Appendix C, table 2). The psychological role should be broader than this to include assessments to aid the team in care planning and risk management, as well as in diagnosis (in order to make judgements about suitable and recommended treatment) and intellectual assessments in order to pitch the therapy at the appropriate level.

Trust Guidelines
Turning to look at the existing provision alongside trust guidelines, a *Skill Mix Review* of the inpatient services in 2006/7 established there should be a core of essential clinicians on the ward, namely: nurses, OTs, Psychologists (and Psychology Assistants), Support Workers and Associate Practitioners. Specialist support to these core services was to come from (Psychologists, OTs), Psychotherapists, Dieticians Physiotherapists, Social Workers, Pharmacists and Speech and Language Therapists (SALT). It also stated that therapies offered should reflect NICE guidelines and be capable of being evaluated.

In more detail, the skill mix review noted that all wards were to have a dedicated named senior member of psychological services who would provide consultation to staff and encourage the development of psychological mindedness in the staff group. It was noted that 'psychological mindedness' happens when staff work alongside a clinical psychologist or other senior member of psychological services staff who works directly with clients (point 14). In addition for each unit to have 'Assistant Psychologists' (under Clinical Psychology guidance) working alongside the qualified senior psychology staff (point 15). See also Appendix A for external guidelines on psychological provision on acute mental health inpatient services.

Of note, the latest Health Care Commission rated this trust (NEPFT) as 'fair' and highlighted that it needed to improve on personalised and individualised care for inpatients (July 2008). This could

be addressed by offering inpatients a *range* of options in terms of psychological assessment and intervention

Conclusions (from matching current provision against external guidelines):
As the guidelines indicate it is good practice to have psychotherapy of various kinds on the ward. However, the Lakes current provision is limited to assessment and intervention related to psychodynamic psychotherapy which, whilst useful, is not sufficient for the adequate provision of a psychological service in a psychiatric inpatient service. What is required is a broad range of highly specialist skills in psychological assessment and intervention rather than a specific theoretical approach.

Thus the job description does not match what is currently prioritised for inpatient services and although K may work according to her job description, **the job description of Senior Adult Psychotherapist doesn't meet the psychological requirements of a modern ward according to current external governmental guidelines.**

PART THREE:

FEEDBACK FROM CURRENT STAFF AND SERVICE USERS

Views of Staff and Service Users on the current psychological provision at the Lakes

Service Users
The service users I spoke to informally on the ward were positive about the psychological therapies input on the ward. When asked about psychological services most took it to mean 'were they having therapy?' (as opposed to appreciating the broader role, for example including specialist assessments). Everyone I spoke to knew who K was and had spoken with her. In terms of how the service could be improved, one service user wanted the opportunity to work long term with the same clinician if they started therapy as an inpatient. There was positive feedback about Music and Drama therapy from both staff and service users. In spite of this, in general Service Users said they preferred one-to-one work rather than groups. Despite feedback that individual sessions are the preferred option, evidence suggests that group work is valued also (as well as being more resource efficient). However it should be noted that the HCC recommendation was to 'personalise and individualise' inpatient care, which could be interpreted as a need to give one-to-one work more priority than is currently the case.

Staff: Clinicians (Nurses, OTs, Psychiatry)
This group of staff were clearly appreciative of the role psychotherapy (K in particular) played within the wards, although I was informed that an impression had formed that some of the psychotherapists running groups on a 'group by group' basis were reluctant to come to the ward. This group of staff identified many gaps in psychological service provision and made requests for further psychological input as detailed below:

- Broader psychological assessments (beyond an assessment of suitability for psychotherapy) i.e. assessments of personality, cognitive function, symptoms (e.g. within psychosis), risk, or motivation to manage alcohol and drug misuse etc…, leading to guidance for teams on care and management issues.
- Practical psychological advice such as 'how to help with lack of confidence, or low self-esteem, how to improve self-care, and how to motivate people. Staff expressed frustration with hearing about someone's past history: 'yeah, but what do we do now'. This may be because (I/S training and the job description means) assessments are geared towards suitability for psychotherapy rather than (for example) informing and guiding the team approach with an individual. So psychological input should contextualise someone's current presentation but then offer practical suggestions and recommendations based on this.
- There were requests for assessments of suitability for other forms of psychotherapy (beyond psychodynamic) e.g. CBT for psychosis and DBT for those diagnosed with a Personality Disorder.
- Consultation around complex issues e.g. deliberate self-harm, as well as eating disorders and somatisation.
- A need for family work was identified including: systemic formulation; family therapy; as well as more practical issues – how to work with difficulty and stressed families and how to give advice to family (psycho-education).

It is noted that the requests from clinicians highlight the broader and more specialist psychological services that are not offered in the current psychological provision.

Staff: Managers

- There was a sense of not knowing exactly what K (in particular) does. This seemed to relate to a sense of her working on her own, rather than as part of the team. This may relate to the Managerial target of integrating the team.
- There was a question about whether 'psychodynamic psychotherapy' was appropriate for inpatient settings due to the nature and degree of inpatients' difficulties, but also because of the time constraints. I would note that from my very limited exposure to K's work, she had adapted her style sufficiently and appeared containing and supportive. She offered practical advice in her groups and although rather didactic, the service users seemed to accept this. In addition, feedback was very positive about Music Therapy Groups from both service users and the facilitator.
- Managers' reported that service users found the Art Therapy difficult to use due to the quiet style of the facilitator. The suggestion was that a strict analytic style provoked too much anxiety in inpatients for them to feel able to use this form of therapy (this opinion was also echoed by service users).
- Recent reviews indicated that on average, the 'relationships' and 'transitions' groups were attended by 2-3 service users. The feeling was that this was on the low side.

PART FOUR:
CONCLUSIONS AND SUGGESTIONS

Conclusions

To summarise, it appears from this scoping exercise that the job description relating to the Inpatient Senior Adult Psychotherapist is limited to psychodynamic psychotherapy assessments and brief interventions. In addition this is a style of assessment and intervention not currently championed by NICE guidance. Although useful, this specific approach is not broad enough to match the current priorities and requirements of a modern psychiatric ward according to both external and internal guidelines and feedback.

Suggestions

What the inpatient service requires is a broad and specialist psychological service offering:

- specialist psychological assessments of neuropsychological functioning, personality, risk, specific behaviours and symptoms;
- tailor made, individualised formulations that can be helpful for both service user and for the staff working with them, informing care plans, risk plans and discharge management plans;
- a range of brief interventions which include some of those recommended in NICE guidelines;
- joint working, in order to improve psychological mindedness amongst staff
- staff support, including informal support, consultation and complex case discussions;
- training

Suggestion One: Augment?

One way to achieve this would be to add to the existing psychotherapy service by adding a senior experienced Clinical Psychologist who would be able to meet and deliver to the service gaps outlined above (including specialist psychological assessments and formulations such as of personality and cognitive functioning; brief therapies that took account of NICE guidelines such as CBT).

Suggestion Two: Enhance psychological therapy skills in existing staff to augment the current psychological service.

I was informed that some of the existing staff had training in psychological approaches such as family therapy, solution focused therapy and CBT. It is possible these skills could be 'revived' given supervision and further training. This would clearly be the cheapest option, but I'm uncertain about the quality of the psychological therapies offered given they may have lain dormant. I think it is also difficult for nurses in particular to offer therapy to someone who they might have also needed to practice some of the more invasive nursing practices (e.g. enforced injections, restraints etc). However, the main disadvantage with this approach is that although the range of therapies offered increases, the provision remains focused on therapeutic interventions and continues to neglect the role of broader and more specialist psychological assessments, formulations and consultation.

Suggestion Three: Re-evaluate the job

Rather than augmenting, another option would be to take a decision that the current job description of Senior Adult Psychotherapist (being psychodynamically oriented) is too narrow for the ward's needs and thus needs reviewing to offer a broader psychological role offering other forms of assessment and intervention as outlined in more detail above. However, such a role will have budget implications as broader and more specialist expertise will have cost implications.

Dr I/S
Clinical Psychologist and Psychotherapist
March 2008

References

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- *Acute Problems'* Sainsbury Centre for Mental Health , 1998
- *Delivering the Governments Mental Health Policy,* Sainsbury Centre for Mental Health (2007)
- *Mental Health Policy Implementation Guide Adult Acute Inpatient Care Provision*, Dept of Health (2002)
- *National Acute Inpatient Project,* Department of Health (2005)
- *New Ways of Working,* British Psychological Society
- *NICE Guidelines*, Department of Health (via Website)
- *NSF 5 years on,* Department of Health (2004)
- *Onwards And Upwards - Sustaining Service Improvement In Acute Care,* CSIP (2006/07)
- *Pathway to Recovery,* The Healthcare Commission (2008)
- *The Search for Acute Solutions,* Sainsbury Centre for Mental Health (2006)
- *Star Wards*
- *Virtual Ward Mental Health Digest* (accessed via the CSIP website)
- *Ward Watch,* Mind.
- *We need to talk – the case for psychological therapy on the NHS,* Mental Health Foundation (2006).

APPENDIX

A Provision and Skill Mix

In ***Delivering the Government's Mental Health Policy,*** it is suggested that for every 80 beds (2010/11) there should be four whole time equivalent (wte) qualified clinical psychologists, 4 technicians/assistant psychologists (wte) 0.5 psychotherapy and 1 wte music, art and drama therapist. Relating this to the Lakes this would approximately mean 2 full time psychologists plus 2 full time psychology assistants 0.25 psychotherapy and 0.5 Music, Arts and Drama therapies [Sainsbury Centre for Mental Health (2007)].

B Matching the Lakes against British Psychological Society suggestions:

These take the form of suggestions of what a psychological therapy service should/could offer on the wards (adapted from John Hannah, a representative for the BPS, Division of Clinical Psychological (DCP) Psychosis and Complex Mental Health Faculty).

Table 1

Matching the Lakes against British Psychological Society suggestions:

Suggestions/Recommendations:	What is currently offered at the Lakes
DIRECT CLINICAL WORK:	
Assessment Assessment and formulation	Specifically assessment for suitability for psychotherapy.
Psychometric assessment (cognitive, neuropsychological)	No
Interventions: Cognitive-behavioural therapy	No (although CBT group to start)
Group psychological therapies	Yes
Psychodynamic	Yes
Functional behavioural analysis	No
Individual psychological therapies	Yes
Components of dialectical behavioural therapy	No
Integrative psychotherapy	Don't know

Family systemic psychotherapy/family work	No (although existing skills within staff team?)
Solution-focused therapy	No (although existing skills within staff team?)
CBT for psychosis	No.
Integrative formulation	No
Systemic	No.
Psychosocial skills building	Living Skills via OT
Relapse prevention	Don't know
Psycho education	OT run CBT group to start
Engagement, rapport building	Yes
Patients awareness of psychological therapies	Yes
Focal themes (Leaving Hospital)	Yes
Working with Home Treatment Team (assessment & treatment)	Consultation (plus individual therapy intervention if ongoing after discharge from inpatient services - up to 6 sessions)
Clinical consultation (Complex case review for HTT)	Yes
Care Reviews (what were known as Ward Rounds)	Yes: Attendance at preliminary meeting
Staff groups / Staff support	No
Supervision of psychological, psychosocial work	No
Teaching/training programme	No
Nursing one-to-ones	Don't know.
Community meetings	Yes
In-vivo training	Don't know
Group co-facilitation	Yes (community group)

Of note, Mind's Ward Watch warns that *improving access to psychological therapies* did not mean improving east of access at primary care level at the expense of other specialist services such as inpatient care.

C Matching the Lakes against NICE Guidelines:

Bearing in mind the NICE guidelines for treatments, 84,702 people were admitted to inpatient wards in England with a psychosis, depression or anxiety disorder in 2005-06 (NAO 2007a). In a national survey of people using mental health services (N=7,446) only 46% had received or been offered CBT in the last 12 months: for individual Trusts the figures range from 20% to 96% (Healthcare Commission & CSCI 2007). Of those for whom family intervention would be appropriately, only 53% nationally had received any in the last 12 months (Healthcare Commission & CSCI 2007) [all figures from CSIP website: Virtual Ward: mental health digest statistics).

Referring to the NICE guidelines the psychological input to the ward ought to be able to offer some of the following types of assessment and treatment for service users.

Table 2

Matching the Psychological Provision at the Lakes against the NICE guidelines

Recommended treatment	For …	Provided at the Lakes
Bibliotherapy	Anxiety disorders	No
Cognitive Analytic therapy (CAT)	Anorexia	No
CBT	Anxiety disorders, depression, depression associated with Bipolar Disorder, Post Traumatic Stress Disorder (PTSD), Obsessive Compulsive Disorder (OCD), eating disorders, schizophrenia as well as with long term conditions to help people manage their condition more effectively	No (CBT Group to start)
Counselling (supportive and practical)	Mild depression and schizophrenia and where CBT or Family Therapy not available.	Yes
Dialectical Behaviour Therapy (DBT)	Binge eating and Personality Disorder with self harm	No (but provided at the Haven)
Family Therapy (FT)	Anorexia, schizophrenia, depression (if individual therapy hasn't been successful)	No
Groups	OCD, depression	No
Interpersonal	Eating disorders, depression	No
Motivational interviewing	Alcohol and substance misuse	No

Psychodynamic	Anorexia and depression	Yes

D Matching the Lakes against Star Wards (2006) recommended psychological provision:

"Professionally chartered, applied psychologists who practice psychological therapies after many years of doctoral-level training – are widely recognised as the most capable psychological therapy practitioners in the context of severe, enduring and/or complex and risky distress. They are also the best candidates for training and supervising other mental health professions, such as nurses, psychiatrists, occupational therapists and social workers, who would ordinarily use psychological interventions in their everyday practice.

Table 3

Matching the Lakes against the Star Wards ideas relevant to psychological provision:

Category of change (based on investment)	Suggestion	The Lakes
Tweaking	*Self-help books*	Don't know
	Protected engagement time	Yes
	Women's and men's groups take place and other culturally specific groups	Yes (a womens group focused on pampering or walking- part of OT)
Turning	*Psychology assistant for each ward.*	No
	At least 1 member of staff has counselling qualify.	Yes
	Each patient has at least one hour of therapy or recovery management a day: diagnosis related (e.g. eating disorders), treatment related (e.g. CBT), creative therapies (e.g. drama therapy). Group therapy could be carried out across wards, especially for inpatients with a minority condition, e.g. body dysmorphic disorder.	To some extent – groups and individual therapy although currently limited to psychodynamic/analytic orientation.
Transforming	*Full day's programme of therapy groups available.*	Yes
	Placements for student counsellors, providing one-to-one sessions.	Don't know
	Individual talking therapy for all who need it, with continuity when patients leave hospital.	Yes. Therapy available, unclear whether for 'all who need it', but all meet with I/S on admission.
	On-ward and cross-ward involvement of OTs & creative therapists (e.g. drama therapists).	Yes
	Core programme of on- and off-ward activity	Yes
	Patients can choose to use a Personal Recovery Workbook	Yes under 'Acute Solutions', unclear whether continues.
	A mini-library of Mind information leaflets	No.

Although clinical psychologists are specialists in delivering psychological therapies, especially with challenging clinical presentations, all mental health professionals are responsible for providing psychologically therapeutic interventions— from supportive counselling to solution-focused problem solving to behavioural symptom management. Without psychologists and other specialists in psychological therapy, however, both service users with challenging difficulties, and staff with psychological training and supervision needs, will struggle to meet challenges in the psychological and psychosocial treatment spheres.

The evidence base for psychological therapies, especially cognitive behavioural therapy (CBT) has grown substantially over the past few years. Specific psychological therapies for all of the mental health conditions related to hospital admission, from suicidal depression to psychosis to borderline personality difficulties, have been demonstrated as effective through numerous research trials. Each is endorsed and recommended as an essential part of standard care by the National Institute for Clinical Excellence (NICE). Not only does psychology now have a weighty evidence base, but psychological therapies are now more in demand from service users than ever before. Many people who use mental health services state a preference for talking therapies, or a combination of therapy and medication, over medication alone. Yet the NHS has a long way

to go before meeting either the NICE guidance implementation targets or achieving widespread satisfaction in its psychological therapy service delivery.

Every review of mental health services from service user and other organisations, such as Mind and the Sainsbury's Centre, note a widespread dissatisfaction among service users with the quality and quantity of one-to-one therapeutic contact with staff, especially on wards in mental health hospitals, as well as with access to psychologists, who remain in short supply. For all of these reasons, psychologists are increasingly being employed to help train and support multidisciplinary staff while taking on the most challenging psychological therapy work on inpatient wards. Some psychologists work mainly in a community team and work with their sector-based ward for a session or two a week, while others are employed within a hospital and work across wards exclusively with inpatient.

Psychologists assess and formulate their clients' difficulties and, as such, provide a different and valuable perspective on distress to both the client and the treatment team. They often provide an individual assessment and therapy service while contributing to or supporting an inpatient group programme. In therapy, psychologists help to address existential challenges related to suicidality, make sense of delusions and hallucinations, work through past trauma and loss, focus on thought patterns and lifestyle choices which can promote recovery and improve relating within social systems.

Psychologists are increasingly called upon by other professional groups to support training initiatives, as all professions are now expected to provide at least basic psychological interventions as part of routine care. It has, in the past, been argued that scarce psychological therapy resources should be reserved for outpatients, as they may be in a better position to engage in such treatment. A counter-argument to this is offered by the evidence base for psychology: NICE regularly recommends prioritising psychological therapy for those candidates whose distress is persistent and whose risk of relapse is high—this clearly includes inpatients . The counter-argument is further strengthened by the Department of Health's National Service Framework, which similarly argues that gaps in services for people with severe, enduring and complex difficulties must be a first priority. There is no doubt that NICE recommendations need to be adapted to the time-limited nature of an acute admission, as well as to the acute distress experienced by many inpatients which will, at times, pose challenges to effective engagement. But the immediate aftermath of a breakdown necessitating admission is often the best opportunity to make sense of the precipitating factors contributing to a personal crisis.[2006]

...

*Unfortunately, there is relatively little known about the benefits, or otherwise, of psychotherapy for acute in-patients. It's tempting, almost common sense, to think it can only be a good thing. But there are complex issues about patients' ability to engage in what can be painful or challenging therapy when they are seriously ill, as well as concerns about potential discontinuity of treatment when they leave hospital. [2008]***.**