The Regulation and Quality Improvement Authority

A Review of Acute Mental Health Inpatient Access to Psychological Interventions and Therapies 2014/15

npm national preventive mechanism

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1.0 Background

In 2013, following a review of Serious Adverse Incidents (SAIs), the Professor of MHLD Clinical Psychology Professional Adviser undertook 'An Audit of Access to Evidence Based Psychological Therapies for Adults who Subsequently Complete Suicide'[1]. The audit identified a number of concerns about the patient treatment history, including poor access to psychological therapies. It was therefore agreed that a review of acute mental health inpatients' access to psychological interventions and therapies should be undertaken.

2.0 Standards

The standards used to assess services were drawn from the following sources;

a) NICE guidance on evidence based psychological interventions,
b) The Royal College of Psychiatry (RCPsych) guidance, 'Do the right thing; how to judge a good ward' (2011)[2]
c) DHSSPS Mental Health Services Frameworks[3]
d) The DHSSPS 'Strategy for the Development of Psychological Therapy Services' (2010).
e) The British Psychological Society (BPS) and RCPsych College Centre for Quality Improvement (CCQI) standards for the organisation and delivery of mental health services (AIMS)[4] ,
f) The Quality Network for Inpatient CAMHS standards (QNIC)[5]

The guidance emphasises the requirement of access to low intensity interventions (e.g. therapeutic ward activities, groups, relaxation, art therapy, physical activity, psycho-education) as well as evidence based high intensity psychological therapies and interventions (e.g. cognitive behaviour therapy, dialectical behaviour therapy, interpersonal psychotherapy, psychodynamic psychotherapy, mentalisation, family therapy, EMDR etc.)

3.0 Methodology

The methodological approach was indicative rather than summative, with six wards being inspected regarding their psychological therapies provision. These included one adult acute mental health inpatient ward per trust, and a regional CAMHs ward.

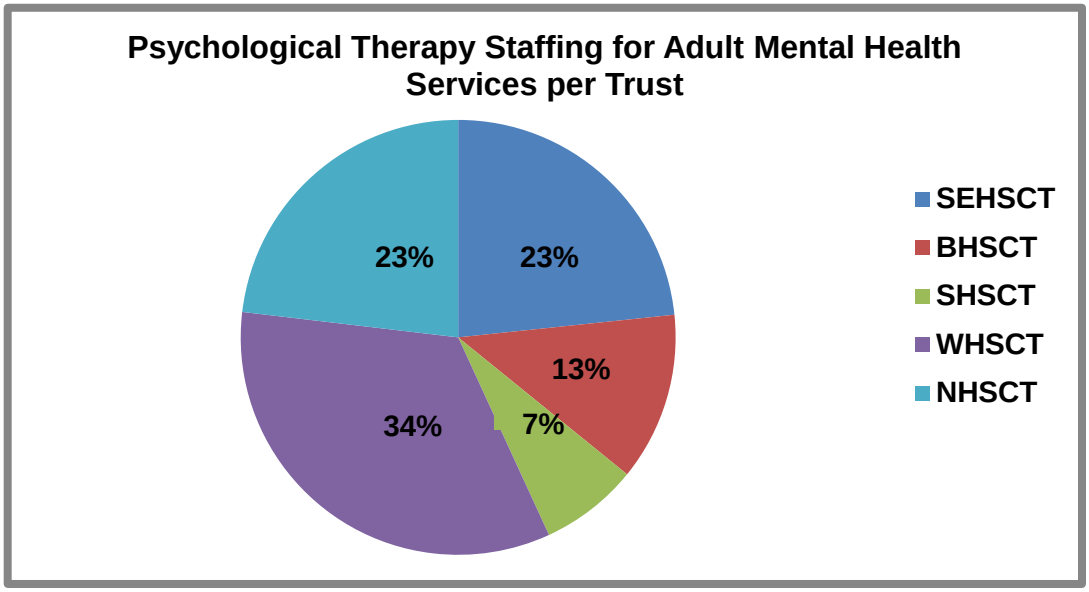
Evidence was gathered from ward documentation, patient files and interviews with patients, service and ward managers, consultant psychiatrists, nursing

[1] An Audit of Access to Evidence Based Psychological Therapies for Adults who Subsequently Complete Suicide (2013) RQIA
[2] 'Do the right thing; how to judge a good ward' (2011) RCPsych OP79
[3] DHSSPS Service Framework for Mental Health and Wellbeing (2011)
[4] Accreditation for Inpatient Mental Health Services (AIMS), CCQI
[5] The Quality Network for Inpatient CAMHS (QNIC), CCQI

staff, occupational therapists, social workers, clinical psychologists, psychological therapy staff, as well as patient advocates.

Figure 1

Psychological therapy staffing for adult mental health services per Trust



4.0 Context

The DHSSPS Mental Health Services Frameworks[6] and 'Strategy for the Development of Psychological Therapy Services' (2010) highlight the need to improve access to evidence based psychological interventions for patients using mental health services. The RCPsych College Centre for Quality Improvement (CCQI)[7] have developed standards for wards to improve the quality of organisation and delivery of mental health services which includes regular access to low intensity therapeutic activities and evidence based high intensity psychological interventions.
Such access requires appropriately trained and supervised staff, as concluded in the HSCB review of training needs in mental health services[8].

Contextual information regarding psychological therapies staffing was derived from a survey of Trust Heads of Clinical Psychology and Psychological Services the HSCB training needs review. This information demonstrated large variation in psychological therapies staffing across trusts and specialisms. Figure 1 summarises the psychological therapy staffing for adult mental health services per Trust (December 2013).

[6] DHSSPS Service Framework for Mental Health and Wellbeing (2011)
[7] Accreditation for Inpatient Mental Health Services (AIMS), CCQI
[8] 'Mapping Training Needs and Outcomes Measurement in Psychological Therapies Services, Mental Health Services and Community and Voluntary Organisations'(2013) QUB, commissioned by HSCB Psychological Therapies Implementation Group

A survey of the Heads of Clinical Psychology and Psychological Services revealed that little had changed in terms of overall capacity, but also demonstrated disparity in inpatient service provision. Only the Belfast Heath and Social Care Trust reported a dedicated clinical psychology and psychological therapies service for inpatients (2.5 WTE staff for AMH wards and 1.8 WTE for CAMHs inpatients). None of the other Trusts had specific inpatient services, although the NHSCT and SEHSCT reported limited access in exceptional circumstances, for example when assessment or intervention was viewed to be critical to patient care.
The WHSCT reported no dedicated acute in-patient service, but described limited in reach from the community Personality Disorder and Recovery services.

The SHSCT did not respond to the survey, but the inspector was informed during ward visits that no inpatient psychological service was provided and that patients could only be referred when discharged.

5.0 Findings

It is acknowledged that many patients are admitted to inpatient wards for short periods of time, when they are particularly distressed and could not avail of psychotherapeutic intervention. However, a significant number of patients are in hospital for over three months and during the ward inspections it was noted that some patients had been in hospital for more than 12 months.
All staff and managers interviewed acknowledged the need for patients to have access to psychological therapies. However, considerable variation in service provision was noted across the wards and trusts, particularly related to the provision of NICE recommended high intensity interventions.

6.0 Evidence of Good Practice

<u>The multidisciplinary team (MDT)</u>
Evidence of good practice included the involvement of clinical psychologists and trained high intensity psychological therapists as members of the MDT.

<u>Treatment plans and records</u>
Concomitant with involvement of psychological therapists on the MDT was evidence of psychological formulation in patient review at ward rounds, treatment meetings and in care plans. Also evidenced within the patient clinical notes was access to the appropriate psychological interventions as per NICE guidance.

<u>Patient report</u>
Those patients who were receiving psychological therapies commented positively on the helpfulness of the interventions. One patient who attended clinical psychology in the community stated that the psychologist had visited them on the ward and was continuing therapy on discharge. However, two others who previous positive experience of psychology had complained that were having to wait to be re-referred on discharge and suggested that it should be available to them as inpatients.

Low intensity therapeutic activities

Many wards had evidence of therapeutic activities available to inpatients. These were most likely to happen on a regular basis where staff had ring-fenced time to deliver groups and activities. One ward had access to a psychological therapies nurse as part of the psychology department. As he was supernumerary to the ward nursing ratio group activities were not dependent on ward pressures and were regularly available to patients. The same ward had joined with other acute in patient wards to share psychological therapy staffing and resources, so that patients could access a range of activities which were also provided in evenings. Some wards had access to specialist therapists, such as art or music therapists.

Staff training and supervision

Access to training in psychological interventions for nursing, medical and AHP staff was noted in a number of wards inspected. This tended to be provided on an ad hoc basis and was led by specific staff interest rather than ward models of treatment. Even on wards were training was encouraged, lack of records on who was trained in what together with poor access to supervision often meant that newly acquired skills were not put to the best use.

Innovative staff

A number of staff stood out during the inspections for their innovative approach to ensuring best support for patients. One example was nursing and occupational therapy staff using community arts projects to deliver high quality interventions for patients. These activities had achieved prizes for quality and innovation and provided an uplifting therapeutic environment for patients. Another example involves a newly appointed medical consultant working to develop partnerships with community teams to provide consultancy and training for staff on the wards where no psychological therapy resources were available.

7.0 Areas of Concern

Access to evidence-based psychological interventions

Depending on the trust, some patients were unable to access any psychological assessment or evidence based therapeutic intervention. Consultant psychiatrists and senior nursing staff often expressed frustration over the lack of service and concern that many patients were unable to access NICE recommended interventions and were therefore largely managed by medication. The general opinion was that there was no point in even trying to access psychology, with some senior long term staff reporting they had never seen a psychologist on the ward. While all patients did receive 1:1 nursing time, it was suggested that this was often focused on monitoring patient mood and behaviours as opposed to providing therapeutic intervention.

Some specific examples of the impact on patients of the lack of access to psychological services are described below.

Example One

The consultant psychiatrist in one ward described a patient who was given a diagnosis of “treatment resistant schizophrenia”. After some time in hospital with drug treatment and following external consultation, it was advised that the patient be referred to clinical psychology to assess for autistic spectrum disorder (ASD). This service was unavailable to the ward, despite the trust having the necessary expertise within the limited clinical psychology service, as it could only be accessed by outpatient referral. It was therefore necessary to discharge the patient before an assessment was provided. The patient was found to have Asperger’s syndrome.

Example Two

A patient with a number of admissions for depression was noted to have developed an unusual gait and cognitive difficulties. No neuropsychological service was available to assess the patient, despite it being available within the trust Community Brain Injury Team (CBIT).

Example Three

A patient who presented with a needle phobia was unable to access appropriate psychological interventions to treat the phobia.

Example Four

A number of patients across trusts who were described as suffering from PTSD, did not have access to relevant therapeutic interventions as recommended by NICE (e.g. trauma focussed CBT, EMDR).

Low Intensity ward-based activities

It was concerning to note that the majority of wards provided no activities in the evenings and at weekends. Patients regularly complained about this during RQIA inspections and during this review. Also of concern was the frequent cancellation of patient therapeutic activities due to staffing issues. Two of the wards inspected reported that they did not include activities on a ward timetable as it only raised patient expectations and disappointed them when they were inevitably cancelled. Some wards saw such activities as the remit of OT, while others provided OT on an individual patient basis only.

Treatment plans and records

It is unsurprising that there was a lack of consideration of psychological interventions evidenced in patient treatment plans and records where there was no access to specialist psychological therapists. The inspector noted a number of patients who presented with anxiety, depression, PTSD, schizophrenia, substance misuse, loss and bereavement, etc. who could have

benefitted from NICE recommended interventions, other than or in addition to medication.

Staff training and supervision
Access to training in psychological interventions for nursing, medical and AHP staff was generally only recorded in relation to trust mandatory training. Where staff had accessed training in psychological therapies and interventions there were no records on who was trained in what intervention. Access to supervision was extremely poor which often resulted in the underuse and loss of newly acquired skills.

Lack of outcomes measurement
Even where psychological interventions were utilised, there was little if any assessment of effectiveness and patient outcomes. Thus staff were unable to describe what interventions were successfully applied and how these benefited patients' recovery and length of hospital stay.

8.0 Summary

Six wards (five adult acute mental health and one CAMHS) were reviewed in relation to patient access to evidence based psychological interventions.

There was considerable variation across trusts, with some patients unable to receive any NICE recommended psychological therapies, while others had access to high quality dedicated services.
Where staff were trained to deliver evidence-based high intensity psychological interventions there was little organisation and governance of the skills and treatments available to patients and no clear pathway for referral. Few wards demonstrated access to psychological therapies as recommended in the British Psychological Society and Royal College of Psychiatry CCQI standards.

9.0 Recommendations

1. In keeping with the DHSSPS 'Strategy for the Development of Psychological Therapy Services' (2010) it is recommended that evidence-based low and high intensity psychological interventions should be available to all patients in acute mental health wards.

2. Clinical psychology and/or professionals trained to deliver a range of evidence based psychological interventions should be members of the MDT

3. The range of evidence-based psychological interventions available to patients should be clearly identified to patients and carers

4. Inpatients should be able to access required neuropsychological and cognitive assessments

5. Trusts should develop staff training portfolios to include additional mandatory therapeutic training relevant to the ward purpose and patient profile. These should include a range of appropriate evidence-based interventions and include training in outcomes measurement

6. A mapping of therapeutic skills, across wards should be conducted to identify existing knowledge and skills as well as gaps in and hindrances to the delivery of therapeutic interventions.

7. Trusts should engage with clinical psychology services to identify a psychological therapy lead/champion to ensure the development of relevant training and the provision of appropriate supervision.

8. Clinical supervision for all professionals delivering psychological therapies and interventions should be mandatory, and recorded as part of governance reporting. Accredited training for supervisors should be an imperative.

9. All wards should have planned therapeutic and activities available and recorded on a timetable, easily accessed on the ward. There should be ward activities available in evenings and at weekends. Ward therapeutic activities should be ring-fenced or delivered by supernumerary nursing or AHP staff and should only be cancelled in exceptional circumstances.

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