Reflections on the coproduction of a crisis-focused intervention for inpatient settings underpinned by a Cognitive Behavioural Therapy for psychosis (CBTp) model

Lisa Wood, Arthur Rowe, Karen Persaud, Patrick Nyikavaranda, Nira Malde-Shah, Ella Guerin, Ceri Dare, Callam Constant & Mary Birken

Published online: 03 Jul 2023.

Submit your article to this journal ☑

View related articles ☑

View Crossmark data ☑

Reflections on the coproduction of a crisis-focused intervention for inpatient settings underpinned by a Cognitive Behavioural Therapy for psychosis (CBTp) model

Lisa Wood[a,b], Arthur Rowe[a], Karen Persaud[a], Patrick Nyikavaranda[a], Nira Malde-Shah[a], Ella Guerin[c], Ceri Dare[a], Callam Constant[b] and Mary Birken[a]

[a]Division of Psychiatry, University College London, London, UK; [b]Research and Development, North East London NHS Foundation Trust, Goodmayes Hospital, Ilford, UK; [c]School of Health Sciences, University of Nottingham, Nottingham, UK

ABSTRACT

Background: Psychological interventions delivered in inpatient settings have rarely been coproduced with those who receive them. The aim of this study is to outline the coproduction process which led to the development of an adapted inpatient intervention underpinned by a Cognitive Behaviour Therapy for psychosis model.

Method: Our coproduction group was comprised of experts by experience, family and carers, multi-disciplinary clinicians, and researchers. The group met monthly to develop the intervention and focused on eight key areas of the intervention, including therapist values, assessment, formulation, coping strategies, crisis/safety plans, and discharge plans.

Results: The coproduction panel highlighted the importance of flexible delivery of the intervention, developing a trusting relationship with the therapist, advocacy, prioritising patient safety on the ward, managing the impacts of inpatient care, preparing for discharge, and having family, carer and community involvement. Challenges of the coproduction process included having a pre-existing intervention model that was being adapted rather than coproducing a new one, discussing emotionally charged issues, and having limited time to coproduce the intervention.

Discussion: Coproduction brought immense value to the development of this intervention, ensuring it was culturally competent and suitable for the inpatient setting. Further research should be undertaken exploring the coproduction process applied to clinical research.

Introduction

Cognitive Behaviour Therapy for psychosis (CBTp) is the recommended psychological therapy for people experiencing psychosis and should be offered to people experiencing a mental health crisis (American Psychiatric Association, 2020; National Institute of Health and Care Excellence [NICE], 2014). Although there has been much debate, there is general consensus that CBTp is helpful in supporting people experiencing psychosis (Van der Gaag et al., 2014). It has been offered to different populations, including those who experiencing their first episode psychosis and those with more long-term difficulties, however it less likely to be offered to people receiving inpatient care and in acute crisis (Jacobsen et al., 2018; Van der Gaag et al., 2014). There have been three recent reviews

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

which have examined the usefulness of psychological therapies offered in inpatient settings, which have demonstrated limited improvements in patient's experiences of psychosis, relapse and rehospitalisation (Jacobsen et al., 2018; Paterson et al., 2018; Wood et al., 2020). The reviews demonstrated that the research undertaken in this setting was of poor to moderate quality and the interventions were not specifically tailored to this setting.

Acute mental health inpatient hospitals provide care for those in significant distress and often at high risk towards themselves, others, or from others. The average length of stay is usually about a month and patients receive intensive biopsychosocial treatment from a multi-professional team aiming to reduce distress and related risk (Royal College of Psychiatrists, 2018). The acute mental health inpatient setting is a challenging and restrictive environment and there are many things to consider when developing a psychological therapy for patients in this setting. For example, many patients are under section of the Mental Health Act (MHA) and have limited leave from the ward, are experiencing significant distress, and are being cared for in restrictive environments (Evlat et al., 2021). Moreover, it is well-acknowledge that patients from racially minoritised backgrounds, particularly Black African and Black Caribbean backgrounds, are four times more likely to be compulsorily detained under the MHA and are overrepresented in this setting (HM Government, 2018). Therefore, it is imperative that any psychological therapy is culturally competent, adapted to be delivered in this setting, and aims to prevent future admissions.

Patient and Public Involvement (PPI) in research has become essential to all aspects of research delivery with increasing use internationally, including Europe, Australia, the United States and Canada (Boote et al., 2015; Fortuna et al., 2021). In many countries, it has rightly become a compulsory requirement of any large-scale funded research (INVOLVE, 2018). Common activities for PPI within the research process include designing study materials, advising on methods, and research management (Blackburn et al., 2018; Boote et al., 2015). It has been demonstrated that PPI can improve the quality of the research produced, improve relationships between researchers, clinicians and patients, and improve service provision (Blackburn et al., 2018). The National Institute of Health Research (NIHR) have also produced standards for PPI in research and they emphasise the importance of using a "coproduction" model whereby those with lived experience are involved as "co-researchers", and valued as equal members within the research team (National Institute of Health Research, 2021). Coproduction is an involvement approach in its own right and has been defined as a process where "researchers, practitioners and the public work together, sharing power and responsibility from the start to the end of the project, including the generation of knowledge" (INVOLVE, 2018). Coproduction goes beyond traditional PPI and moves towards a shared model of power and responsibility for decision making (Boote, Wong & Booth, 2012; Fortuna et al., 2021).

Best-practice coproduction guidelines outline five key principles for quality coproduction (National Institute of Health Research, 2021). These principles include the sharing of power (the research is jointly own and people work together to achieve a joint understanding), including all perspectives and skills (making sure the research team includes all those who can make a contribution), respecting and valuing the knowledge of all those working together on the research (everyone is of equal importance), reciprocity (everybody benefits from working together), and building and maintaining relationships (there needs to be joint understanding and consensus and clarity over roles and responsibilities). A patient led guideline, produced by the National Survivor User Network (NSUN), called the 4Pi document also outlines key coproduction principles including; shared principles, a clear purpose, diverse representation, careful planning of processes, and meaningful impact (NSUN, 2013). The value of co-production is clear, and it can increase the quality of the research and ensure meaningful outputs are produced. Moreover, coproduction can be particularly helpful for intervention development as it can ensure that the intervention is relevant and meeting the needs of patients, is deliverable, and useful (Rapaport et al., 2018).

An intervention, underpinned by a CBTp model, specifically focused on supporting inpatient patients during crisis was proposed to be developed and evaluated for feasibility and acceptability

using a Randomised Controlled Trial (RCT) design following guidance from the Medical Research Council (MRC) complex intervention development guidelines (Skivington et al., 2021). An integral part of this study was the coproduction of the intervention. This current study aims to outline and reflect upon the coproduction process that led to the adaptation of the intervention and help inform future coproduction research.

Methodology

Design

This study outlines the coproduction approach used to adapt a crisis-focused intervention underpinned by a CBTp model for use in inpatient settings. It describes the process by which the coproduction group was formed, what work was undertaken, and reflections. This manuscript follows a reflective framework approach for describing a coproduced psychosocial intervention utilised in Rapaport et al. (2018). Full Health Research Authority (HRA) and NHS Research Ethics Committee (REC) approval was gained for the intervention development process (IRAS ID: 272043; 20/LO/0137/AM01) and the study was sponsored by University College London (UCL). The feasibility Randomised Controlled Trial (RCT) of the coproduced crisis focused CBTp intervention is registered on the ISRCTN trial registry (ISRCTN59055607) and the protocol for the study has been published (Wood et al., 2022). The development of this manuscript was co-developed by the coproduction group.

Coproduction member recruitment

The opportunity to be a member of the coproduction group was advertised through several means. For lived experience and carer members, a recruitment leaflet was circulated via the McPin Foundation, a charity organisation that increases lived experience expert involvement in research, and the Policy Research Unit lived experience working group based at UCL. A particular effort was made to recruit members from racially minoritised backgrounds due to their over representation in the inpatient setting (HM Government, 2018). Clinician members of the group were recruited via LW's multi-disciplinary professional network and via twitter. Emails were sent out to academics at UCL who were asked to disseminate to colleagues who may be interested in being in the group. Potential members contacted LW via email or phone if they were interested. An informal meeting between LW and individual potential members took place to ensure the coproduction group was the right fit and, if it was, they were recruited into the coproduction group. During this meeting LW gave and overview of the study and the role of the coproduction group. Potential members were asked why they wanted to join the group, their hopes, and expectations about joining the group, and any support that might be required.

Coproduction team

The coproduction group comprised experts in acute mental health inpatient care. The group consisted of two experts by experience, one expert by experience researcher, two carer experts by experience, two clinical psychologists (one being the principal investigator of the research trial), one occupational therapist, one mental health nurse, and one assistant psychologist/research assistant all with experience of inpatient mental health care. Participants' time to attend the meetings were paid, and data usage costs were covered in line with NIHR INVOLVE guidance (National Institute of Health Research, 2021).

Process of coproduction

The intervention development process was underpinned by the Medical Research Council (MRC) guidelines on complex intervention development (Skivington et al., 2021). The guidelines outline that the first stage is to undertake a review of relevant exsting literature to inform the intervention development process. Secondly, an appropriate theory is developed to underpin the intervention. Thirdly, the intervention and related outcomes are examined for feasibility and then evaluated. The coproduction process contributed to adapting the research and theory into a workable intervention. The coproduction group were presented with summaries of relevant research and theory and used this information to adapt different aspects of the intervention.

Stage 1 and 2: literature review and first draft

The intervention began its development in January 2020. LW gathered together relevant evidence to underpin the intervention development including a systematic review (Wood et al., 2020), relevant psychological theory (Brabban et al., 2016; Morrison, 2017), core competency frameworks for working with people experiencing psychosis (Roth & Pilling, 2012), crisis care (Dass-Brailsford, 2007), and acute mental health inpatient care respectively (Wood et al., 2021), three qualitative interviews studies (Wood et al., 2018, 2019; Wood et al., 2020), and a Delphi study (Morrison & Barratt, 2010). The first author presented plain English summaries of the research to the coproduction group and they discussed how the research should be used to inform the intervention development. For example, the lead author summarised the CBTp theoretical model and the group decided how this should be applied to crisis situations. This process was used to underpin a first draft of the intervention.

Stage 3: coproduction input

The coproduction panel met for seven monthly meetings (August 2020 to February 2021) to develop and refine the intervention. All meetings were undertaken on zoom due to the COVID-19 pandemic. Each session lasted two hours and would focus on a different area of the intervention development. In the initial meeting, the group rules were discussed and collaboratively agreed, which included maintaining confidentiality, being respectful and understanding of differences of opinions, understanding that everyone has equal expertise to bring to the project, and that everyone has an opportunity to share their opinions. The group were also presented with the INVOLVE and NSUN coproduction principles and discussed how to ensure the principles were adhered to. These were then briefly presented at the start of each meeting to remind the group of the principles we were adhering to.

We spent time in the first meeting getting to know one another and discussing how to make the meeting a safe space given that coproduction is based on respectful and meaningful relationships. This was especially important given the meetings were remote, which can potentially reduce the ability to bond and connect. We shared about our experiences and reasons for being in the group and would ensure there was some time during each meeting to share and update on how each group member was doing.

Each meeting was audio recorded and detailed minutes taken to ensure that information could be used to inform the intervention development. The start of meetings would always include feedback on how previous group discussions were integrated into the intervention development. The meeting discussion topics are outlined in Table 1. At each meeting, the group would discuss one or two key topic areas which related to the intervention development. Initially, the group focused on the existing research and considered what should be extracted to inform the current intervention. On some occasions, the group would be presented with pre-existing resources to guide the sessions, for example, an assessment sheet or a safety plan, and discussed if and how such resources should be part of the intervention. The group chair (first author) would always ensure that every member had an opportunity to share their thoughts and opinions but there was no pressure to speak. All

Table 1. Aspects of the intervention covered and discussion questions.

Topic 1: Values underpinning the intervention and the therapeutic relationship
What are the important attitudes, values and ways of interacting for staff to have when delivering a talking therapy in inpatient care?
Topic 2: Initial assessment session
The coproduction group were presented with an assessment template. What is important to consider at the assessment session(s)?
Topic 3: Intervention priorities
"What should be the targets/priorities of a talking therapy in an inpatient setting? Should it focus on the current crisis?"
Topic 4: Formulation template
The coproduction team were presented with a formulation template. They were asked: What do you think of the formulation template? Is it clear? Are there any improvements that can be made?
Topic 5: Safety and stabilisation
What do you think is important for patients to feel safe on the ward?
Topic 6: Coping strategies
What are other helpful coping strategies that can be done on the ward?
Topic 7: Crisis/safety/discharge planning
The coproduction group were presented with a crisis/safety plan. They were asked: What do you think of this safety plan? What do you think is important to include in a safety plan?
The coproduction group were presented with a draft discharge plan. They were asked: What do you think of the discharge plan? What do you think is important in discharge planning?
Topic 8: Managing difficult thoughts and emotions
The coproduction group were presented with a summary of key strategies used in Cognitive Behaviour Therapy for psychosis. They were asked: What is helpful in managing difficult thoughts and emotions? What has helped you, your loved one or patients in the past?

members were offered the opportunity to contact the group chair for additional support or debrief outside the meeting.

This coproduction process led to a final intervention protocol being drafted.

Stage 4: final intervention and piloting

The final product was a crisis-focused modularised intervention, underpinned by a CBTp model, consisting of approximately six to eight sessions of therapy. The therapy aimed to help people with crisis-related goals and support them in managing distress and adverse impacts of being hospitalised. The intervention protocol outlines seven modules including: engagement, assessment and identifying priorities; formulation of the crisis; stabilisation and safety; coping, self-management and problem solving; crisis plans and crisis cards; change strategy work focusing on crisis appraisals and safety behaviours; and discharge, relapse planning and recovery toolkits. The first two components (engagement, assessment and identifying priorities, and formulating the crisis) are essential components of the intervention and the remaining ones are flexible and collaboratively chosen based on the patient priorities. The number and length of sessions will be determined by the collaborative priorities set by the patient and therapist. The therapy will also include at least one follow-up sessions post discharge to ensure support through the discharge process. The intervention includes strategies to involve the individual's network, for example, family sessions, and formulation sharing with the multidisciplinary team. Further detail about the intervention can be found in trial protocol paper (Wood et al., 2022). The final intervention was deemed acceptable by the coproduction group and the protocol was then tested in a Randomised Controlled Trial (RCT) for feasibility and acceptability. This is currently ongoing.

Results

The results have been composed based on the coproduction meeting minutes, audio recordings, and a coproduction meeting which specifically focused on planning this publication. The key topics

below summarise the groups key reflections on the intervention and were agreed upon by the group. The results outline the key adaptations that have been made to the intervention based on group discussions and reflections on the coproduction process.

Key topic areas

Topic 1: values underpinning the intervention and the therapeutic relationship

The coproduction group highlighted that the therapist's values and ability to develop a trusting relationship with a patient on the ward was the utmost priority. It was especially important given the potentially distressing inpatient environment that the patient would be in.

Personal qualities of the therapist. The therapist should be empathetic, patient, non-judgmental, tolerant, honest, transparent, kind, have open and welcoming body language, use lay language, and always assume the patients has capacity. The therapists should also have integrity and follow-through with any agreed plans as this was not often the case with wider inpatient staff.

Cultural awareness and competence. Therapists should attempt to understand a patient's personal cultural, religious, and spiritual beliefs, and enquire about negative experiences such as racism and discrimination, within the context of their current crisis to ensure these needs were met. Therapists should not make assumptions based on cultural stereotypes and instead should remain curious and sensitively enquire about a patient's culture. Importantly, therapists should lead on this as patients may not feel comfortable raising such issues.

Empowerment, flexibility and control. The therapist should ensure that control and decision making is given to the patient during the therapy at every opportunity, for example, by letting them select what is covered in sessions, identify the goals of therapy, and decide when and where to meet, and empower them to make decisions about their wider inpatient care plan. The therapist should be flexible in their approach in building the relationship, which can include more informal interactions such as, having a cup of tea with the patient, and also be flexible in the delivery of therapy, for example, in terms of timing, length, pace, and place.

Location of therapy. There should be opportunities to have therapy sessions outdoors to both have some time in nature and have some space from the ward. If this was not possible, it was important for the therapist to think carefully about where therapy took place, for example, finding a clean, warm, welcoming, light, and private room with comfy chairs and a relaxing atmosphere.

Instilling hope and focusing on discharge. Instilling hope that discharge and wider recovery was possible was imperative as patients could be at their lowest and most distressed during crisis. This could be done through normalising distressing thoughts, feelings and behaviours, offering reassurance that recovery is possible (i.e. that inpatient care is not a "forever" situation), and having discharge as a goal of therapy. Working towards discharge will include both direct and indirect therapy work to shape the wider care plan. This should be done in collaboration with the patient.

Seeing the person as a whole. Therapists should see the whole person and consider both their physical health, mental health, and wider social context (e.g. socioeconomic issues, family and community). Thus, therapists should incorporate this whole person focus into all aspects of the therapy and work with the team to care plan for these issues.

Family, carer and wider network involvement. With the patient's consent, family and carers should be involved at all stages of the therapy. Although CBTp is seen traditionally as an individual

therapy, it was emphasised that family and carers, and relevant people in the patient's wider network should be included in sessions, particularly in meetings when key decisions were being made and discharge was being planned.

Continuity of care. The importance of continuity of care, particularly during discharge, was highlighted. Therapists should be offering follow-up sessions to provide support through transitions. Transitions are a time where patients can feel vulnerable and destabilised, and moving from the ward back home can be a very big change.

Topic 2: initial assessment meeting

The group highlighted important considerations when conducting an initial assessment meeting in an inpatient setting, in addition to usual assessment processes.

Confidentiality, information sharing and transparency about the therapist's role within the team. As inpatient care is multidisciplinary, it is important for the therapist to be clear about their role within the team, what they do (for example, offer talking therapy), do not do (for example, prescribe medication), and what information is shared with the team (for example, risk updates). The therapist needs to be clear about the limitations of confidentiality, when it will be broken, and be honest about this from the beginning. This will allow patient to make informed decisions about what they share.

Strengths and values focused. The therapy should always draw on people's strengths and assume that the person has the skills to recover and have their own positive coping strategies. Therapist should also ask the patient about strengths they had before the crisis to help connect the patient to their previous self.

Enquiring about their experiences of admission and inpatient care. It is important for the therapist to explicitly ask patients about their experiences of inpatient care and admission (past and present) in the assessment. This includes asking about the positive and negative aspects of their care. It was also highlighted that therapists should explicitly acknowledge that inpatient care can be (re)traumatising to make the patient feel comfortable about disclosing their experiences.

Topic 3: intervention priorities and the goals for talking therapy

The group highlighted that the goal of therapy should be determined by the patient, which is in line with CBTp (Morrison, 2017), but did identify potential priority areas. The group promoted caution when using the word goals as this might be invalidating to someone in crisis.

Managing the current crisis to prevent readmission. The consensus was that therapy should generally focus on supporting the patient to manage the current crisis and admission. However, it was important to be patient led so if a patient has other priorities, therapy should also focus on this. Moreover, the therapist should ask about difficulties leading up to admission including experiences of community services and what was working/not working, and experiences of taking anti-psychotic medication and their side effects. By addressing these issues, therapists can support a safe discharge and hopefully prevent future hospital admissions.

Safety on the ward. Another priority was supporting the patient and family/carers with their admission experiences, losing control (due to being in a restrictive setting), and being in a traumatising environment. The therapist should prioritise patient safety before moving onto other crisis-related goals. The group reflected upon the fact that wards are very de-stabilising,

frightening, and isolating. Patients can often witness incidents, for example a restraint, which can increase fear. The therapist should be considering a variety of direct (supporting the patient to feel safe) and indirect interventions (working with the staff team to make the ward feel safer). Strategies such as identifying safe peers or staff members and safety plans were identified as crucial.

Peer support and signposting. Peer support is vital on the ward whether it is informal (i.e from fellow patients) or formal (i.e. from a ward or external peer support worker). Thus, the therapist should help facilitate access to this support. Signposting to ward activities, and wider outpatient or third-sector support was also key. It was important for therapists to have a good knowledge of the wide array of ward activities and local services to signpost. For example, housing and financial support services, peer support groups, charity groups, and wider community organisations. A list of services was described as a helpful way of doing this.

Topic 4: the formulation model

The group were presented with a basic CBTp formulation model informed by Morrison (2017). They outlined that value of having a visual map of presenting issues and the importance of having paper copies available for patients so they can review it in their own time. The group thought it was important for the formulation to map out how the crisis has happened and psychological aspects which may have contributed to this (such as difficult experiences, thoughts, feelings and behaviours) but also to include a clear section strengths and resources too. The group wanted the formulation to have prompting questions on it to help remind patients what should go in each box. The group also wanted the patient's environment, social and cultural context, family context, and experiences of inpatient admission as an explicit part of the formulation.

Topic 5: coping strategies

The coproduction team identified that coping strategies are crucial to managing a crisis and the therapist should have a variety of resources available to share with patients, if required. Any strategies used should be collaboratively agreed, meaningful, and in line with the patients' values. Strategies could be for coping with their own mental health or the challenging ward environment. Broader well-being strategies were important such as good nutrition, exercise, and a healthy diet. As outlined, peer support, linking with wider ward activities, outdoor space and private time were all highlighted as important too.

Topic 6: helping people with difficult thoughts and emotions

The group were very clear that a focus on difficult thoughts and some routine CBT cognitive strategies may not be possible or a priority for patients in acute distress and these should be approached cautiously. A focus on managing emotional distress and behavioural strategies were more helpful. The group valued the use of psychological strategies to reduce emotional arousal such as grounding, mindfulness, relaxation, and some strategies from the Dialectical Behaviour Therapy (DBT) approach such as TIPP and IMPROVE (Linehan, 2015). Other strategies they identified that were helpful in reducing emotional distress were art and drawing, prayer and medication, private quiet time away from the ward, and going for a walk outdoors.

Topic 7: crisis and safety planning

The group identified that crisis and safety planning should be a part of the intervention and outlined several key considerations. Crisis and safety plans are usually utilised to forward plan for when someone is at risk of harm to themselves.

Important process issues. Crisis planning should be a collaborative process with the therapist and patient working together to develop the plan. The therapist should be careful about the language

used, use their clinical judgement about when and how to ask questions, and have a clear rationale for its use. The therapist should be careful about their language when suggesting a crisis plan, especially when patients do not agree that they are in crisis, and consider other terms such as safety plan. Moreover, a new plan should not be started if one has already been developed, instead the previous one should be updated to avoid duplication.

Crisis plans for inpatient and home settings. The crisis plan should be suitable for both ward and home settings due to the contrasting nature of both contexts. The priority is to develop the ward crisis plan to contribute to patients' safety on the ward. The plan should identify any ward-based threats/triggers, whether they would like access to an advocate, and how comfortable they felt raising problems with staff. Safety on the ward was highlighted as particularly important to plan for. In relation to the home setting, it was imperative for the plan to be adapted to identify threats/triggers in the community that may not be present on the ward. In terms of wider support, it was important to ask patients "is there anybody you feel confident you can talk to and trust?" and for these people to be identified as contacts. It was also important to review the crisis plan as circumstances can change rapidly.

Involving the system. It was important that the crisis plan involved family, carers, and trusted members of staff. The crisis plan should outline the support network's role in supporting the patient to manage the crisis and stay well. If a patient did not have a large social network, it was important to signpost to different community support groups, such as youth centres, and church groups.

Topic 8: discharge and relapse planning

The group identified that discharge and relapse planning was important to do as part of the therapy to prevent readmission, and can be approached early on if this was a priority for the patient. A "recovery plan" or "recovery toolkit" may be a more hopeful approach for patients than relapse as this had negative connotations. It may be appropriate that these plans build upon any existing crisis plans. No matter the type of plan several key sections were highlighted including: a section about the patient's strengths as people may forget their strengths when they are in crisis, list of numbers and contacts to call when in a crisis, and a list of places to go when in a crisis.

Group reflections on the coproduction process

There are inherent power imbalances between professionals and people with lived experience and although the first author attempted to minimise this at all times it was not possible to fully eliminate this due to the context in which the coproduction group was set up, i.e. on a funded study which had been already designed by the lead author. This is exemplified by the lead author already having an intervention model (CBTp) in place, which the group had to adapt rather than coproducing something new. Some members found aspects of CBTp less helpful, for example cognitive exercises such as thought challenging, but the model itself could not be changed. Instead, we tried our best to prioritise emotional and behavioural components and coping strategies within the intervention. The group felt that they were able to make positive changes about how the intervention was used by therapists, for example, ensuring therapy was culturally competent, that the model prioritised managing the impacts of inpatient care itself, and ensuring mind and body were conceptualised as a whole and of equal importance in the intervention. The coproduction group valued being told from the outset that the CBTp model was not changeable as it meant they knew the restrictions to the coproduction process from the beginning.

Another challenge was the limited time the group had to make change. The group met monthly for two hours but this sometimes did not feel like enough time to cover all aspects of the intervention. However, our capacity to meet was restricted by study finances that were set prior to the start of the study. The group would have liked more flexibility to be more directly involved in the research itself by designing intervention resources and undertaking broader research activities, such as

recruitment. Nevertheless, the group were able to undertake some additional tasks including presenting at a research conference (with those not able to attend contributing to the content of the presentation), being involved in peer reviewed publications, undertaking and analysing qualitative interview data about patients experiences of the intervention, and contributing to the training of the therapists delivering the intervention.

The nature of the study meant that the group were having quite detailed discussions about potentially distressing experiences and topics, for example, about previous experiences of inpatient care, racism, and discrimination. The group felt that these conversation were well handled due to the support, compassion and empathy shown by all group members. The group supported one another and checked-in with one another after difficult discussions, which contributed to the group being a safe space. This was something the group thought went well throughout the coproduction process, which was due to the establishment of meaningful and respectful relationships. Finally, another aspect that went well was the regular feedback about how the groups contributions had shaped the intervention development. Group members felt valued and that their contributions were making meaningful change rather than being tokenistic.

Discussion

This study aimed to give and overview of the coproduction process that was utilised to develop a complex psychological intervention for use in acute mental health inpatient settings. The results demonstrated the invaluable contributions that the coproduction process made to the development of the intervention. It helped shape both the content of the intervention as well as the process of delivering the intervention. The group stressed the importance of the therapeutic relationship and the therapist's values as being essential parts of the intervention. The group identified instilling hope, seeing the person as a whole, and empowerment as key components which is in line with previous patient led literature (Brabban et al., 2016). However, we were also able to identify inpatient specific values that were of importance such as focusing on safety, discharge, and continuity of care, which has not been identified previously. We were also able to identify more specific relationship building competences for inpatient therapists such as being clear on their role within the wider team and issues of confidentiality, regularly checking in, and being strengths focused.

The group made important suggestions about ensuring the intervention prioritises the safety of the individual on the ward first and foremost, which is an important adaptation for inpatient settings. This will likely involve the therapists working with the wider team to achieve this, which is not a traditional part of CBTp (Morrison, 2017). Moreover, the group were able to make helpful recommendations about other key aspects of the intervention such as coping strategies, crisis planning and discharge planning. This is extremely important as traditionally CBTp interventions have not been developed in partnership with those who have lived experience. The group were able to identify important values to ensure CBTp was carefully and sensitively delivered and instil hope for recovery, some of which were in line with values identified in previous CBTp research (Brabban et al., 2016).

There is limited published research outlining the coproduction processes undertaken within complex intervention development (Rapaport et al., 2018). Thus, this paper makes an important contribution to the literature. Moreover, this paper was co-developed by the coproduction group which has been done minimally in previously published research. There were also several strengths to the coproduction process outlined in the paper. We followed a rigorous process and were in line with the Medical Research Council (MRC) complex intervention development guidelines (Skivington et al., 2021), INVOLVE PPI guidelines (National Institute of Health Research, 2021), and NSUN 4-Pi guidelines (NSUN, 2013). We strived for the process to be collaborative and for all decisions to be made collectively by the group. Our group was also diverse with members from different intersecting sociodemographic backgrounds which enriched the intervention development. We spent time building genuine relationships which allowed space for constructive conversations and debate

about key issues. This allowed to group to feel comfortable to share differing opinions which enriched the process. As outlined, one limitation was that the group were not able to decide on the therapy approach (CBTp) as this had already been decided before the group was formed. This meant some key aspects of the intervention were fixed and could not be changed. In the future, it would be imperative to have coproduction in place from the outset in order for key research design decisions to be coproduced. The online format of the group may have been exclusionary for some potential members due to digital poverty. However, efforts were made to ensure people could attend by having a dial in option and for participants to be renumerated for data usage (National Institute of Health Research, 2021). Finally, the manuscript did not utilise formal qualitative analysis methods and rather focused on group reflections. This would have reduced the rigor of the study and limited findings. Nevertheless, we followed an already published structure for reflecting on the coproduction process and believe the findings in this paper are valuable given the paucity of research outlining the applied processes of coproduction.

In conclusion, coproduction was an invaluable process which enriched the development of a CBTp informed intervention for inpatient settings. This paper outlines key processes undertaken and demonstrates how coproduction can be meaningfully used in complex intervention development.

Disclaimer

The research team recognise that the terms and language used in this paper are not universally endorsed. We chose terms that were preferred by the coproduction group while also respecting the views of others.

Disclosure statement

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

References

American Psychiatric Association. (2020). *Treatment of patients with schizophrenia*. APA. https://doi.org/10.1176/appi. books.9780890424841

Blackburn, S., McLachlan, S., Jowett, S., Kinghorn, P., Gill, P., Higginbottom, A., Rhodes, C., Stevenson, F., & Jinks, C. (2018). The extent, quality and impact of patient and public involvement in primary care research: A mixed methods study. *Research Involvement and Engagement*, *24*(4). https://doi.org/10.1186/s40900-018-0100-8

Boote, J., Wong, R., & Booth, A. (2015). "Talking the talk or walking the walk?" a bibliometric review of the literature on public involvement in health research published between 1995 and 2009. *Health Expectations*, *18*, 44–57. https://doi. org/10.1111/hex.12007

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

Dass-Brailsford, P. (2007). *Crisis intervention (Chapter 5). A practical approach to trauma: Empowering interventions*. Thousand Oaks. https://doi.org/10.4135/9781452204123

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

Fortuna, K. L., Myers, A., Brooks, J., Collins-Pisano, C., Marceau, S., Pratt, S., Lyons, K., Walker, R., Thompson, S., Greene, K., Pringle, W., & Carter, K. (2021). Co-production of the quality of patient-centered outcomes research partnerships instrument for people with mental health conditions. *Patient Experience Journal*, *8*(1), 148–156. https://doi.org/10. 35680/2372-0247.1533

HM Government. (2018). *The independent review of the mental health act: Interim report*. HM Goverment.

INVOLVE. (2018). *Guidance on co-producing a research project*. National Institute of Health Research.

Jacobsen, P., Hodkinson, K., Peters, E., & Chadwick, P. (2018). A systematic scoping review of psychological therapies for psychosis within acute psychiatric in-patient settings. *British Journal of Psychiatry*, *213*(2), 490–497. https://doi.org/10. 1192/bjp.2018.106

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

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

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

National Institute of Health Research. (2021). *Briefing notes for researchers - public involvement in health and social care research*. NIHR.

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

NSUN. (2013). *4pi national standards for patient involvement*.

Paterson, C., Karatzias, T., Dickson, A., Harper, S., Dougall, N., & Hutton, P. (2018). Psychological therapy for inpatients receiving acute mental healthcare: A systematic review and meta-analysis of controlled trials. *Clinical Psychology Review*, *57*(4), 453–472. https://doi.org/10.1111/bjc.12182

Rapaport, P., Webster, L., Horsley, R., Kyle, S. D., Kinnunen, K. M., Hallam, B., Pickett, J., Cooper, C., Espie, C. A., & Livingston, G. (2018). An intervention to improve sleep for people living with dementia: Reflections on the development and co-production of DREAMS: START (Dementia RElAted manual for sleep: STrAtegies for RelaTives). *Dementia (London)*, *17*(8), 976–989. https://doi.org/10.1177/1471301218789559

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

Royal College of Psychiatrists. (2018). *Standards for inpatient mental health services*. Royal College of Pscyahitrists.

Skivington, K., Matthews, L., Craig, P., Baird, J., Blaseby, J., Boyd, K. A., Craig, N., French, D. P., McIntosh, E., & Petticrew, M. (2021). A new framework for developing and evaluating complex interventions: Update of medical research council guidance. *BMJ: Research Methods and Reporting*, *374*. https://doi.org/10.1136/bmj.n2061

Van der Gaag, M., Valmaggia, L. R., & Smit, F. (2014). The effects of individually tailored formulation-based cognitive behavioural therapy in auditory hallucinations and delusions: A meta-analysis. *Schizophrenia Research*, *156*(1), 30–37. https://doi.org/10.1016/j.schres.2014.03.016

Wood, L., Williams, C., Billings, J., & Johnson, S. (2018). The role of psychology in a multidisciplinary psychiatric inpatient setting: Perspective from the multidisciplinary team. *Psychology & Psychotherapy: Theory, Research & Practice*. https://doi.org/10.1111/papt.12199

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

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

Wood, L., Williams, C., Kumary, A., Luxon, L., & Roth, T. (2021). *Acute mental health inpatient competency framework*. UCL https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/competence-frameworks/delivering.

Wood, L., Williams, C., Pinfold, V., Nolan, F., Morrison, A. P., Morant, N., Lloyd-Evans, B., Lewis, G., Lay, B., Jones, R., Greenwood, K., Johnson, S. (2022). Crisis-focused Cognitive Behavioural Therapy for psychosis (CBTp) in acute mental health inpatient settings (the CRISIS study): Protocol for a pilot randomised controlled trial. *Pilot and Feasibility Studies*, *8*(1), 205. https://doi.org/10.1186/s40814-022-01160-7