



**Acute Mental Health Inpatient
Competence Framework
Adults and older adults**



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Authorship statement

Lisa Wood and Claire Williams originated the work and oversaw its development together with Anthony Roth. Lisa Wood devised the competence framework map and extracted and wrote the competences, with assistance from Claire Williams, Leah Luxon, Ajvir Kumary and Anthony Roth. Lisa Wood wrote the background documents with support from Claire Williams, Leah Luxon, Ajvir Kumary and Anthony Roth. Lisa Wood conducted preliminary literature reviews. Lisa Wood edited the final document.

Contents

Dedication	4
1. About the competence framework.....	5
1.1. Competence and competence frameworks.....	5
1.2. A note on language.....	5
2. Background	6
3. How the competences were identified	7
4. Scope of the work.....	8
4.1. Audience.....	8
4.2. Population.....	9
4.2.1. Meeting the needs of those most marginalised	9
5. Using the competence framework	10
5.1. Clinical and professional issues relevant to supporting patients in acute mental health inpatient care.....	10
5.2. Flexible person-centred care rather than routine driven	10
5.3. Planning for discharge back into the community.....	11
5.4. Safety (risk) assessment and management.....	11
5.6 Support for staff, patient's and wider networks following a serious incident	12
5.7 Conducting inquiries into serious incidents	12
5.8 Multidisciplinary team working.....	12
5.9 Reflective practice	13
6. Organising the competence list.....	15
6.1. Competences.....	15
6.1.1. Attitudes, values, and style of interaction when working with patients in acute mental health inpatient care	16
6.1.2. Basic knowledge of issues related to acute mental health inpatient care	16
6.1.3. Communication skills.....	17
6.1.4. Professional competences for all healthcare workers	17
6.1.5. Generic relationship competences	18
6.1.6. Assessment, formulation and planning.....	19
6.1.7. Structured care and intervention.....	20
6.1.8. Psychosocial interventions.....	21
6.1.9. Meta-competences.....	22
6.1.10. Professional competences for organisations	22
7. Application of the competence framework	23

7.1. Curricula..... 23

7.2. Training 23

7.3. Commissioning 23

7.4. Service organisation 23

7.5. Clinical Governance..... 23

7.6. Supervision..... 23

7.7. Research 24

Appendix 1: Expert Reference Group members 25

References 27

Dedication

We would like to dedicate this framework to our dear colleague and friend Ajvir Kumary who was a member of the competency framework team and Expert Reference Group. She sadly passed away before the final publication of the framework. We are very grateful for her contributions and unique perspective that we have tried to capture throughout the framework.

1. About the competence framework

This document describes a competence framework for staff working in acute mental health inpatient settings with adults and older adults, recommending skills and knowledge for professionals across a broad range of backgrounds and experiences who work in this setting. The framework is underpinned by a psychosocial model and has a particular focus on delivering care from this approach.

1.1. Competence and competence frameworks

Competence is usually defined as the integration of knowledge, skills, and attitudes. Professionals need background knowledge relevant to their practice, but what marks out competence is whether the person has:

- the ability to draw on and apply knowledge in different situations
- the relevant skills and the ability to use them in different situations, and
- an appropriate attitude and set of values

Competence frameworks are a collection of competences that have been outlined for certain professional groups and specific types of intervention or areas of focus. These frameworks identify and bring together all the relevant knowledge, skills and values that are key to working effectively in the specified area.

1.2. A note on language

We acknowledge that this framework uses terminology that may not be endorsed by all. We agreed on terms in partnership with the Expert Reference Group. We have used the term patient to describe a user of inpatient services. We have also used the term ‘family and carers’ to refer to the patient’s social network. This term is not limited to immediate family or carers and may also include other social relationships such as friends, partners, community members, or any other important relationship in the patient’s life.

2. Background

Improving inpatient mental health care is a central issue for the National Health Service (NHS), as outlined by the recent Long Term Plan (NHS England, 2019), and Five Year Forward View for Mental Health (Independent Mental Health Taskforce, 2016). Acute mental health inpatient hospitals care for those with acute, severe and enduring mental health difficulties who may be at high risk of harm to themselves or others (The Kings Fund, 2017). An increasing majority of admissions are compulsory detentions under the Mental Health Act. Mental health inpatient admissions are becoming briefer with the current average stay only being 32 days (NHS Benchmarking Network, 2019). Consequently, acute mental health inpatient settings are high pressured and high-risk environments, with a high incidence of violence towards staff (538 per 100,000 occupied bed days) and towards other patients (286 per 100,000 occupied bed days) (NHS Benchmarking Network, 2019).

The Long Term Plan notes that the severity of need of psychiatric inpatients and forced admissions continues to rise, indicating a systematic failure to provide effective crisis care for inpatients (NHS England, 2019). It suggests that acute wards are often not safe, therapeutic, or conducive to recovery; one of its key recommendations is to improve the delivery and quality of acute mental health inpatient care. The government has also recently undertaken an independent review of compulsory MHA detention to understand why they occur and how to prevent them (HM Government, 2018). This identified that inpatient care should restore the dignity of the patient, improve choice and decision making, and ensure that human rights are respected at all times. The development of this competence framework is a response to this set of recommendations.

The framework has a range of applications:

- developing training curricula for practitioners from a range of clinical and professional backgrounds
- evaluating existing training
- evaluating practice in existing services
- reflecting on and supervising individual professional practice
- identifying good practice and helping those receiving support to understand what they can expect from their care

3. How the competences were identified

This work was overseen by an Expert Reference Group (ERG), of which the authors were also members. Appendix A lists the members of the group, which included people with lived experiences of acute mental health inpatient admission, carers of people who have experience of acute mental health inpatient admission, frontline multi-disciplinary clinicians, academics, and national experts in the field of acute mental health inpatient care. There was a spread of professionals from nursing, psychiatry, psychology, occupational therapy, and health care support work, which was essential given the multidisciplinary holistic approach required for inpatient care delivery.

The project team undertook a literature search to identify relevant research and potential resources, including:

- national guidance and policy documents
- training resources
- treatment manuals
- primary research indicating evidence for the efficacy of interventions or approaches
- existing competence frameworks such as the self-harm and suicide framework and the children and young people's inpatient framework

Alongside this, the National Institute for Health and Care Excellence (NICE) guidelines and quality standards were reviewed to identify recommendations relevant to inpatient care delivery. This ensured that the competence statements are consistent with NICE guidance. The process of extracting competences was undertaken by LW who drew on the resources identified above, along with source materials identified by the Expert Reference Group. Initial drafts were edited iteratively within the team and then passed to Expert Reference Group members for independent review. There was also collective discussion and debate during Expert Reference Group meetings. Further external reviewers were identified based on their specialist expertise and they were asked to ensure that interventions were described accurately and comprehensively. This process of iterative peer-reviewing was undertaken to provide assurance that the competence statements are clinically relevant and applicable, academically robust, in line with professional standards, written at the right level (and so readily understood by their target audiences), and reflect the stance and values that people with lived experience and families and carers have identified as important.

4. Scope of the work

4.1. Audience

This competence framework is intended for (and may be used by) a wide range of people across several domains. They may wish to use the competences to inform their current practices or to develop curricula and training around inpatient care delivery. Not all competences will be relevant to all staff, so those who are not specialists may require fewer of the listed competences. Staff, employers, and professional bodies should pay attention to the competences that are most relevant to them.

Domains	Constituents
Frontline clinical staff	Staff working in inpatient settings from the following professional groups: <ul style="list-style-type: none"> • Health care support workers • Psychiatrists • Psychologists • Psychotherapists/therapists • Occupational therapists • Mental health nurses • Pharmacists • Social workers
Frontline non-clinical staff	Staff working in inpatient settings from the following groups: <ul style="list-style-type: none"> • Peer support workers • Chaplaincy • Advocates • Administrative staff • Service support staff
Organisations involved in acute mental health inpatient care	<ul style="list-style-type: none"> • Professional membership bodies for acute mental health inpatient practitioners, particularly those involved in producing curricula • Organisations that develop and deliver acute mental health inpatient training • Academic institutions
Other/public	<ul style="list-style-type: none"> • Patients of acute mental health inpatient care • The family, carers and support networks of people who use acute mental health inpatient care • The public

This framework is mostly relevant for professionals working in acute mental health inpatient settings, patients, and their family and carers. However, because many mental health patients will have an acute mental health inpatient admission at some point during their lives, some of the competences outlined in this framework (such as communication skills and areas of knowledge) will be relevant to professionals working in other mental health settings supporting patients through their admission.

4.2. Population

This competence framework applies to adults aged 18 currently receiving care from an acute mental health inpatient hospital. Acute mental health inpatients are a diverse population who can often be facing several social and interpersonal challenges.

4.2.1. Meeting the needs of those most marginalised

The project team and the Expert Reference Group identified that acute mental health inpatients are likely to have experienced trauma, marginalisation, racism, and discrimination throughout their lifetime. They may also be facing many ongoing social difficulties such as homelessness, unemployment, financial difficulties, and social isolation. All professionals working in acute mental health inpatient settings should work collaboratively with patients and their family and carers to address these issues and a recovery and social inclusion approach is taken throughout the document. This will ensure that patients can meaningfully engage in the care provided. The project team carefully considered these issues and integrated relevant competences throughout the framework.

It is well acknowledged that there is an over-representation of people from ethnic minority backgrounds due to challenges such as racism, discrimination, and difficulties accessing culturally appropriate mental health care, which make an acute mental health admission more likely (Halvorsrud, Nazroo, Otis, Hajdukova, & Bhui, 2018). Recent evidence has demonstrated that patients from black African and black Caribbean backgrounds are four times more likely to be detained under the Mental Health Act compared to their white counterparts and are more likely to experience restrictive practice when receiving inpatient care (NHS Digital, 2020). The framework has taken these issues into account and aims to be 'culturally competent', and so meet the needs of diverse inpatient populations.

5. Using the competence framework

5.1. Clinical and professional issues relevant to supporting patients in acute mental health inpatient care

Professionals should endeavour to work collaboratively with all acute mental health inpatients, even when they are compulsorily detained under the Mental Health Act. A trusting, compassionate, flexible, and transparent relationship from the outset enables patients to make choices and decisions regarding their care and ensures they feel empowered and in control. Given that compulsory detention under the Mental Health Act can restrict the control patients have over their care, efforts should be made to give them control over care decisions at every opportunity.

It is also important that professionals can actively engage with the patient's family and carers as they can often feel excluded from inpatient care. This is often due to a patient being admitted abruptly, and family or carers going from having extensive to minimal involvement in their care. Decisions about the involvement of the patient's family and carers should always be discussed with the patient before making contact and should be reviewed throughout care because their wishes may change over time. Professionals should involve family and carers by regularly communicating and involving them in all key care decisions. Their involvement will contribute to the development of a shared understanding of the patient's difficulties and help build a collaborative relationship amongst all those engaged in supporting them. This is particularly important when planning discharge.

All inpatient care should be a collaborative process between the professional, the patient and (according to the patient's wishes) their family and carers as far as possible. This collaborative relationship should be reflected in the development of a shared language that accurately reflects the way the patient understands their problems and care. Without a collaborative approach, patients can feel that interventions are imposed on them, which then increases the risk of challenges in the relationship. Therefore, even when patients are under the care of the Mental Health Act, collaborative care delivery should be prioritised at all times.

5.2. Flexible person-centred care rather than routine driven

Inpatient care is underpinned by structured routines, which are often necessary to ensure that equitable and safe care is provided. Examples include standardised admission assessments, weekly ward rounds, daily one to ones with a named nurse, set mealtimes, and set leave times. However, these routine processes can be experienced by patients and their family and carers as restrictive. This is often due to the lack of collaborative agreement about when and how such processes are undertaken. Moreover, negative attitudes from staff towards patients can also contribute to rigid care delivery, for example, if staff perceive patients to be incapable or too unwell to make their own decisions. Inpatient care should be delivered in a person-centred and flexible manner to meet the needs of the patient and their family and carers.

5.3. Planning for discharge back into the community

The first few weeks following discharge from an inpatient admission represent heightened periods of risk, particularly of self-harm and/or suicide. A patient may present at low risk before discharge but this may significantly increase following discharge due to the removal of protective factors provided by the inpatient care plan (e.g. strategies to manage suicidal ideation) or the ward environment (because this limits access to means to end one's life). Thus, inpatient care needs to incorporate careful care planning of a patient's discharge, which should be underpinned by a formulation of their risk in the community. It is vital to ensure that a patient has appropriate support from services post-discharge, which may include support from a crisis home treatment team. Inpatient services should also follow up on patients post-discharge to ensure the transition to other community services is successful and is meeting the patient's needs.

5.4. Safety (risk) assessment and management

Assessing and managing a patient's safety is a key priority of inpatient care as behaviours that may cause a patient or others harm is often the reason for admission. In particular, risks to self, including neglect and intentional harm, are a key priority. Unfortunately, it can be very difficult to accurately predict harmful behaviours, leading either to an overestimation or under-estimation of the actual risk at a given moment in time. Research suggests moving away from prediction to focusing on the immediate needs of the person and seeing risk assessment as informing management rather than as a stand-alone activity.

In inpatient settings, risk classification scales and risk assessment tools are widely used when assessing a patient's safety and risk. Using these in addition to clinical interviewing may make sense, as they can provide a helpful structure and prompt the person who is completing the assessment to ask about current feelings and motivations. However, using tools and scales in isolation from a broader discussion with the person about their life as a whole can be both misleading and possibly unhelpful. As well as the evidence suggesting that risk assessment tools and scales do not have predictive value, their use can also cause the patient to disengage from support. One reason for this is that these tools tend to be in a checklist format, which means that patients may be asked about matters that are not relevant to them and may not be given the opportunity to raise matters of personal significance. This can contribute to feelings of not being listened to or not having an open space in which to discuss concerns. In addition, because they are problem-focused they do not usually explore a patient's strengths, values, and resources.

This framework outlines a collaborative assessment and management of a patient's safety, drawing upon their strengths and resources. The safety assessment and management process must engage the patient and their family and carers in a meaningful dialogue about their safety. It is important that the management plan that emerges is underpinned and shaped by a formulation and includes both pharmacological and psychosocial intervention strategies.

5.6 Support for staff, patients and wider networks following a serious incident

A serious incident, such as the loss of a patient to suicide, can be an extremely distressing experience that can bring about strong feelings of guilt, shame, anxiety, and depression for those affected. Because an individual's reaction to an incident is idiosyncratic the type of support, they may require will also be idiosyncratic. Organisational support following a serious incident is essential to ensure affected individuals feel appropriately supported. This is particularly important in an inpatient setting where the occurrence of incidents, particularly suicide, may lead to an increase in the risk of others. Suicide prevention research has identified an elevated risk of suicide in those bereaved by suicide.

5.7 Conducting inquiries into serious incidents

After a serious incident such as suicide, it is standard practice for health and social care organisations to conduct an independent inquiry into the circumstances that led to the suicide and to identify any changes that are needed to prevent it from happening again in the future. This comprises an internal inquiry as well as a public hearing (inquest). These are carried out by an independent team of skilled investigators who have the training, clinical experience, and knowledge to conduct a serious incident investigation. The terms of reference for the scope of the investigation, as well as the timescale for reporting, will be set out before the process begins. The dissemination of any learning that comes out of these investigations should be timely.

Regardless of the possibility of a pending investigation, organisations should not forget to first communicate with the patient's family and carers. Their needs should be met and they should be provided information as quickly as possible. To enable an organisation to learn from these events, inquiries need to be conducted in a manner that enables family members, significant others, and staff to talk openly, give evidence and comment on findings. This might be unlikely if there is any sense that the aim is to apportion blame to individuals. Staff are likely to feel considerable guilt and distress after a death by suicide, and the inquiry process itself can add to this stress if this is not recognised or is poorly managed. Family members, significant others and staff should be helped to understand the process of both an inquiry and an inquest and should be supported to understand the legal aspects of an inquest.

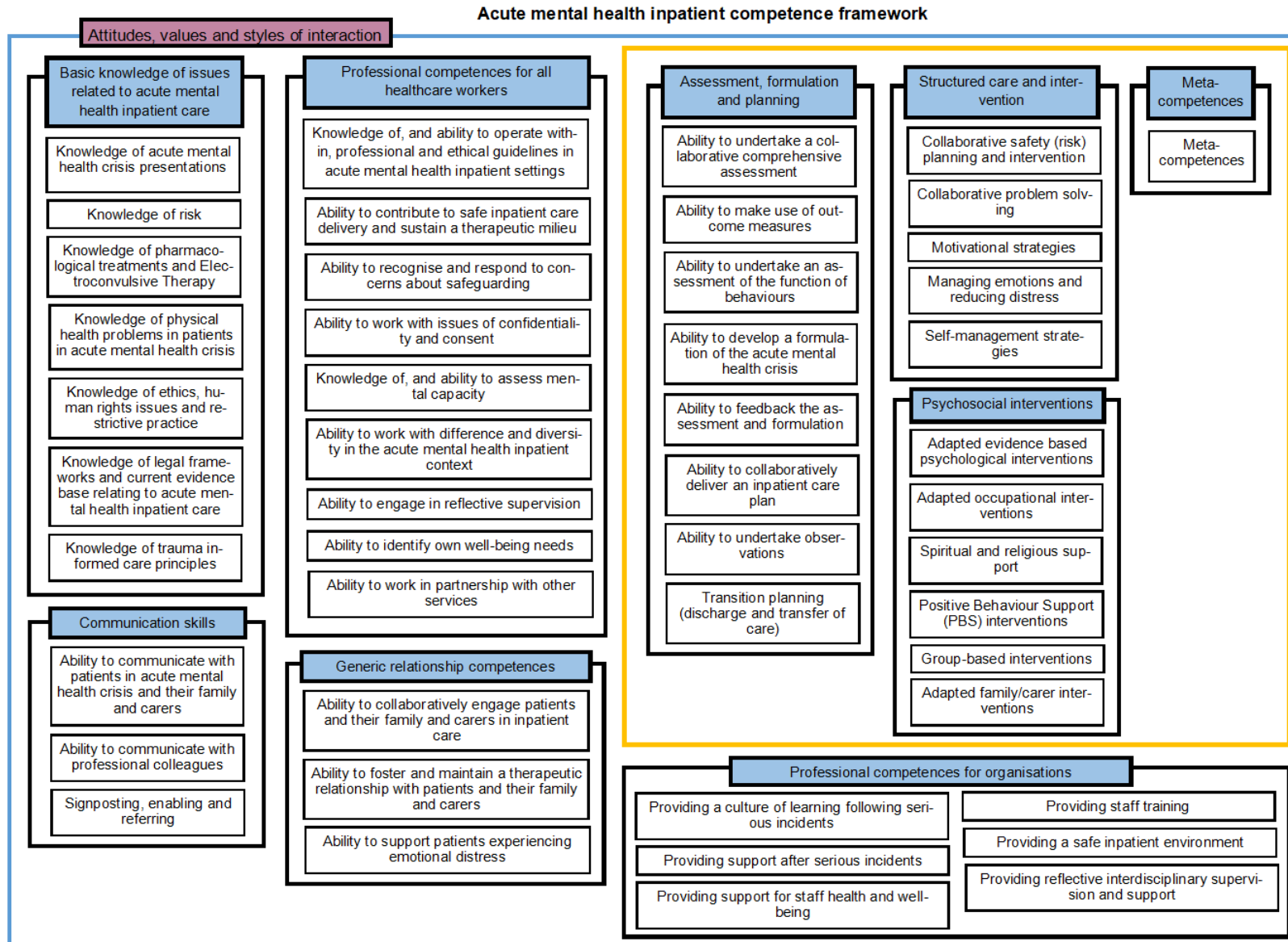
5.8 Multidisciplinary team working

It is well established that acute mental health inpatient care is most effective when underpinned by a biopsychosocial framework and delivered by multidisciplinary professionals (Royal College of Psychiatrists, 2010). Thus, inpatient staff teams should have representation from a variety of professional backgrounds including psychology, psychiatry, occupational therapy, nursing, health care support work, and pharmacy. Professionals should have the skills to work effectively alongside one another to deliver multidisciplinary inpatient care plans. This will include communicating effectively with one another and being able to overcome differences in opinion to prioritise holistic person-centred patient care.

5.9 Reflective practice

Reflective practice is the process by which professionals reflect on their actions, learn from their experiences, and consider how to make improvements in their practice. This is part of continuous self-learning by professionals, and it requires them to be self-aware and appropriately self-reflective. There is evidence that this stance can improve the way that care is delivered. As inpatient services are particularly challenging environments, reflective practice is crucial for the delivery of high-quality patient care and the maintenance of staff wellbeing, and there should be regular opportunities for reflection in individual and group settings.

Figure 1: Acute mental health inpatient competence framework map



6. Organising the competence list

Competence lists need to be of practical use. To achieve this, they need to be structured in a way that reflects the practice they describe, be set out in a structure that is both understandable (in other words, is easily grasped) and be valid (recognisable to practitioners as something which accurately represents inpatient working, both as a theoretical model and in terms of its clinical application). Figure 1 shows how the competences have been organised. The competence framework map is organised into three sections:

1. **Core knowledge and skills** for acute mental health inpatient practitioners (section on the left)
2. **Intervention skills** for acute mental health inpatient practitioners (section on the right)
3. **Organisational competences** for managers, leaders and senior members of staff working in acute mental health inpatient services (section on the bottom right)

There is no expectation that all workers will be able to deliver all the competences on the map. However, any healthcare professional contributing to inpatient care delivery would be expected to demonstrate the majority of the competences highlighted on the left side of the map (unless otherwise specified) because these underpin any effective work. The competences on the right-hand side mostly require a core profession and/or further appropriate training (more detail can be found in the relevant sections of the framework). The organisational competences are expected of managers, leaders and senior members of staff working in acute mental health inpatient settings.

Within these sections, there are several activities on the map that contribute to individual competences. This document provides an overview of each of the activity areas outlined on the map and their related competences, whilst the specific detail of the competences can be found in the map. The level of detail contained within these competences is required to facilitate the development of curricula.

6.1. Competences

Competence is usually defined as the integration of knowledge, skills, and attitudes. Professionals need background knowledge relevant to their practice, but it is the ability to draw on and apply this knowledge in different situations that marks out competence. Knowledge helps the professional to understand the rationale for applying their skills. Beyond knowledge and skills, the professional's attitude and stance are also critical. This is more than their attitude towards, and relationship with, a patient receiving inpatient care. It also includes how the contexts in which they work shape the way they approach their work (for example, the organisational, professional, ethical, and societal context). All of this needs to be held in mind since all have an influence on the professional's capacity to deliver interventions that are ethical, meet professional standards and are adapted to a person's strengths, needs and cultural context. This includes seeing the person holistically, while considering their intersectionality, identifying the strengths and needs of each characteristic of their identity, and

appreciating how these might interconnect with each other and contribute to the way the person expresses themselves, experiences life or how they are perceived.

6.1.1. Attitudes, values, and style of interaction when working with patients in acute mental health inpatient care

Working with patients and their family and carers should be underpinned by a compassionate, respectful, and non-judgmental human relationship. Practitioners working in this setting should be mindful of the inherent power imbalances present within this setting between professionals and patients, particularly when the patient is compulsorily detained under the care of the Mental Health Act, as these conditions can be detrimental to the therapeutic relationship. The 'Attitudes, values and style of interaction' competences focus on addressing this power imbalance, treating patients and their family and carers respectfully and compassionately, and working from a person-centred position.

Professionals should be able to:

- Prioritise the development of a transparent, open, honest, and trusting therapeutic relationship
- Understand a patient's mental health crisis within their social and cultural context
- Ensure patients feel that their freedoms and rights are respected at all times
- Give patients as much control as possible over their circumstances and care, even when they are detained under the Mental Health Act
- Understand the fundamental importance of the therapeutic relationship and how a positive therapeutic relationship can improve outcomes for patients and their family and carers
- Be person-centred and flexible in approach

6.1.2. Basic knowledge of issues related to acute mental health inpatient care

This part of the framework focuses on the 'Basic knowledge of issues related to acute mental health inpatient care' required by all professionals working in this setting. The first knowledge competency, 'Knowledge of acute mental health crisis presentations', sets out the knowledge of the characteristics of an acute mental health crisis and the common reasons for admission. 'Knowledge of risk' describes main risk behaviours that occur within the context of an acute mental health crisis. The competences contained within 'Knowledge of pharmacological treatments and Electroconvulsive Therapy' highlight the importance of understanding recommendations related to these interventions and the knowledge needed to prescribe them. 'Knowledge of physical health problems in patients in acute mental health crisis' highlights the importance of physical healthcare provision in inpatient settings and the problems of diagnostic overshadowing.

'Knowledge of ethics, human rights issues and restrictive practice' describes key ethical and human rights considerations when delivering restrictive practices within an inpatient setting. 'Knowledge of legal frameworks and current evidence base relating to acute mental health inpatient care' reflects the importance of professionals being knowledgeable about legislation and frameworks relevant to providing safe inpatient

care. This is key to working in this area, as knowledge of mental health law and issues such as consent and capacity are part of daily practice. It is particularly important for professionals to be familiar with the legislation that is relevant to their own discipline. Finally, 'Knowledge of trauma-informed care principles' describes core knowledge about how inpatient services can be trauma-informed, provide sensitive and safe care, and not retraumatise patients.

6.1.3. Communication skills

Communication skills are fundamental to care delivery within inpatient settings. In particular, 'An ability to communicate with patients in acute mental health crisis and their family and carers' is imperative. It is important that patients and their family and carers feel heard and understood, can express themselves in their own words and are involved in all care decisions. 'An ability to communicate with professional colleagues' is also crucial as inpatient care should be multidisciplinary and underpinned by a biopsychosocial approach. Thus, communicating with colleagues from different services and professional backgrounds is important for effective and quality care provision. Finally, in this part of the framework, the role of 'Signposting, enabling and referring' is outlined, setting out the competences needed to direct patients to resources and sources of support. There is a need not only to identify these sources of support but also to facilitate their uptake by the patient, as well as their family and carers if they also require support.

6.1.4. Professional competences for all healthcare workers

This set of professional competences applies to all healthcare workers regardless of the level of support and care that they are providing. All professions and regulatory bodies set out ethical standards that professionals are expected to know and apply in their practice. The competences within 'Knowledge of, and ability to operate within, professional and ethical guidelines in acute mental health inpatient settings' draw attention to the application of these principles in areas such as autonomy, consent, confidentiality and the minimisation of harm. 'Ability to contribute to safe inpatient care delivery and sustain a therapeutic milieu' outlines the competences required for individual practitioners to cultivate a safe and therapeutic culture in inpatient settings.

Safeguarding refers to the protection of individuals who are at risk of harm from various forms of abuse or neglect. In order to keep people safe from harm, professionals should have an 'Ability to recognise and respond to concerns about safeguarding'. These harms can be experienced by people of any age, so these competences will be key when working with everyone in the patient's network.

'Knowledge of, and ability to work with, issues of confidentiality and consent' is a potentially complex area that includes judgements about when it is in the patient's best interests to maintain or to breach confidentiality, and to whom information is appropriately passed or withheld from. Related to this is 'Knowledge of, and ability to assess, capacity', a skill that is critically relevant to this area of working. When assessing capacity, professionals should be able to adjust their communication style so that they can make themselves understood; this will reduce the chance of making incorrect judgments of capacity.

Respecting diversity, promoting equality of opportunity for patients, and challenging inequalities and discrimination, are all important parts of practice. The 'Ability to work with difference and diversity in the acute mental health inpatient context' includes the ability to take account of how patients differ, along with how a patient's defining characteristics can influence the way they experience life, the way that they present to services and which interventions might be offered to them. All professionals should be able to support and care for patients from all backgrounds, including those with protected characteristics (as set out in the Equality Act 2010), or additional characteristics that might be relevant, such as socioeconomic status. Patients who are societally disadvantaged in any way (for example those from ethnic minority backgrounds) may experience a double burden, with discrimination and stigma not only making them more vulnerable but also making it harder for them to access healthcare. Wherever professionals do identify inequalities to access and care, they should begin to take the necessary steps to overcome these.

Supervision and support for professionals should be the norm, so the 'Ability to engage in reflective supervision' is an important competency to incorporate into this framework. This references the skills that professionals need to have in order to get the best out of supervision and to subsequently gain support and improve the quality of care they deliver through reflection and learning.

Inpatient environments can be highly stressful and emotive settings which can lead to compassion fatigue, burnout, and stress. As such it is important for professionals to identify when their well-being is compromised. The 'Ability to identify own well-being needs' outlines how professionals can address this.

The 'Ability to work in partnership with other services' is an important skill to hold as it requires knowledge of the roles and responsibilities of other services they might work with. For support to be delivered seamlessly across multiple services, professionals need to understand local pathways of care and which criteria apply to each service. This will help ensure that the patient can be supported by the most appropriate services and that their experience of accessing them will be smooth and consistent.

6.1.5. Generic relationship competences

'Generic therapeutic competences' are a set of underpinning areas of knowledge and skills common to the delivery of inpatient care. The therapeutic alliance is the capacity to build and maintain a therapeutic relationship in which the professional develops a 'bond' with the patient and reaches agreement on the priorities for inpatient care. Developing a therapeutic alliance is a key priority in inpatient settings. Professionals should have the 'Ability to collaboratively engage patients and their family and carers in inpatient care'. Developing the alliance depends on an ability to recognise how patients and their family and carers understand themselves and the world around them, as well as their own goals, strengths and needs. This makes the 'Ability to foster and maintain a good therapeutic relationship with patients and their family and carers' an essential area of skill. The 'Ability to help patients experiencing emotional distress' is central to all interactions with a patient. The professional should reflect on the meaning of the patient's expression of emotion and behaviours, and during interactions should elicit emotions that facilitate change. To understand these

emotions fully, the professional should also speak to the patient's family and carers, if the patient agrees. The people involved in the patient's life may be able to provide insight into any meaning behind changes in behaviour. Professionals should also be able to help patients manage their emotional distress at all stages, particularly when it is acute and they are highly aroused, which is likely to be common in this setting.

6.1.6. Assessment, formulation and planning

'Assessment, formulation and planning' starts with the 'Ability to undertake a collaborative comprehensive assessment'. It is important to undertake a collaborative person-centred assessment that considers a patient's safety within the context of their needs. It is important to consider the patient's views on their difficulties and the changes they have noticed before and during admission to hospital. It is also important to recognise the limitations of an assessment, particularly regarding risk. Research and practice have identified several factors associated with risk behaviours, but these have limited predictive value, meaning that, at best, assessments can only apply to the short-term outlook and should not be used to plan for the longer term. This is not to say that risk assessments should not be undertaken, but to emphasise that they cannot be solely relied on or used as a way of neglecting ongoing observations and assessments that might identify shifts in the person's mental state and intentions. If risk assessments are undertaken, they should be completed as part of safety planning and not in isolation.

It is good practice for professionals to have the 'Ability to make use of outcome measures' so that these changes can be recorded systematically. Measures usually capture phenomena that are common to people with a particular difficulty, whereas qualitative records are a way of helping the person to note down their concerns in their own way. These can be used in conjunction with assessment, interventions, and treatments because they draw on current information. Thought should also be given as to how to collect both pre and post treatment data, as the brief nature of admission and sudden discharge can make this challenging.

Inpatient professionals should have the 'Ability to undertake an assessment of the function of behaviours'. Patients in inpatient settings may present with behaviours that challenge their environment or may put them at risk to themselves and others, and a comprehensive clinical assessment may not be possible or adequate. In these cases, an assessment of the functions of behaviours can provide information that can be used to formulate the behaviour and develop a positive behaviour support plan. This process must be collaboratively undertaken in partnership with the patient as far as possible.

The 'Ability to develop a formulation of the acute mental health crisis' is a key step in the assessment process, as this is the point at which information is gathered together into a coherent account that helps to understand the determinants of a patient's crisis experiences. Arriving at a formulation is an exercise that should be shared with the patient, both to test its accuracy and to confirm the patient's sense of its relevance. Relevant competences are set out in the 'Ability to feedback the assessment and formulation'. Although the 'Ability to collaboratively deliver an inpatient care plan' is the

final part of the assessment process, this is in no way an afterthought. A care plan should not be imposed on a patient. Rather, professionals should engage the patient (and their family and carers) throughout the decision-making process to give them the ability to explore treatment options and understand each fully. Together with the professionals' guidance, they can develop an inpatient care plan that all parties agree with and understand. If the patient feels a lack of control over decisions relating to care, there is a risk that they will disengage, so this is an important part of ongoing support with patients. When patients are cared for under the Mental Health Act, they should still be collaboratively deciding on their inpatient care plan alongside professionals as far as possible.

An 'Ability to undertake observations' is an important assessment activity that can maintain the safety of patients known to be at high risk of harm to themselves or others. Appropriate training and support need to be available to professionals undertaking this task, which should be seen as part of the clinical intervention rather than a stand-alone, 'tick-box' exercise.

Transitions in care, including discharge from the ward, represent periods of risk for patients, particularly those who present with self-harm or suicidal behaviours. Given that discontinuation of care usually happens during transitions, a patient can be lost within the system unless the transitions are anticipated and well planned. This is particularly true when a patient is being discharged from the ward back into the community. Because the first few weeks post-discharge are well documented to be a high-risk period for suicide, careful 'Transition planning (discharge and transfer of care)' needs to be undertaken. Transitions of care can be difficult for patients if they have to disengage from those they have come to trust or are required to connect to an unfamiliar service without the appropriate support in place to do so. For these reasons, individuals with responsibility for a patient's transfer of care should coordinate the transition with the receiving service, support the patient in whichever ways are required, and monitor the success of the transition.

6.1.7. Structured care and intervention

Patients in inpatient settings usually have an array of complex needs that need to be responded to and managed in a time-limited fashion. This often involves drawing upon a range of brief interventions to help increase safety and address the crisis. Five components are included here: 'Collaborative safety (risk) planning and intervention', 'Collaborative problem solving', 'Motivational strategies', 'Managing emotions and reducing distress', and 'Self-management strategies'. Although there is inevitable overlap between these areas, each is part of a process, applicable at different points in a patient's presentation. Although these may not be the only approaches that work in this context, they have been used in practice and if delivered proactively have been found to contribute to keeping a person safe.

'Collaborative safety (risk) planning and intervention' is a crucial part of inpatient care as threats to safety are often the primary reason for admission. When patients are in crisis, they often face a multitude of problems and struggle to manage these difficulties. Therefore, 'Collaborative problem solving' can be an important intervention

to help patients manage key problems contributing to and maintaining their crisis. Inpatient patients may also benefit from 'Motivational strategies' when they are overwhelmed with hopelessness and suicidal ideation or struggling to overcome drug and alcohol misuse, which may be perpetuating their crisis.

Mental health crises are often characterised by high levels of emotional distress and supporting patients with 'Managing emotions and reducing distress' may be an important intervention to increase a patient's sense of safety. However, strategies should be utilised in a manner that does not invalidate a patient's distress. Finally, 'Self-management strategies' are important interventions for crisis management. Professionals should support patients to develop their autonomy and manage their own crisis, which should include strategies such as psychoeducation, coping strategy engagement and relapse prevention.

6.1.8. Psychosocial interventions

Multidisciplinary psychosocial interventions are essential components of inpatient care. Because it is well documented that patients want access to a wide range of activities when admitted to the ward professionals should be delivering a variety of psychosocial interventions that aim to reduce the crisis, increase a patient's safety, and improve their functioning. As inpatient admissions are brief and within the context of a restricted environment, psychosocial interventions need to be focused to meet the needs of patients receiving care.

Patients should receive 'Adapted evidenced-based psychological interventions' which support them with their crisis experiences and increase their feelings of safety. There is a limited evidence base for psychological therapies in this setting, but there is some evidence that Cognitive Behaviour Therapy (second and third wave approaches) and Family Intervention may be useful. 'Adapted occupational interventions' are also important as occupational difficulties are a key characteristic of an acute mental health crisis. Patients should have access to a variety of group and individual interventions which aim to address any disturbances in occupation. Patients may require 'Spiritual and religious support' during their time on the ward. Spirituality and religion are important frameworks for understanding and coping with mental health crises for many patients.

'Positive Behavioural Support (PBS) interventions' are important when a patient presents with behaviours that challenge those around them. A PBS intervention should be based on a comprehensive assessment of the function of behaviours, be collaboratively delivered and involve the patient and their family and carers as much as possible. An integral component of inpatient care delivery is the provision of a comprehensive interdisciplinary group programme. 'Group-based interventions' should be underpinned by a therapeutic model and offer opportunities for coping and interpersonal skill development, and peer support. Family and carers often find having their relative in a hospital an understandably difficult experience and may need support themselves or assistance to support their relative. Moreover, family and carer involvement has been shown to prevent relapse and rehospitalisation. Therefore, 'Adapted family/carer interventions' should be offered to patients and their family and carers during an inpatient admission.

6.1.9. Meta-competences

The next part of the framework identifies overarching meta-competences, which refer to the use of judgement when carrying out an activity or intervention. These are relevant to all aspects of practice, and professionals often need to make decisions about whether, when or how to carry out an activity. Adapting and updating practice in a way that is tailored to the person and consistent with appropriate principles and evidence is an important marker of competence.

6.1.10. Professional competences for organisations

The final group of professional competences within the framework relates to competences for organisations. Because inpatient settings are highly complex and challenging work environments organisational competences are essential to the delivery of a safe environment for staff, patients and their family and carers. The first set of competences in this group reflects the importance of 'Providing a culture of learning following serious incidents', which involves arranging an independent investigation into the serious incident of the patient in compliance with institutional and statutory requirements. This investigation should be completed in a way that does not seek to blame but is open and thorough, and conducted in a manner that is sensitive to the needs of the family/carers who may have been bereaved by the suicide, as well as staff who were involved in supporting the patient the serious incident relates to. This also highlights the importance of a learning culture where incidents are learnt from and practice is continuously improved. Closely linked to this last point is the need for 'Providing support after serious incidents', which is a specific form of postvention that recognises the potential impact of a serious incident of those affected.

Another key organisational competency is 'Providing support for staff health and well-being'. It is widely acknowledged that inpatient care settings have some of the highest rates of staff burnout, sickness, and stress. Therefore, staff must be well-supported to manage the challenges of working in this setting. The next set of competences relate to 'Providing staff training'. In order for staff to be competent in delivering care to a group of patients with complex health needs, staff need regular and up to date training provision. This improves the quality of care provided and ensures that staff feel valued and confident in care delivery. 'Providing a safe inpatient environment' outlines key factors which ensure the inpatient context can operate safely, which relate to physical safety, safe staffing numbers and ongoing service improvement. Finally, 'Providing reflective interdisciplinary supervision and support' outlined the importance of multidisciplinary group spaces where professionals can learn and reflect with one another. This is important for service quality, improving staff-patient relationships and facilitating a culture of learning.

7. Application of the competence framework

There are several areas in which this competence framework can be applied. Some of these are outlined below.

7.1. Curricula

The framework lends itself to the development of curricula for those entering into professional practice from many different backgrounds, ensuring that professionals will be well versed in the competences required to work with patients receiving acute mental health inpatient care, and equipped with the confidence to work with them.

7.2. Training

Effective training is vital to ensuring increased access to well-delivered, psychosocially informed approaches and interventions. The framework can support this by providing:

- a clear set of competences that can guide and refine the structure and curriculum of training programmes, including pre- and post-qualification professional training, across all professions, as well as the training offered by independent organisations
- a system for the evaluation of the outcome of training programmes.

7.3. Commissioning

Commissioners can use this framework to ensure that the services they commission and the training programmes they provide meet the competences. This will help to inform commissioners about any local policies and procedures that need to be updated or put in place, such that services can operate within the bounds of the framework.

7.4. Service organisation

Services should use this framework to evaluate their current practice and processes to ensure that professionals are able to meet the competences set out in the framework. This may include creating safer environments for individuals and ensuring that there is enough capacity within the service. This will mean that professionals can deliver care effectively, which will subsequently enhance and improve both the quality of care and the safety of those receiving it.

7.5. Clinical Governance

This framework can be used in clinical governance processes by ensuring that the care delivered is in line with the competences. By evaluating existing practice against the framework, services and professionals can begin to improve the quality of care they provide.

7.6. Supervision

The competences described in the framework can be used in supervision by both the person receiving supervision and the supervisor. The person receiving supervision can use the competences in their reflective practice, considering the areas where they could improve their practice in line with the framework. Similarly, the supervisor can

use the framework as a tool to guide discussion on reflective practice, identifying areas for growth and learning. This can then be addressed through additional training and support during future supervision.

7.7. Research

Research studies and audits can be used to benchmark the degree to which services comply with the competences listed in the framework and how these patterns of service delivery change with time.

Appendix 1: Expert Reference Group members

Authors:

Lisa Wood, Specialist Care Pathway Lead for Acute and Inpatient Psychology, North East London NHS Foundation Trust, and Clinical Associate Professor, University College London

Claire Williams, Professional Lead for Inpatient and Crisis Psychology and Lead for Adult Mental Health, Consultant Clinical Psychologist, North East London NHS Foundation Trust

Leah Luxon, Assistant Psychologist, North East London NHS Foundation Trust

Ajvir Kumary, Counselling Psychologist, North East London NHS Foundation Trust

Anthony Roth, Professor of Clinical Psychology, University College London

Members:

Katherine Berry, Professor of Clinical Psychology, University of Manchester

Mary Birken, Occupational Therapist and Research Fellow, Mental Health Policy Research Unit, Division of Psychiatry, UCL

Selma Ebrahim, Associate Director, Consultant Clinical Psychologist, Approved Clinician Chair, Complex Mental Health Network ACP-UK, Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Jarka Hinksman, Carer Expert by Experience

Pamela Jacobsen, Lecturer in Clinical Psychology, University of Bath

Winnie Liu, Expert by Experience

Kieran Mahoney, Occupational Therapy Lead, Acute and Rehabilitation Directorate, North East London NHS Foundation Trust

Fiona Nolan, Professor of Mental Health Nursing, Anglia Ruskin University, Health Education England

Patrick Nyikavaranda, Expert by Experience, PhD student, UCL, University of Brighton

Stuart Reid, Head of Psychological Services, Consultant Clinical Psychologist, Acute Mental Health Services, West London NHS Foundation Trust

Abdi Sanati, Consultant Psychiatrist, East London NHS Foundation Trust, Chair of the Philosophy Special Interest Group, Royal College of Psychiatry

Alan Simpson, Professor of Mental Health Nursing, Co-Director UCL-KCL Mental Health Policy Research Unit, Kings College London

Susan Smyth, Director of Nursing, North East London NHS Foundation Trust

Paul Ware, Expert by Experience, Peer Support Worker, Camden & Islington NHS Foundation Trust

Suzie Willis, Head of Profession Occupational Therapy & Art Therapy and Allied Health Professionals Lead, Camden & Islington NHS Foundation Trust

Older adult consultant:

Mina Patel, Interim Strategic Lead for Acute and Inpatient Psychology, North East London NHS Foundation Trust

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