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ORIGINAL RESEARCH ARTICLE

Developing 'Comprehend, Cope and Connect' training for acute and crisis mental health services: staff, patient and carer perspectives

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'Comprehend, Cope and Connect' (CCC) is an evidence-based psychological intervention for psychological crisis designed for use in inpatient settings. The aims of the current study were to gain the perspectives of multidisciplinary team (MDT) staff, patients and carers to inform the design of a potential CCC training programme for MDT staff to deliver CCC interventions. Staff, patient and carer perspectives on developing a CCC training programme were collected through video call-based group consultations and written feedback. Thematic analysis was employed to organise and explore latent themes within the data. Thirteen MDT inpatient staff and an expert patient and carer panel of four participated in the study. Feedback showed that the CCC model supported staff in understanding patients beyond labels in a patient-centred and led capacity, and that CCC was helpful in bringing clarity to crisis. Staff participants stated that learning and practicing psychological skills and encouraging confidence would be important when training staff in CCC. They identified needs to embed CCC into ward culture and integrate CCC with care planning for successful implementation of CCC in inpatient settings. The patient and carer panel focused on the needs of patients, concluding that CCC training should emphasise the need to understand patient experience, and promote compassion and empathy. These findings provide evidence for what staff, patients, and carers consider to be important when training MDT staff to deliver CCC interventions in an inpatient setting and form a foundation for implementation of CCC training.

Key words: inpatient psychology; psychiatric ward; psychological intervention; psychological formulation; staff training; qualitative research

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Introduction

The National Institute for Health and Care Excellence recommends that psychological interventions be offered to patients in inpatient settings for a range of psychological problems, including those who acquire diagnoses of 'depression', 'complex psychosis' and 'borderline personality disorder' (NICE 2014; 2020). In keeping with these recommendations, the National Health Service's Long Term Plan (NHS 2019) calls for more staff to be trained to deliver psychological therapies and for psychological therapies to be placed at the beginning of acute care pathways, to ensure patients are detained in hospital for the least amount of time necessary. Patients, families and professionals have all voiced a need for greater accessibility to psychological interventions and alternatives to medication during hospital admissions (Kramarz et al. 2020).

There is emerging evidence for psychological therapies in acute care settings, including cognitive behavioural therapy (CBT), dialectical behaviour therapy (DBT), interpersonal psychotherapy, and positive psychology interventions (Schramm et al. 2008; Mueller et al. 2013; Huffman et al. 2014; Schefft et al. 2019; Tebett-Mock et al. 2020; Kouvaras et al. 2022; Williams et al. 2022). A recent systematic review has shown that psychological therapy in acute care services leads to significant improvements in clinical, economic and patient experience outcomes, including reductions in depression, anxiety, and hospital readmission rates (Paterson et al. 2018). Patients and psychologists have suggested that the need to make sense of a crisis leading to admission is an important reason for psychological interventions to be implemented in acute services, with psychological formulation providing a sense of hope and empowerment (Small et al. 2018).

One formulation-driven psychological approach for supporting patients in crisis in inpatient settings, which integrates several evidence-based therapeutic approaches, is Isabel Clarke's 'Comprehend, Cope and Connect' (CCC; Clarke & Nicholls 2017; Clarke 2021). CCC is a trauma-informed third-wave cognitive behavioural approach which prioritises the individual's emotional world; their 'felt sense'. It is a framework which reconceptualises 'mental illness' as a 'stuckness' within patterns of behaviour that initially arises out of attempts to cope with overwhelming affect. These attempts at coping arise because they are effective in the short-term; they allow avoidance of the painful emotions at the heart of the crisis. However, in the long-term they are unhelpful and create behavioural cycles that perpetuate the intense crisis state. These cycles may involve coping strategies such as avoidance, substance use, dissociation, and self-harm (Clarke & Nicholls 2017; Clarke 2021). Through this reconceptualization of mental illness, acknowledgement is given to social movements and research which name diagnostic and medical conceptualisations of distress as unhelpful and detrimental to recovery (Bentall et al. 1998; Watson 2019). CCC is therefore transdiagnostic, or even non-diagnostic as it 'dismantles' diagnosis (Clarke & Nicholls 2017, Clarke 2021).

As an integrative approach CCC has a strong theoretical basis primarily grounded in Barnard & Teasdale's (1991) Interacting Cognitive Subsystems (ICS) model of cognitive architecture. According to ICS, the human mind is organised into two main higher-order systems, each with distinct forms of information processing and memory encoding: the 'propositional' and the 'implicational'. The propositional subsystem is postulated to underpin logical thought and make use of verbally-encoded memory. The implicational subsystem is postulated to underpin emotional felt sense with body-based sensory memory. These qualitatively different 'ways' of remembering have important consequences. Propositional (rational) remembering is connected to a perception of time; what is remembered will be experienced as belonging to a particular context within a particular time period (i.e. in the past or the future, as in prospective memory). In contrast, and due to its body-based nature, implicational (emotional) remembering produces a greater sense of immediacy due to internal representations of the event or experience being re-experienced through the body (Clarke 1999). CCC draws particular comparisons with DBT's 'states of mind' (Linehan 1993), with the concepts of the 'Reasonable Mind' and 'Emotion Mind' mapped directly onto the propositional and implicational subsystems, respectively.

During daily life, the implicational (Emotion Mind) and propositional (Reasonable Mind) systems function together smoothly in operation. However, during states of high or low arousal, implicational processing dominates over propositional thinking; emotional experiencing takes over as the balance between emotion and rationality is lost. An aim of CCC is to support the individual in reaching a state of 'wise mind' (Linehan 1993), in which rationality and emotion can be balanced. Herein

lies CCC's trauma-informed perspective; implicational body-based memory retrieval gives a felt sense of 'past in present' as emotional arousal is experienced in real-time, either adding to whatever current difficulties are being experienced or leading to a re-experiencing of past trauma (Clarke 1999). How these emotions are coped with then determines the course of the crisis (Clarke & Nicholls 2017; Clarke 2021). For example, according to CCC, in a state of very high arousal (e.g. panic, confusion) current adverse experiences (e.g. the breakdown of a relationship) that resonate with past adversity (e.g. experiences of loss, abandonment or neglect) will trigger a remembering of the past that is disconnected from rational thinking and the boundaries of time. This emotional remembering triggers the physical threat reaction relevant to the past traumatic event (e.g. faster heart rate, quickening of the breath, physical tension in musculature) and the past is re-experienced in the present.

This framework has also been applied developmentally. It has been proposed that the body-based implicational processing system plays a crucial role in the experience of the self, and is shaped by early adverse experiences in ways that may lead to reactive chronic states of arousal, demonstrating another route by which the past can influence the present (Clarke 1999). CCC also draws on evolutionary theory by emphasising the importance of social hierarchy and power, highlighting how negative relational experiences are registered as sources of threat at the Implicational level (Clarke 1999).

CCC's theoretical basis informs its formulation-driven approach, which centres on an emotion-focused model to identify how ways of coping with powerful and difficult emotions create vicious cycles that maintain the crisis state. This formulation underpins the CCC intervention, bringing understanding to the crisis and identifying ways of breaking maintaining cycles. Recent developments incorporate a focus on strengths (e.g. creativity) and protective factors (e.g. spirituality, a supportive relationship) in the formulation to be drawn upon to break the maintaining cycles (Clarke & Nicholls 2017; Clarke 2021). The accessibility of the CCC formulation also bridges individual and team formulation, allowing a teamwide goal-based approach to crisis support in which all members of a multidisciplinary team (MDT) are involved (Araci & Clarke 2017).

There is growing evidence that CCC is an efficacious crisis intervention in acute inpatient services in both individual and group therapy formats (Durrant et al. 2007; Durrant & Tolland 2008; Owen et al. 2015) as well as being successfully incorporated into ward cultures and delivered via a teamwide approach (Araci & Clarke 2017). CCC has also been validated cross-culturally, proving to be both acceptable and feasible for use with diverse populations (Phiri et al. 2021); the non-diagnostic/non-medicalising focus on the universal need to reach a tolerable emotional state was found to fit with non-Western conceptualisations of distress. CCC's emphasis on mindfulness was further found to be in line with non-Westernised perspectives on managing distress, along with the incorporation of spirituality.

CCC has more recently been adapted into a single-session intervention to further meet the needs of patients on inpatient wards, where timing of discharge (and thus length of therapy) is highly unpredictable (Bullock et al. 2021). This single-session CCC intervention involves a structured collaborative CCC formulation developed with the patient followed by a brief intervention. The formulation component involves a step-by-step approach to supporting patients in making sense of their current crisis through consideration of recent precipitating events and the interaction of these with past trauma, identification of maladaptive coping strategies which perpetuate the crisis state by creating maintaining cycles, ways in which these maintaining cycles might be broken, and strengths and resources which patients have available to draw upon in overcoming their difficulties. The intervention component of the session involves skills-training to break maintaining cycles (e.g. practicing mindfulness or grounding techniques in response to feelings of anger in place of responding with aggression) with the setting of behavioural goals to practice these skills following the session (Bullock et al. 2021). Evaluations of the single-session CCC adaptation have indicated positive quantitative and qualitative outcomes, including feasibility of video-based and face-to-face delivery (Riches et al. 2020; Bullock et al. 2021).

CCC looks to be a promising way forward in improving access to psychological interventions in inpatient services in line with the aims of the NHS Long Term Plan. However, common barriers to psychotherapeutic intervention in acute services still stand. These include a lack of psychological therapists and resources, institutional constraints and the prioritisation of the medical model of care (Corrigan et al. 1992; Ebrahim 2021; Raphael et al. 2021a). One potential route to overcoming such barriers is to share in the delivery of psychological interventions, such as CCC, with MDT ward staff (e.g. nurses, support workers and healthcare assistants) in inpatient settings. In line with the recommendations of Bullock et al. (2020), this will involve training staff to collaboratively apply and undertake CCC to support patients in overcoming their crises.

In order to design and implement training in CCC, it is important to understand what staff feel is important for them to be able to successfully deliver CCC sessions as a part of their routine clinical practice. Additionally, patient involvement in designing mental health provision is necessary for ethical and evidence-based practice (Thornicroft & Tansella 2005). It will be important

to co-produce CCC training with patients and carers to ensure that it is informed by their expertise and is in line with their values (Kvæl et al. 2019; Curran et al. 2022).

The present study aimed to undertake a qualitative exploration of patient, carer and ward staff perspectives on the CCC model, what factors would be important to consider when designing a training programme for ward staff in delivering CCC interventions, and what factors would be important to consider when implementing a teamwide CCC approach in acute and crisis mental health settings. The study was conducted in two parts: first, workshops and consultation groups with MDT staff; and second, consultation with an expert patient and carer panel.

Method

All participants received an information sheet about the study and informed consent was obtained. Ethical approval was granted by the South London and Maudsley NHS Foundation Trust.

Staff consultation groups

A convenience sampling approach was used in which MDT staff from five acute and crisis teams in a South London hospital were invited to take part in a session titled 'A novel psychological technique – Supporting service users in crisis'. The information sheet explained that this would involve participating in a video call-based consultation group aiming to explore views on a psychological approach to working with emotional distress in acute and crisis services. Signed consent was obtained for the purpose of collating the feedback given in the groups, which was anonymised. It was explained to staff that the purpose of their feedback was to inform future training on a psychological intervention that would be presented in the consultation groups. Four consultation groups were facilitated in total, in line with guidance on the number of groups required to identify prevalent themes and to maximise methodological quality (Guest et al. 2016). Demographic information on participants' multidisciplinary professional roles were collected via a brief demographics survey administered prior to the commencement of each consultation group.

Multidisciplinary acute and crisis staff participated in consultation groups facilitated by a trainee clinical psychologist. Staff participated in one group each lasting between 30 and 45 minutes, with three to four staff members in each group. The aim of the groups was to obtain staff feedback and opinions on the CCC intervention evaluated by Bullock et al. (2021). Participants were told that this project was being led by the wards' psychology service as a response to the National Health Service's Long Term Plan (NHS 2019) and that any subsequent training on and supervision for CCC interventions would be delivered by psychologists.

A presentation detailing CCC was produced by the local psychology team (JH, SR) in consultation with Isabel Clarke. Presentations were facilitated via Microsoft Teams, using the screen sharing function, due to social distancing measures in place in response to the Covid-19 pandemic.

This presentation began by outlining CCC as an evidence-based intervention for supporting people in making sense of and managing a psychological crisis (Clarke & Nicholls 2017; Bullock et al. 2021). CCC was presented more broadly as an attempt to reconceptualise 'mental illness'; rather than seeing patients as 'ill with symptoms' it supports patients and clinicians to understand crises as being maintained by the ways in which people try to cope with very difficult emotions. These understandable ways of coping are helpful in the short-term but perpetuate the crisis in the long-term. CCC was described as an approach that can be used non-diagnostically or trans-diagnostically.

Participants were then introduced to the concept of maintaining cycles in the context of unhelpful coping strategies, as well as how these cycles can be broken through goal-setting and behavioural interventions. Following this, the group was introduced to the underlying theory of the CCC approach to support them in developing an understanding of the trauma-informed nature of the approach. This involved references to the implications of Barnard & Teasdale's (1991) ICS model for how the past may be re-experienced in the present. Clarke's (2015) 'States of Mind' diagram was used to demonstrate a disconnect between the Reasonable Mind and Emotion Mind and their respective ways of remembering at times of crisis. This was presented with a narrative of re-experiencing (such as in the case of post-traumatic stress or the power of anniversaries) wherein attempts at coping keep the past locked in the present. This provided space to then consider the intervention aspect of the CCC model. This theoretical basis of CCC was communicated to participants in an accessible way, referring to every day real-life examples to demonstrate application of the underlying theory, with opportunities for participants to ask the facilitator questions.

After presenting the underlying theoretical basis, the single-session CCC model (Bullock et al. 2021) was shown, to contextualise the model for participants. This was done through a step-by-step application of the model to an anonymised clinical case brought by the facilitator, with opportunities for participants to ask questions. Participants were then supported to participate in a role-play activity where they were given the opportunity to apply the model to their own anonymised clinical cases with support from the facilitator. The model as it was

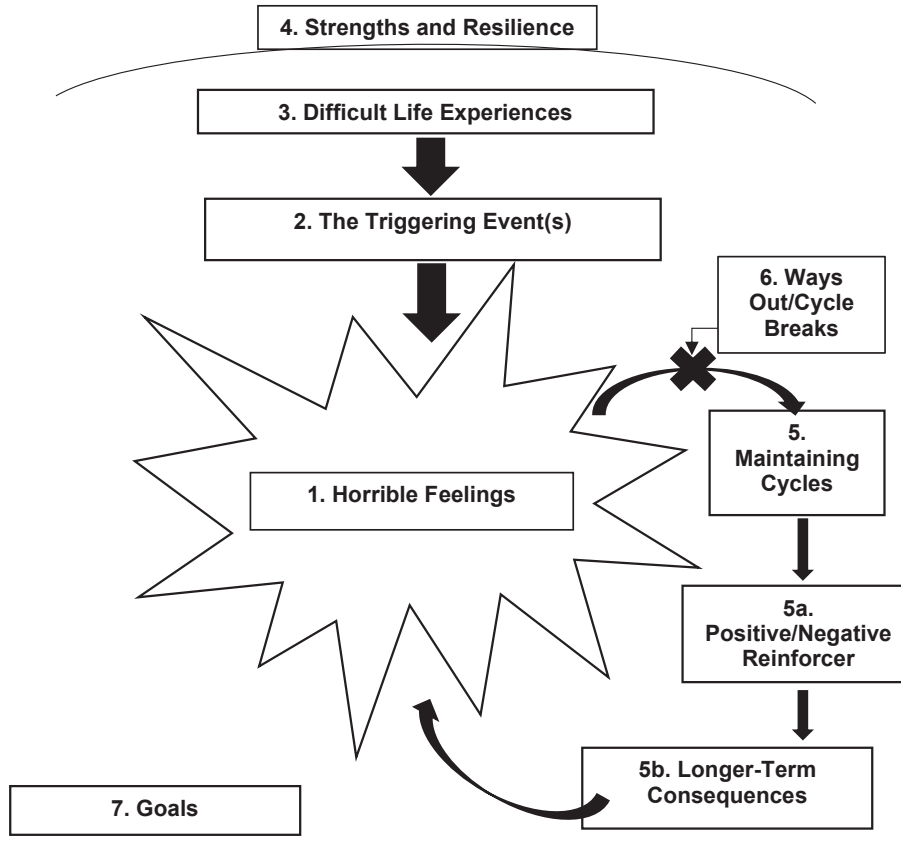

Fig. 1. Single-session CCC model presented to participants and used during role-playing exercises (adapted from Bullock et al. 2021).

presented is shown in Figure 1. After presentation of the model and cases, a semi-structured discussion aimed at exploring participants' views on the CCC approach and staff training needs to be able to deliver CCC interventions was facilitated. Pre-planned questions were used to stimulate discussion on certain topics but the structure of the group was flexible based on where participants felt it was important to take the discussion. Facilitator questions focused on participant perceptions of the model more generally (e.g. 'What do you make of that as an approach to understanding distress and what keeps it going?') and potential staff training needs (e.g. 'If you were to receive formal training to be able to undertake this intervention in your clinical practice, what would you find helpful in that training session?').

Expert patient and carer panel consultation

The Feasibility and Acceptability Support Team for Researchers (FAST-R) provided the anonymous patient and carer feedback. FAST-R is a free, confidential service in England provided by the National Institute for Health Research Maudsley Biomedical Research Centre via King's College London and South London and Maudsley NHS Foundation Trust. FAST-R patients and carers provided written feedback on the single-session CCC model and gave their perspectives on what would be important to prioritise in staff training on the CCC approach. Written feedback was used as this was the panel's method of choice. Demographic information on the panel members' roles was provided by FAST-R.

An assessment from FAST-R of the materials presented to staff during the workshop and consultation groups was requested online. Both a video recording of the consultation group presentation and written documentation detailing the adapted CCC model were submitted for assessment. These materials were then reviewed by a team with experience of mental health problems and their carers, who have been specially trained to advise on research proposals and documentation.

Data analysis

Consultation group discussions were video recorded and transcribed via the 'Record' and 'Transcribe' functions on Microsoft Teams. Data were cleaned, anonymised and pooled, after which the video recordings were destroyed. Written feedback from the patient and carer panel was pooled.

Thematic analyses were carried out on each dataset. Thematic analysis is an approach to identifying and analysing patterns within data, which take the form of themes, and is a useful way of describing what the data is describing about a particular issue or topic (Braun & Clarke 2006). Thematic analysis was used to identify key patterns in the data that were thought to accurately represent the meanings behind what participants discussed in relation to the CCC model and what they felt they would need to be trained to undertake the CCC intervention.

NVivo12, a qualitative analysis software tool, was used to analyse and code all data. Codes that appeared repeatedly in the data were then arranged into organising categories by the research team in order to give structure to the data. Each organising category consisted of several individual themes identified within the data. Organising categories for the staff consultation group data were: 'Benefits of the CCC model', 'Training needs for undertaking the single-session CCC intervention' and 'Implementation of the CCC approach'. The organising categories created for the patient and carer panel data were 'Feedback on the CCC model' and 'Feedback on MDT staff training'.

An interpretivist position was adopted when identifying latent themes within the data (Peterson 2017). In relation to this, the first author's (JH) positionality on person-centred and non-diagnostic ways of working as a clinician was noted. Multiple coding allowed SR to control for potential biases and validate the interpretation of themes in all data transcripts. Discrepancies in interpretation were resolved through discussions between members of the research team.

Results

Staff consultation groups

Staff participants (N = 13) came from a variety of professional backgrounds: psychiatrists (n = 3), nurses (n = 3), assistant psychologists (n = 3), occupational therapists (n = 2) and activities coordinators (n = 2). Mean (SD, range) number of years in occupation was 4 (3.2, 1–10) and years in acute and crisis services was 3 (2.3, 1–8).

Table 1 provides details of themes, explanations, and illustrative quotes. The 'Benefits of the CCC Model' category consisted of three themes. Participants felt that the CCC model supported understanding patients' crises, in that it went 'Beyond labels' (n = 9) in a 'Patient-centred and led' (n = 8) capacity, whilst 'Bringing clarity to crisis' (n = 6). The CCC model was seen to encourage staff to take a more holistic, non-labelling approach to supporting patients in crisis. This was seen as validating for patients and helpful for encouraging staff to consider resources patients may have that might not otherwise be recognised (e.g. spirituality). The model was praised for its simplicity and capacity to bring clarity to the crises experienced by patients: what has caused the crisis, and what is keeping it going.

The 'Training needs for undertaking the single-session CCC intervention' category consisted of four themes that reflected what participants identified as important for the design of a CCC training for MDT staff. Participants felt that 'Learning and practicing psychological skills' (n = 9), 'Developing confidence' (n = 6) and a 'Need for list of cycle break interventions' (n = 5) would be important components of CCC training. Participants stated that 'Making training relevant and appealing' (n = 4) would be an important aspect of promoting CCC training to MDT ward staff. Participants highlighted the importance of training staff in the delivery of psychological techniques that could be drawn upon when delivering CCC sessions, with opportunities during the training session for staff to practice these skills (e.g. in the form of role-plays) and explore their underlying theory. Participants suggested the provision of resources in the form of a list of examples to be given during the training session, which staff could use for cycle break interventions during CCC sessions. Participants highlighted a need for CCC training to support staff in developing their confidence in the delivery of CCC interventions, and for the training to be made appealing to staff from wide-ranging professional backgrounds who may not otherwise show interest in psychological ways of working with crises.

The 'Implementation of the CCC approach' category consisted of four themes that represented important information about what would be important if the single-session CCC model were to be implemented in an acute inpatient setting. Participants felt that 'Embedding CCC into ward culture' (n = 9), 'Integrating CCC with care planning' (n = 6), receiving 'Support from senior staff' (n = 6) and that 'Psychologists to model the intervention' (n = 3) on wards would be important for successful implementation of CCC on an inpatient ward. Primary importance was given to the CCC approach needing to be embedded into the culture of wards through the nurturing of a culture of therapy. Additionally, the single-session CCC intervention was seen to fit well with standard care planning procedures, which led to a suggested way for the model to be integrated into the culture of each ward. Participants noted how support from senior staff (e.g. ward managers, consultants) would be important for MDT staff to have protected time to undertake CCC sessions with patients. The presence of psychologists on the wards was also seen as a factor that would aid implementation of CCC through legitimising the intervention and role modelling its use.

Table 1. Themes from staff workshops and consultation group discussions on the CCC single-session intervention (N = 13).

Theme	n (%)	Explanation	**Quotes** [staff (S) ID]
Benefits of the CCC model			
Beyond labels	9 (69%)	The model was seen to recognise patients for who they are beyond their diagnosis, which was seen as empowering and helpful	'If you go in and start talking about symptoms and diagnosis, patients immediately start thinking "Okay. This is the staff and patient dynamic". But if you've actually talked about how they're feeling they're more equal. I think they'd be able to open up a lot more.' [S9]
			'We can easily get lost in diagnosis and ticking all these boxes, but this [model] is sort of bringing it back to the patient.' [S8]
			'I think obviously the medics focus a lot on sectioning patients and stuff. So then to kind of suddenly go to this model where they're getting beyond that, I think it's good to think beyond diagnosis.' [S11]
			'It's empowering as they are being seen more holistically than diagnoses and … this might help engagement as some patients are not in agreement of their diagnosis.' [S6]
			'I think it makes sense to look at it non-diagnostically and just look at what happened before to try to explain why the person is acting the way she is now.' [S1]
Patient-centred and led	8 (62%)	The model was seen to foreground the patient and empower them to take the lead, encouraging clinicians to work collaboratively and consider aspects of the whole person they might not have otherwise thought of (e.g. spirituality)	'It's that difference between a more collaborative process and … a more passive role … so giving them more power in a way to be more equal.' [S8]
			'It allows them to take back control... and will help with patients feeling heard.' [S4]
			'It's them telling you and you both coming up with a plan on saying what the problem is and how you can move forward.' [S1]
			'It's patient-centred to explore their strengths.' [P6]
			'It [consideration of spirituality] stuck out to me … Spirituality is something everybody engages in to a greater or lesser extent.'[S2]
			'It's hopefully going to make [patients] feel more listened to and I know that one of their main complaints is, is often 'My priorities were not seen as priorities and people weren't listening to me'. [S8]
Bringing clarity to crisis	6 (46%)	The model was seen to help through its simple yet useful way of making crisis understandable	'I think it's quite simple, but very straightforward. It can break it down and you can look into things.' [S12]
			'I feel like it's a very simple way of like trying to explain what is going on for someone.' [S1]
			'You could apply it to lots of different sorts of clinical [crisis] scenarios.' [S8]
Training needs for undertaking the single-session CCC intervention			
Learning and practicing psychological skills	9 (69%)	Participants wanted skills-focused training with a chance to practice these skills, and have opportunities to learn about the theory behind relevant cycle breaks	'I'd be interested in a bit more of the theory behind... what kind of stuff that's underpinning it.' [S2]
			'If I'm, you know, supposed to suggest some sort of techniques, I'd like to know more about them because right now I know a little bit about CBT and a little about DBT… We need to have more skills.' [S13]
			'It's really difficult to change if they don't want to, if you're not at that point … Where are they in their readiness to change circle?' [S12]
			'Role-playing … People would just be paired up and then one would be the therapist and the other would be the patient … start doing it with the patient … get some feedback from the facilitator on how you could improve and what you should have said…' [S1]
			'It's important to get people involved as much as possible because I know sometimes when I'm doing training I switch off a little bit.' [S11]

Table 1. (*Continued*)

Theme	n (%)	Explanation	**Quotes** [staff (S) ID]
Developing confidence	6 (46%)	Participants highlighted a need for training to support staff in developing confidence to deliver the intervention and linked this with having confidence in the model itself and its evidence base	'About kind of, what to do if things don't go as you'd expect or take you to uncomfortable places?' [S12] 'Perhaps if there was a fear of like, what if I do it wrong? What if I make it worse and I can't contain it? So to be prepared for dealing with it, in case I can't contain it…' [S13] 'Delivering an activity, for example, it could just be something as simple as karaoke, but to have that confidence to do so is a bit demanding … I think being able to confident enough to deliver an effective session will definitely be something.' [S4] 'It seems like it would be [simple] as long as you were confident.' [S1]
Need for list of cycle break interventions	5 (38%)	Training on specific interventions to break maintaining cycles was suggested as important, with an additional list of potential interventions staff can apply with patients	'It would be challenging to think of other ways that someone could cope with something.' [S5] 'Not everyone's gonna have the same ideas available. For me as a person who is trying to talk to them and empower them, maybe it would be helpful to have, like, the whole list of things that can be used.' [S13] 'It's about making sure that maybe we have like a list of resources that we can use… it's really hard to think on the spot about 'Why don't you try this?'' [S12]
Making training relevant and appealing	4 (31%)	Participants expressed that training would need to appeal to MDT staff who might not naturally be interested in psychology and tailored to more practically-minded members of the team	'So remember, [you will have] staff that want to read the patients and apply this model… and staff that they're not interested.' [S10] 'There will be some people like, where we're coming along to this session because we're interested in it, we want to know, but not everyone's got the same interests.' [S11] 'I don't want theoretical knowledge, I want something that I can actually use.' [S13]
Implementation of the CCC approach			
Embedding CCC into ward culture	9 (69%)	Participants related successful implementation to all clinicians being on the same page and the model being integrated into the ward culture	'Bits and pieces without integration improves things, but… if you introduce this, it has to be integrated. Everyone has to be on the same page… It has to be a culture of therapy.' [S10] '[It will be important] to have a coherent and consistent approach from ward staff.' [S7] 'I'm just thinking about my current workplace now and it's a culture thing isn't it? It's about getting everybody to do it routinely.' [S8] 'I think it would be important to do the training for everyone you know. Support workers quite often get missed out from training when they're the ones that are usually interacting with patients the most.' [S9] 'It needs a whole team approach and… a little bit of persistence.' [S13]
Integrating CCC with care planning	6 (46%)	Participants noted how the CCC model could be usefully integrated into standard care planning procedures already in place	''Cause you're almost in a way, you're almost creating a care plan… but it's already come from the patient themselves rather than us trying to make a care plan and asking patients for their input.' [S10] 'It's like a really nice addition to care planning really, because it fits, you know it fits in.' [S13] 'We can put that in [the patient's] chart and put that as the rationale.' [S5]

Table 1. (*Continued*)

Theme	n (%)	Explanation	Quotes [staff (S) ID]
Support from senior staff	6 (46%)	Participants stated that if they were to be able to undertake this intervention, support from management and senior staff would be required to ensure that protected time is given for CCC sessions	'We need support from the senior nursing staff on the floor and the manager….'[S13]
			'Again, having like support from a senior level. So… to the medics, that's probably more the consultant." [S11]
			'Having support from the managers. For example, they're going to need to be given time out their shift to do this.' [S12]
			'We need to have the sessions [time] to talk about this.' [S5]
			'I think in terms of support having a supervisor that you could go to with any kind of issues that came up…' [S2]
			'It would be a fairly simple thing to implement provided you've got someone you can kind of go back to and refer to anything you're struggling with.' [S3]
Psychologists to model the intervention	3 (23%)	Participants highlighted the need for psychologists to be more present on wards to role model and legitimise the application of the CCC intervention	'Because obviously everyone's been trained in some psychological models but… they get deprioritised.' [S8]
			'You can't be outside and apply this if you want everyone to be on the same page, if you want this kind of culture… Psychologists on the ward in itself gives more credibility and weight to this kind of model, you know?' [S10]
			'It seems that when patients need psychology, they're sort of referred to psychology like it's some sort of external thing… It feels a bit separate.' [S9]

Expert patient and carer panel consultation

The patient and carer panel consisted of two expert patients and two expert carers (N = 4). The panel gave written feedback on the CCC model and what they thought would be important to consider when training staff in the CCC approach. Table 2 provides details of themes, explanations and illustrative quotes.

The 'Feedback on the CCC model' category consisted of the themes: 'Seeing the whole person' (n = 3), 'Bringing clarity to crisis' (n = 3) and 'Highlighting the role of emotion' (n = 3). These themes reflected the panel's views that the CCC model supports viewing patients holistically as people beyond diagnoses and as possessing personal strengths. Participants felt that the CCC model helped in making sense of crises by disentangling crises and bringing clear understanding to feeling states that are normally difficult to comprehend. Participants noted that the CCC model acknowledged the role of powerful emotions in the experience of crises and how these emotions can prevent the individual in crisis from thinking more rationally about their situation.

The 'Feedback on MDT staff training' category consisted of the themes 'Emphasising the need to understand patient experience' (n = 4) and 'Promoting compassion and empathy' (n = 4). The panel highlighted the importance of a training session focusing on connecting with and understanding patients' experiences and what led them to the crisis they have found themselves in. The panel thought it important to ensure that staff training promotes active listening skills to ensure that patients feel heard during the intervention, as well as supporting staff to be able to undertake the intervention with compassion and empathy.

Discussion

The present study aimed to undertake a qualitative exploration of patient, carer and ward staff perspectives on the CCC model to inform the development of a CCC training programme for MDT staff. Staff participants and the expert patient and carer panel felt that CCC is a useful approach to working with crisis and saw value in its holistic and non-labelling framework. Both staff participants and the panel welcomed the CCC model and the idea of a CCC training for MDT staff, with staff participants feeling that they would be able to undertake the intervention with the right support. Staff, patients and carers shared views on what would be important to include when developing a CCC training programme. In particular, findings indicate the importance of a CCC training programme supporting staff confidence in delivering CCC, providing opportunities for staff to practice psychological skills, for staff to receive prompts such as a list of 'cycle breaks' to use in practice, and to support empathic and compassionate understanding of patient experience. Additionally, the findings suggest the importance of embedding CCC into the culture of wards, integrating CCC with standard care planning procedures, and legitimising CCC practice

Table 2. Themes from patient and carer panel feedback on the single-session CCC intervention (N = 4)

Theme	n (%)	Explanation	**Quotes** [carer (C)/patient (P) ID]
Feedback on the model			
Seeing the whole person	3 (75%)	The panel stated that the CCC model would encourage clinicians to look past labels and medical conceptualisations to see the patient as a whole person with strengths that are key to solving their crisis	'Rather than focusing on being unwell, patients are given agency to work with their own insights towards their own self-selected goals.' [C2]
			'An understanding of background and context would benefit ward staff.' [P1]
			'It will prevent them from thinking 'Oh, yet another condition I have' and prevents them from feeling labelled and stuck-in-a-box… The stuck feeling is removed' [P2]
			'[It] could help patients contextualise what they're going through to offer themselves understanding and compassion… a 'no wonder why' type feeling.' [P2]
			'I particularly like the focus on strengths... so that patients can feel empowered. It could make someone feel like they are more in control.' [P2]
Bringing clarity to crisis	3 (75%)	The panel praised the CCC model for being simple, without sacrificing its usefulness and capacity to validate patients' experiences	'It helps disentangle the 'messiness' of the mind that happens in crisis… It also helps with validating the patient's experience, making them feel like their problems are important and are taking time to be dealt through.' [P2]
			'I see the merits of the model for… raising awareness of the causes of distress… the positive effects of exploring strengths… to break these cycles.' [C2]
			'This approach is an effective and accurate way to address people in distress.' [P1]
Highlighting the role of emotion	3 (75%)	The panel saw the CCC model as acknowledging the powerful role of emotion, and attempts at coping with it, as key to understanding crisis	'Emotions can be more powerful, and lead to breakdowns in societal norms that cannot be understood by reasoning and rationality.' [P1]
			'Talking to those in a highly emotional state means that they can't take the message in until they feel a sense of calm.' [C1]
			'…Activating the 'Reasonable Mind' of the patient [would] help them cope with the experience and think of ways to 'hold' their crisis without drowning in it.' [P2]
Feedback on MDT staff training			
Emphasising the need to understand patient experience	4 (100%)	Focusing on connecting and hearing, not just listening to, patients should be key when training staff to collaboratively working through the model with patients	'To train staff on the 'importance of active listening'. Staff need to understand how to really listen to the patients. So much is said but so often not enough is heard, and this would result in being frustrating for patients and detrimental to the success [of the intervention].' [C1]
			'Really try to understand what they have gone through in the past. They'd probably want you to know that this is how their lives have been and continue to hurt them. It's important to feel like your experiences are seen…' [P2]
			'An [important] understanding within the staff would be that the rational mind cannot always be in control, and reasoning will not always make a difference.' [P1]
			'[Staff need to understand] they are facilitators, not controllers.' [C1]
Promoting compassion and empathy	4 (100%)	The panel felt it important for staff to deliver the model with compassion and empathy	'Help them to treat the patient with more of an informed view, and help them empathise.' [P1]
			'[Staff] will need empathy and compassion.' [C1]
			'Ward staff would then get a fuller experience of what it's like to be this person, what has made the patient how they are today, and its influence on their presenting crisis.' [P2]
			'Sensitivity to the level of support each individual needs at that particular time of their life [will be important].' [C2]

through the support of senior staff and the presence of psychologists if wishing to implement the CCC approach in inpatient services.

Findings of the present study suggest that staff, patients and carers hold multi-layered perspectives on the acceptability of the CCC intervention in acute inpatient settings; psychological approaches that look beyond diagnostic labels; training acute and crisis staff in delivering psychological interventions; and how CCC can be successfully implemented in acute inpatient services. CCC was seen as well-suited to and fulfilling the needs of patients in inpatient settings. These perspectives are consistent with previous research indicating high levels of intervention uptake and programme fidelity of CCC in inpatient settings (Araci & Clarke 2017; Riches et al. 2020; Bullock et al. 2021). The findings of the current study deepen understandings of why CCC has previously been found to be highly acceptable to both patients receiving the intervention and inpatient staff delivering the intervention, despite the changeable atmosphere of ward environments. Indeed, inpatient wards are highly spontaneous and emotive environments that do not naturally create a psychologically 'safe' backdrop conducive to psychotherapeutic intervention; inpatient wards have been noted by patients as environments where alcohol and drug use, theft of personal belongings, violence, intimidation and bullying and experiences of racism are common (Jones et al. 2010). Research has highlighted the importance patients in acute care settings place on their relationships with clinical staff and the wider symbolic relationship they have with acute services themselves, with these relationships determining whether an inpatient ward is experienced as a 'safe' or 'unsafe' place (Muir-Cochrane et al. 2013). Despite the importance of these relationships, clinical staff are often seen to be too busy to talk with patients (Stenhouse 2010).

The CCC model was viewed by participants as offering a compassionate approach to supporting patients in making sense of their crises. These findings indicate that CCC sessions might fit with what patients in inpatient services want and need: opportunities to talk with staff about their difficulties and to feel heard. By meeting these needs, it is likely that CCC sessions will in turn strengthen therapeutic relationships between patients and MDT staff by providing structured opportunities for these needs to be met. In addition to these relationships, patient involvement in treatment plans has also been cited as a main area of concern for patients in inpatient settings (Walsh & Boyle 2009). It was found that participants thought CCC sessions could be integrated into standardised care planning practices. As the CCC formulation is developed collaboratively with patients, this would enable inpatients to have greater input into their treatment plans. This is particularly important to consider as patients often experience a loss of voice at various transition points during their time with acute inpatient services (Wright et al. 2016). Integrating CCC sessions into care planning procedures could therefore support patients in feeling empowered and as having a more active role in the care they receive in inpatient services. Overall, the perspectives offered by staff, patients and carers in the present study are well-aligned with the emotional, relational and decision-making needs expressed by patients in inpatient settings.

The non-diagnostic and contextual understanding of crisis offered by CCC was seen as empowering and validating of patient experience. Similar views on psychological formulation have been shared by numerous clinicians, researchers, and patients more broadly, with the process of diagnosing mental 'illness' seen as resulting in a 'loss of meaning' (Johnstone 2017). Although a topic of much debate, diagnosis has been highlighted as disempowering people through locating vulnerabilities and problems within them, ignoring important social and contextual factors showing their crisis to be a normal and understandable reaction to difficult circumstances (Watson 2019). Indeed, the patient and carer panel emphasised the importance of the contextual understandings of crisis facilitated by the CCC approach.

Psychological formulation has been proposed as an alternative to psychiatric diagnosis, as a route to overcoming the limitations of the medical model (Johnstone 2017). In line with this, both staff participants and the patient and carer panel saw the CCC model as offering a flexible and compassionate psychological approach to supporting patients in inpatient settings to make sense of crisis in a way that overcomes some of the difficulties that may arise through diagnostic approaches. This has previously been highlighted by the developer of the CCC approach (Clarke & Nicholls 2017; Clarke 2021). Patient and carer perspectives that CCC sessions would be helpful in supporting patients to make sense of their crises (beyond labels) suggests that the CCC approach fits with a need for patients to understand their situation and hospitalisation. This has previously been shown to be important for patient satisfaction in inpatient settings (Woodward et al. 2017).

CCC was also recognised by the patient and carer panel as identifying the important role of emotion in crisis. It is possible that this prioritisation of emotion resonated with patients and carers in the panel in a way that it did not with staff participants. CCC may therefore promote inpatient staff to proactively focus on the emotional experiences of patients in crisis and their individual situations. Research has demonstrated that psychosocial understandings of psychological difficulties increase clinicians' empathy for patients' distress; knowing patients as individuals has been suggested as the key factor in

fostering this empathy and preventing dehumanisation (Lebowitz & Ahn 2014). In contrast, relying solely on diagnostic classifications to understand psychological problems has been suggested to increase a sense of difference between clinicians and patients (Corrigan 2007; Shrank et al. 2015). For example, certain diagnoses, such as borderline personality disorder, can be particularly stigmatised by clinicians, and such stigma responses have been found to impact a clinician's perceptions of a patient by creating an emotional distance and a disregard for the patient's strengths (Aviram et al. 2006; Gedara et al. 2021; McDonald et al. 2021). As suggested by staff participants, and the patient and carer panel, CCC may therefore encourage greater compassion and empathic engagement from staff by helping staff to look beyond labels and consider the emotional worlds of patients. This in turn will likely promote the development of stronger staff–patient relationships.

The patient and carer panel emphasised the importance of CCC training fostering compassionate ways of delivering the intervention that would support patients in feeling understood, whereas MDT staff focused on more practical suggestions on what to include. Research has demonstrated similar disparities between patient and staff perspectives on the therapeutic needs of patients on inpatient wards, with patients prioritising understanding their difficulties within their unique contexts along with reducing distress, compared to staff priorities relating to symptom reduction (Wood et al. 2019). It will therefore be important for a CCC training programme to balance patient, carer and staff perspectives to ensure that teamwide delivery of CCC sessions fits with the needs and values of patients whilst also meeting the needs of staff.

Implementation of Comprehend, Cope and Connect training for ward staff

The findings of the present study can be used to inform the design of a CCC training for MDT ward staff. A potential framework for designing CCC training could involve training components centred on each component of CCC; separate 'comprehend', 'cope' and 'connect' components. Patient, carer and staff perspectives obtained in the present study should be used to inform each component along with formats previously used by Isabel Clarke to design training in CCC (http://www.isabelclarke.org/clinical/manuals.shtml).

Training should be delivered by psychology teams and should involve input from patients who have experienced the intervention. Based on themes such as 'Seeing the whole person', 'Beyond labels' and 'Bringing clarity to crisis', supporting staff in developing competencies in helping patients and staff teams to 'Comprehend' would involve an introduction to the concept of psychological formulation and then to the CCC approach to formulation. This should include psychoeducation on psychological crisis, introduction to the ICS-informed CCC model, and space for staff to reflect on the role of context and circumstance in the development of crises. The CCC model should be introduced in a similar fashion to that presented by Bullock et al. (2021), simplifying the model into its constituent parts step-by-step to facilitate staff understanding. As outlined by Bullock et al. (2021) these steps can be described ordinally beginning with: (1) a place of 'Horrible feelings'; followed by (2) identifying recent 'Triggering events'; (3) relevant 'Difficult life experiences'; and (4) 'Strengths and resources' to be drawn on; following this, (5) 'Maintaining cycles'; along with (6) appropriate 'Cycle breaks', can be identified; and (7) translated into 'Goals' for intervention.

According to the staff participants' 'Developing confidence' theme in the present study, it will be important to devote space to building participants' confidence in CCC as an efficacious intervention. The model should be introduced along with relevant evidence to promote confidence in staff that the underlying theory of CCC was developed through empirical research. Training could also include the feedback obtained from the present study on how patients, carers and staff participants perceived the CCC model. This could draw on the 'Benefits of the CCC model' category of themes from the present study, including how the model was viewed by all participants as encouraging understanding crises beyond labels in a holistic manner with the patient centred in their care. Staff attending the training session should be given a space to reflect on why this is important for patients and how meeting patients from a place of emotion will be important for staff–patient relationships ('Highlighting the role of emotion').

In line with staff perspectives on 'Learning and practicing psychological skills', opportunities to role-play and practice formulating using case examples would be important for staff developing their personal confidence in their ability to undertake a CCC formulation with a patient. A 'cope' component should build upon the knowledge and skills developed in the 'comprehend' component. This should focus on training in various skill-based cycle-breaking interventions, along with the theory underlying their mechanisms of change (e.g. diaphragmatic breathing; Ma et al. 2017).

The 'cope' component should outline that CCC is an integrative approach that allows clinicians to draw on a variety of psychological approaches to inform intervention. Training on appropriate skills-based interventions from relevant psychological approaches such as CBT and DBT should be provided. This should include a variety of emotion regulation strategies and mindfulness techniques,

with mindfulness being a core intervention of CCC and having proved to be useful in a cross-diagnostic capacity (Clarke & Nicholls et al. 2017; Baer 2007). Emphasis should be placed on how interventions must be aimed at breaking the maintaining cycles that are identified through the CCC formulation, and how these will provide patients with alternative helpful ways of coping that can take the place of maladaptive coping strategies. Staff participants in the study expressed that provision of a list of cycle break interventions would be useful for staff in undertaking CCC sessions. Resources could be provided to staff that can be taken away from the training session, such as a list of examples of cycle break interventions. Such resources could be referred to in later CCC delivery and could draw on evidence which has sought to examine links between various maladaptive coping strategies (e.g. avoidance, rumination) and specific psychological problems (e.g. anxiety, depression; Aldao et al. 2010). By outlining common attempts at coping with 'Horrible feelings' and associated psychological difficulties, staff will have a resource which they can use to guide their clinical decision-making of which interventions to draw upon in CCC sessions. However, emphasis should be given on thinking creatively and flexibly, with CCC being a formulation-driven intervention based on individual and unique circumstances, with any list to act as a prompt for clinical decision-making.

With 'Support from senior staff', use of clinical supervision of CCC sessions should be an additional focus of the 'cope' component, with training participants given information on how to use supervision as a space to reflect on appropriate clinical directions for CCC sessions with specific patients. A 'connect' component will provide an opportunity for patient and carer perspectives on potential CCC training to be voiced explicitly to staff, for staff to understand how patients wished to be worked with when using a CCC approach. The patient and carer panel in the study voiced a need for an active listening component to a CCC training, to ensure that staff can listen authentically to patients and help patients to feel heard. This 'connect' component should therefore focus on skills such as active listening and through 'Emphasising the need to understand patient experience', with opportunities for practicing relevant skills through role-playing of clinical scenarios. These role-plays, which were suggested as important to include by participants in the current study, should link to previous training components to support staff in developing skills learned in the programme.

The 'connect' component should involve presenting to staff the findings from the present study and previous research demonstrating the differing priorities patients and staff may have when approaching psychological distress. This should include discussing the importance of the role of emotion in crisis, as outlined by the patient and carer panel in the present study. It will be of interest to discuss other areas of difference, such as the patient and carer panel highlighting the need for compassion in contrast to staff participants thinking more practically. Linking the level of current distress and severity of reaction to the accessibility of past threat when 'Emotion Mind' takes over will be important for fostering greater staff compassion. This should be aimed at supporting staff to consider how staff and patient priorities can differ more generally and what this might mean for their clinical practice. 'Promoting compassion and empathy' will be important to discuss with staff, along with discussion around therapeutic relationships.

Self-care for staff should also be incorporated into the training; staff will be best able to connect and work compassionately with patients if they are taking good care of themselves. Indeed, levels of emotional exhaustion and compassion fatigue have been found to be negatively associated with more favourable attitudes towards patients with more severe psychological difficulties (Koutra et al. 2021). Patient involvement in delivering this component will likely be important for increasing the depth of staff learning and development.

The perspectives offered by patients, carers and staff indicate that training staff to deliver the CCC intervention would require several structured training sessions to ensure that the training addresses the therapeutic needs of patients and the clinical development needs of staff. A previous trial of training qualified and unqualified ward staff in cognitive behavioural interventions observed that training was carried out across at least four sessions and intensively over several days, with this training structure receiving positive feedback (McCann & Bowers 2005). In contrast, an online 'bitesize' modular staff-support training programme for training ward staff in DBT skills was delivered less intensively with shorter durations (15–20 minutes in length), receiving positive feedback from training participants (Riches et al. 2021).

A CCC training programme is likely to benefit from a modular structure with separate training sessions based on each component (comprehend, cope and connect). Adapting the number and length of training sessions (e.g. brief or 'bitesize') based on service needs may allow for greater participation opportunities for staff in busy ward settings, where participation in training may be restricted by time and resource-related pressures on staff. The success of delivering the workshops to staff online via Microsoft Teams in the present study, due to the Covid-19 pandemic, suggests that delivering the training online could be feasible. Online delivery of CCC training may increase flexibility of delivery and opportunities for participation for staff across different wards or in various locations.

Integration of Comprehend, Cope and Connect within ward culture

Staff provided insights into what would be required for CCC to be successfully integrated into the standard practices of a ward following training. This provides several ideas to be considered more broadly by services intending to implement a CCC approach. Staff particularly emphasised the need for CCC to be embedded into the culture of the ward. Previous research has demonstrated the key role of ward culture in facilitating or obstructing the implementation of new approaches to care (Johansson et al. 2014) and how discussion of ward culture is often an important step in practice development (Wilson et al. 2005). This suggests it would be important to identify, understand, and work with staff in implementing CCC through a bottom-up approach, in fitting with the concept of creating a 'culture of therapy' (Clarke 2015; Clarke & Wilson 2008). According to the perspectives given in the current study, this process is likely to involve CCC being integrated into standard care practices, such as care planning.

Top-down efforts, such as having support from senior staff and role modelling of CCC by psychologists were also cited as important by participants. Support from ward managers, effective leadership, and supervision have previously found to be key facilitators of implementation for cognitive behavioural, family, and conflict resolution interventions on wards (Bailey et al. 2003; McCann & Bowers 2005; Lyons et al. 2021). In line with what staff participants communicated in the current study, previous research has shown ward staff to feel that such leadership needs to take place on wards themselves as opposed to being driven by more distantly located healthcare managers (Lyons et al. 2021). Indeed, a feasibility study of a ward-based psychological intervention identified senior clinical and managerial support as key factors in successful intervention delivery (Raphael et al. 2021b).

Several of the findings in the present study overlap with a recent systematic review which identified facilitators and barriers of implementing psychological interventions in inpatient settings (Evlat et al. 2021). Facilitators of successful implementation included opportunities for staff to observe and cofacilitate the delivery of psychological therapies alongside psychologists, training on the delivery of psychological interventions, and collaborative treatment or care planning. Other facilitators fit with specific aspects of the single-session adaptation of CCC itself, such as the capacity of interventions to be standalone, whether they target the immediate crisis instead of reducing 'symptoms', and whether the amount of material can match acute presentations. Conversely, several identified barriers to implementing delivery of psychological approaches by ward staff included a lack of appropriate resources and lack of training, and factors such as beliefs within a ward culture that talking with patients about their difficulties can make them worse rather than lead to improvement. These findings are consistent with the findings of the present study, and further highlight the importance of the method of implementation of CCC training and provision in inpatient settings. In particular, it will be important for MDT staff trained to deliver CCC to be able to work alongside psychologists in order for the intervention to be role modelled and legitimised, with appropriate support from senior managerial staff and the resources provided to enable staff to deliver the intervention. Group supervision will be an important resource for ensuring adherence and fidelity to the model. Patient formulation diagrams can be closely monitored when brought to supervision.

Working closely with psychologists, and attending individual and group supervision, will provide good governance structures that will allow staff to move beyond the delivery of manualised, skills-based interventions and towards formulation-driven approaches. An important aspect to the role for psychologists supervising these staff, particularly when staff are more junior, will be to address the potential gaps in knowledge, skills, and experience. The findings of this study highlight how important it will be for such supervisors to focus on and develop staff confidence as part of this process.

Strengths and limitations

A major strength of this study is the rich and detailed qualitative data that has come from the semi-structured consultation groups and patient and carer panel feedback. These findings can explicitly inform the design of future training that would meet the needs of staff intending to deliver the intervention, along with such training matching the values of patients and carers. This will therefore enable staff training in CCC to be explicitly informed by patients and carers, thus promoting the co-production of more psychologically-informed acute and crisis services should they adopt the CCC model (Kvæl et al. 2019). Additionally, insights provided by staff participants inform which factors might be relevant for CCC being successfully implemented into ward cultures as a routinely offered psychological intervention. These findings will therefore support future endeavours in delivering training in psychological approaches to staff in acute and crisis services, thus supporting broader aims of developing more psychologically-informed services (Araci & Clarke 2016).

A further strength of the study was the range of professions represented by the participants. It is likely that the participants' views on the CCC model itself will reflect to some extent opinions of consensus within their respective

professions, which will also inform approaches to training in psychological approaches such as the CCC approach.

One potential limitation is that all participants were from a single inner-city London hospital, thus limiting generalisability of the findings. Inpatient wards are known to have their own organisational cultures (Duxbury et al. 2006) and vary in how they are structured by their respective trusts or funding bodies (i.e. in the case of private hospitals). It is therefore possible that what might constitute a barrier to the implementation of psychological approaches in one ward might look very different in another.

Another limitation is the relatively small sample size, which may bring into question the representativeness of the perspectives offered. Although the staff consultation groups were in line with recommendations for qualitative studies (Guest et al. 2016), the patient and carer panel consisted of only two patients and two carers. Psychological difficulties are highly person-specific (Allen et al. 2014) and may not be represented by the panel members' experiences. Additionally, patients and carers may hold a diversity of views towards understanding psychological difficulties and what it takes to recover from them (Jacob et al. 2015). The perspectives offered by the patient and carer panel may therefore not reflect the diversity of experiences within patient and carer populations.

Furthermore, demographic data relating to participant racial and cultural background were not collected. Different cultural groups may have differing understandings and conceptualisations of psychological distress and how it should be coped with (Hwang et al. 2008). Additionally, the role of family members as carers for those experiencing psychological difficulties and the level of family involvement also differs across cultures (Snowden 2007). Due to not recording the cultural backgrounds of staff participants in the study or the patient and carer panel, it is difficult to know the extent to which the perspectives offered by participants in the study on the CCC model may extend cross-culturally. This has implications for attempting to ensure that a CCC training programme for MDT staff is appropriate for patients of a diversity of cultural backgrounds.

Future evaluations

Future clinical evaluations or research aiming to better understand patient and carer perspectives on the CCC approach or other CCC adaptations would benefit from including a greater sized sample of patients and carers who may be at different stages in their relationship to their difficulties. Participants from a diverse range of cultural backgrounds should be recruited to gain an understanding of how perspectives on the CCC model and what should be included in a CCC training programme might differ between patients, carers and MDT staff who identify with different cultural groups.

Future research should involve evaluating multidisciplinary delivery of CCC. This should involve applying the findings of the present study to the planning a CCC training for MDT staff in acute and crisis services, as based on the findings and recommendations of the current study. This training should then be delivered to a sample of MDT staff and evaluated based on staff feedback using methods such as interviews and self-report questionnaires. Following the refining of such a training, subsequent work could involve investigating the acceptability and feasibility of MDT staff delivering CCC interventions, independently or in collaboration with psychologists, similar to the design of Bullock et al. (2020). This should involve recruiting a sample of a range of different multidisciplinary clinicians working in acute and crisis services who have been trained to deliver CCC interventions and a sample of patients who would wish to consent to participating in CCC sessions for the purpose of a research study. Pre- and post-intervention data could be collected to learn about the efficacy of the intervention as delivered by multidisciplinary clinicians (as opposed to psychologists). Variables of interest may include the efficacy of CCC interventions, ability of staff to identify and intervene with maintaining cycles, fidelity to the intervention, and patient engagement and feedback on CCC sessions. Other variables of interest might involve the impact of CCC on the frequency of violent incidences by patients in ward settings and the use of restrictive practices by staff. Qualitative data such as clinician and patient feedback of their experiences of delivering or participating in the intervention could be collected to further develop understandings of what would be important for implementing CCC delivery in a teamwide approach to inform future service development, delivery, and evaluation.

Following investigation of whether it is acceptable and feasible for MDT staff to deliver CCC sessions, the implementation of a teamwide CCC approach itself could be assessed and explored. It will be important to investigate using both qualitative and quantitative methods to gain an understanding of the frequency of CCC session delivery, staff perceptions of how CCC fits within their service, and what factors facilitate or interrupt successful implementation of CCC as a service model. A similar methodology to Araci and Clarke's (2017) feasibility study of CCC-related teamwide interventions should be adopted.

Other future directions might also involve further research into patterns of dysfunctional coping strategies that might be utilised by people experiencing psychological crises in inpatient settings. This research could draw on literature which has already sought to identify patterns

of unhelpful coping, such as the Power Threat Meaning Framework (Johnstone & Boyle 2018), and investigate whether such identifiable patterns are employed by patients in inpatient settings. This research could form the basis of further work to explore the efficacy of specific interventions (e.g. brief mindfulness training) targeted at specific patterns of unhelpful coping strategies. This would support the development of resources for MDT staff to guide which types of intervention would be appropriate for specific patterns of coping, as requested by the participants in the present study.

Conclusion

This study indicates that the prospect of a CCC training programme was received positively by staff participants and the patient and carer panel. Findings of the present study inform the development of a CCC training programme for MDT inpatient staff and suggest subsequent avenues for investigating the efficacy of CCC sessions delivered by MDT staff.

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References

Emotion-regulation strategies across psychopathology: a meta-analytic review. *Clinical Psychology Reviews*, 30(2): 217–237. https://doi.org/10.1016/j.cpr.2009.11.004

Allen, J., Balfour, R., Bell, R. and Marmot, M. (2014) Social determinants of mental health. *International Review of Psychiatry*, 26(4): 392–407. https://doi.org/10.3109/09540261.2014.928270

Araci, D. and Clarke, I. (2017) Investigating the efficacy of a whole team, psychologically informed, acute mental health service approach. *Journal of Mental Health*, 26(4): 307–311. https://doi.org/10.3109/09638237.2016.1139065

Aviram, R.B., Brodsky, B.S. and Stanley, B. (2006) Borderline personality disorder, stigma, and treatment implications. *Harvard Review of Psychiatry*, 14(5): 249–256. https://doi.org/10.1080/10673220600975121

Baer, R. (2007) Mindfulness, assessment, and transdiagnostic processes. *Psychological Inquiry*, 18(4): 238–242. https://doi.org/10.1080/10478400701598306

Bailey, R., Burbach, F. and Lea, S. (2003) The ability of staff trained in family interventions to implement the approach in routine clinical practice. *Journal of Mental Health*, 12(2): 131–141. https://doi.org/10.1080/0963823031000010344 3

Barnard, P.J. and Teasdale, J.D. (1991) Interacting cognitive subsystems: a systemic approach to cognitive-affective interaction and change. *Cognition & Emotion*, 5(1): 1–39. https://doi.org/10.1080/02699939108411021

Bentall, R.P., Jackson, H.F. and Pilgrim, D. (1988) Abandoning the concept of 'schizophrenia': some implications of validity arguments for psychological research into psychotic phenomena. *British Journal of Clinical Psychology*, 27(4): 303–324. https://doi.org/10.1111/j.2044-8260.1988.tb00795.x

Braun, V. and Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3: 77–101. https://doi.org/10.1191/1478088706qp063oa

Bullock, J., Whiteley, C., Moakes, K., Clarke, I. and Riches, S. (2021) Single-session Comprehend, Cope, and Connect intervention in acute and crisis psychology: a feasibility and acceptability study. *Clinical Psychology & Psychotherapy*, 28(1): 219–225. https://doi.org/10.1002/cpp.2505

Clarke, I. (1999) Cognitive therapy and serious mental illness: an interacting cognitive subsystems approach. *Clinical Psychology & Psychotherapy*, 6(5): 375–383. https://doi.org/10.1002/(SICI)1099-0879(199911)6:53.0.CO;2-C

Clarke, I. (2015) The emotion focused formulation approach: bridging individual and team formulation. *Clinical Psychology Forum*, 275: 28–32. https://doi.org/10.53841/bpscpf.2015.1.275.28

Clarke, I. (2021) *Meeting mental breakdown mindfully: How to help the Comprehend, Cope and Connect way*. Routledge. https://doi.org/10.4324/9781003081616

Clarke, I. and Nicholls, H. (2017) *Third wave CBT integration for individuals and teams: Comprehend, cope and connect*. Routledge. https://doi.org/10.4324/9781315281292

Clarke, I. and Wilson, H. (2008) *Cognitive behaviour therapy for acute inpatient mental health units: Working with clients, staff and the milieu*. Routledge. https://doi.org/10.4324/9780203596845

Corrigan, P.W. (2007) How clinical diagnosis might exacerbate the stigma of mental illness. *Social Work*, 52(1): 31–39. https://doi.org/10.1093/sw/52.1.31

Corrigan, P.W., Kwartarini, W.Y. and Pramana, W. (1992) Staff perception of barriers to behavior therapy at a psychiatric hospital. *Behavior Modification*, 16(1): 132–144. https://doi.org/10.1177/01454455920161007

Curran, R., Hignett, R., Fisher, H.L. and Riches, S. (2022) Psychiatric ward staff experience of working with patients who hear voices and their views on voice simulation training: a qualitative study, *Journal of Psychiatric Intensive Care*, 18(2): 69–82. https://doi.org/10.20299/jpi.2022.009

Durrant, C. and Tolland, A. (2008) Evaluating short-term CBT in an acute adult inpatient unit. In Clarke, I., Wilson, H. (eds) *Cognitive behaviour therapy for acute inpatient mental health units: Working with clients, staff and the milieu*. Routledge. https://doi.org/10.4324/9780203596845

Durrant, C., Clarke, I., Tolland, A. and Wilson, H. (2007) Designing a CBT service for an acute inpatient setting: a pilot evaluation study. *Clinical Psychology & Psychotherapy*, 14(2): 117–125. https://doi.org/10.1002/cpp.516

Duxbury, J., Bjorkdahl, A. and Johnson, S. (2006) Ward culture and atmosphere. In Richter, D., Whittington, R. (eds) *Violence in mental health settings*. Springer. https://doi.org/10.1007/978-0-387-33965-8

Ebrahim, S. (2021) Psychologists' perspectives on the contribution of psychology to acute adult mental health inpatient, crisis response home treatment and mental health liaison services. *Journal of Mental Health*, 31(5): 666–672. https://doi.org/10.1080/09638237.2021.1875410

Eviat, G., Wood, L. and 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

Gedara, C., Harpur, R., Jakobsen, H. and Riches, S. (2021) Staff attitudes towards service users with a diagnosis of a personality disorder on acute psychiatric wards. *Clinical Psychology Forum*, 344: 41–46. https://doi.org/10.53841/bpscpf.2021.1.344.41

Guest, G., Namey, E. and McKenna, K. (2017) How many focus groups are enough? Building an evidence base for nonprobability sample sizes. *Field Methods*, 29: 3–22. https://doi.org/10.1177/1525822X16639015

Huffman, J.C., DuBois, C.M., Healy, B.C., Boehm, J.K., Kashdan, T.B., Celano, C.M. and Lyubomirsky, S. (2014) Feasibility and utility of positive psychology exercises for suicidal inpatients. *General Hospital Psychiatry*, 36(1): 88–94. https://doi.org/10.1016/j.genhosppsych.2013.10.006

Hwang, W.-C., Myers, H., Abe-Kim, J. and Ting, J. (2008) A conceptual paradigm for understanding culture's impact on mental health: the cultural influences on mental health (CIMH) model. *Clinical Psychology Review*, 28(2): 211–227. https://doi.org/10.1016/j.cpr.2007.05.001

Jacob, S., Munro, I. and Taylor, B.J. (2015) Mental health recovery: lived experience of consumers, carers and nurses. *Contemporary Nurse*, 50(1): 1–13. https://doi.org/10.1080/10376178.2015.1012040

Johansson, C., Åstrom, S., Kauffeldt, A., Helldin, L. and Carlstrom, E. (2014) Culture as a predictor of resistance to change: a study of competing values in a psychiatric nursing context. *Health Policy*, 114(2–3): 156–162. https://doi.org/10.1016/j.healthpol.2013.07.014

Johnstone, L. (2017) Psychological formulation as an alternative to psychiatric diagnosis. *Journal of Humanistic Psychology*, 58(1): 30–46. https://doi.org/10.1177/0022167817722230

Johnstone, L. and Boyle, M. (2018) The Power Threat Meaning Framework: an alternative nondiagnostic conceptual system. *Journal of Humanistic Psychology*. https://doi.org/10.1177/0022167818793289

Jones, J., Nolan, P., Bowers, L., Simpson, A., Whittington, R., Hackney, D. and Bhui, K. (2010) Psychiatric wards: places of safety? *Journal of Psychiatric & Mental Health Nursing*, 17(2): 124–130. https://doi.org/10.1111/j.1365-2850.2009.01482.x

Koutra, K., Mavroeides, G. and Triliva, S. (2021) Mental health professionals' attitudes towards people with severe mental illness: are they related to professional quality of life? *Community Mental Health Journal*, 58: 701–712. https://doi.org/10.1007/s10597-021-00874-x

Kouvaras, S., Gulotto, M., Schrank, B., Slade, M. and Riches, S. (2022) Character strength-focused positive psychotherapy on acute psychiatric wards: a feasibility and acceptability study. *Psychiatric Services*, 73(9): 1051–1055. https://doi.org/10.1176/appi.ps.202100316

Kramarz, E., Lyles, S., Fisher, H. and Riches, S. (2020) Staff experience of delivering clinical care on acute psychiatric wards for service users who hear voices: a qualitative study. *Psychosis*, 13(1): 58–64. https://doi.org/10.1080/17522439.2020.1781234

Kvæl, L., Debesay, J., Bye, A., Langaas, A. and Bergland, A. (2019) Choice, voice, and coproduction in intermediate care: exploring geriatric patients' and their relatives' perspectives on patient participation. *SAGE Open*, 9(3): 1–13. https://doi.org/10.1177/2158244019876318

Lebowitz, M.S., and Ahn, W.-K. (2014) Effects of biological explanations for mental disorders on clinicians' empathy. *Proceedings of the National Academy of Sciences*, 111(50): 17786–17790. https://doi.org/10.1073/pnas.1414058111

Linehan, M. (1993) *Skills training manual for treating borderline personality disorder.* Guildford Press.

Lyons, O., Forbat, L., Menson, E., Chisholm, J.C., Pryde, K., Conlin, S., Felton, V., Ingle, S., McKenzie, C., Ramachandran, R., Sayer, C., Snowball, C., Strachan-Gadsby, E., Tisovszky, N. and Barclay, S. (2021) Transforming training into practice with the conflict management framework: a mixed methods study. *BMJ Paediatrics Open*, 5(1): e001088. https://doi.org/10.1136/bmjpo-2021-001088

Ma, X., Yue, Z.-Q., Gong, Z.-Q., Zhang, H., Duan, N.-Y., Shi, Y.-T., Wei, G.-X. and Li, Y.-F. (2017) The effect of diaphragmatic breathing on attention, negative affect and stress in healthy adults. *Frontiers in Psychology*, 8: 874. https://doi.org/10.3389/fpsyg.2017.00874

McCann, E. and Bowers, L. (2005) Training in cognitive behavioural interventions on acute psychiatric inpatient wards. *Journal of Psychiatric and Mental Health Nursing*, 12(2): 215–222. https://doi.org/10.1111/j.1365-2850.2004.00822.x

McDonald, C., Seaman-Thornton, F., Mok, C.L.M., Jakobsen, H. and Riches, S. (2021) Impact on staff attitudes of brief personality disorder training for acute psychiatric wards. *Mental Health Review Journal*, 27(1): 89–99. https://doi.org/10.1108/MHRJ-09-2020-0066

Mueller, D., Schmidt, S. and Roder, V. (2013) Integrated psychological therapy: effectiveness in schizophrenia inpatient settings related to patients' age. *The American Journal of Geriatric Psychiatry*, 21: 231–241. https://doi.org/10.1016/j.jagp.2012.12.011

Muir-Cochrane, E., Oster, C., Grotto, J., Gerace, A. and Jones, J. (2013) The inpatient psychiatric unit as both a safe and unsafe place: implications for absconding. *International Journal of Mental Health Nursing*, 22(4): 304–312. https://doi.org/10.1111/j.1447-0349.2012.00873.x

NHS (2019) *The NHS long term plan*. National Health Service, UK. https://www.longtermplan.nhs.uk/

NICE (2014) *Psychosis and schizophrenia in adults: treatment and management*. CG178, National Institute for Health and Care Excellence. https://www.nice.org.uk/guidance/cg178

NICE (2020) *Rehabilitation for adults with complex psychosis*. NG181, National Institute for Health and Care Excellence. https://www.nice.org.uk/guidance/ng181

Owen, M., Sellwood, W., Kari, S., Murray, J. and Sarsam, M. (2015) Group CBT for psychosis: a longitudinal, controlled trial with inpatients. *Behaviour Research & Therapy*, 65: 76–85. https://doi.org/10.1016/j.brat.2014.12.008

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

Peterson, B.L. (2017) Thematic analysis/interpretive thematic analysis. In Matthes, J., Davis, C., Potter, R. (eds) *The international encyclopedia of communication research methods*. Wiley-Blackwell. https://doi.org/10.1002/9781118901731.iecrm0249

Phiri, P., Clarke, I., Baxter, L., Elliot, K., Rathod, S and Naeem, F. (2021) Culture free CBT for diverse groups. In Irtelli, F., Marchesi, B., Durbano, F. (eds) *Psychoanalysis*. IntechOpen. https://doi.org/10.5772/intechopen.93904

Raphael, J., Hutchinson, T., Haddock, G., Emsley, R., Bucci, S., Lovell, K., Edge, D., Price, O., Udachina, A., Day, C., Peak, C., Drake, R and Berry, K. (2021a) A study on the feasibility of delivering a psychologically informed ward-based intervention on an acute mental health ward. *Clinical Psychology & Psychotherapy*, 28(6): 1587–1597. https://doi.org/10.1002/cpp.2597

Raphael, J., Price, O., Hartley, S., Haddock, G., Bucci, S. and Berry, K. (2021b) Overcoming barriers to implementing ward-based psychosocial interventions in acute inpatient mental health settings: a meta-synthesis. *International Journal of Nursing Studies*, 115: 103870. https://doi.org/10.1016/j.ijnurstu.2021.103870

Riches, S., Csehi, R., Steer, N., Azevedo, L., Vasile, R. and Lokhande, M. (2020) Video call-based psychological therapy for inpatients during the Covid-19 lockdown. *Cyberpsychology Bulletin*, 3: 2–3.

Riches, S., Azevedo, L., Steer, N., Nicholson, S., Vasile, R., Lyles, S., Csehi, R., Fialho, C., Waheed, S. and Lokhande, M. (2021) Brief videoconference-based dialectical behaviour therapy skills training for Covid-19-related stress in acute and crisis psychiatric staff. *Clinical Psychology Forum*, 337: 57–62. https://doi.org/10.53841/bpscpf.2021.1.337.57

Schefft, C., Guhn, A., Brakemeier, E. L., Sterzer, P. and Kohler, S. (2019) Efficacy of inpatient psychotherapy for major depressive disorder: a meta-analysis of controlled trials. *Acta Psychiatrica Scandinavica*, 139(4): 322–335. https://doi.org/10.1111/acps.12995

Schramm, E., Schneider, D., Zobel, I., van Calker, D., Dykierek, P., Kech, S., Harter, M. and Berger, M. (2008) Efficacy of interpersonal psychotherapy plus pharmacotherapy in chronically depressed inpatients. *Journal of Affective Disorders*, 109(1–2): 65–73. https://doi.org/10.1016/j.jad.2007.10.013

Schrank, B., Brownell, T., Riches, S., Chevalier, A., Jakaite, Z., Larkin, C., Lawrence, V. and Slade, M. (2015) Staff views on wellbeing for themselves and for service users. *Journal of Mental Health*, 24(1): 48–53. https://doi.org/10.3109/09638237.2014.998804

Small, C., Pistrang, N., Huddy, V. and Williams, C. (2018) Individual psychological therapy in an acute inpatient setting: service user and psychologist perspectives. *Psychology & Psychotherapy: Theory, Research & Practice*, 91(4), 417–433. https://doi.org/10.1111/papt.12169

Snowden, L.R. (2007) Explaining mental health treatment disparities: ethnic and cultural differences in family involvement. *Culture, Medicine & Psychiatry*, 31(3): 389–402. https://doi.org/10.1007/s11013-007-9057-z

Stenhouse, R. C. (2011) 'They all said you could come and speak to us': patients' expectations and experiences of help on an acute psychiatric inpatient ward. *Journal of Psychiatric & Mental Health Nursing*, 18(1): 74–80. https://doi.org/10.1111/j.1365-2850.2010.01645.x

Tebbett-Mock, A.A., Saito, E., McGee, M., Woloszyn, P. and Venuti, M. (2020) Efficacy of dialectical behavior therapy versus treatment as usual for acute-care inpatient adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*, 59(1): 149–156. https://doi.org/10.1016/j.jaac.2019.01.020

Thornicroft, G. and Tansella, M. (2005) Growing recognition of the importance of service user involvement in mental health service planning and evaluation. *Epidemiology & Psychiatric Sciences*, 14(1): 1–3. https://doi.org/10.1017/s1121189x00001858

Walsh, J. and Boyle, J. (2009) Improving acute psychiatric hospital services according to inpatient experiences. A user-led piece of research as a means to empowerment. *Issues in Mental Health Nursing*, 30(1): 31–38. https://doi.org/10.1080/01612840802500733

Watson, J. (2019) *Drop the disorder! Challenging the culture of psychiatric diagnosis*. PCCS Books.

Williams, G., Hann, P. and Riches, S. (2022) Co-produced positive psychotherapy for acute psychiatric ward patients and staff: an evaluation of feasibility and acceptability. *Journal of Psychiatric Intensive Care*. 18(2): 101–106. https://doi.org/10.20299/jpi.2022.010

Wilson, V.J., McCormack, B.G. and Ives, G. (2005) Understanding the workplace culture of a special care nursery. *Journal of Advanced Nursing*, 50(1): 27–38. https://doi.org/10.1111/j.1365-2648.2004.03346.x

Wood, L., Williams, C. and Johnson, S. (2019) Psychologists' perspectives on the implementation of psychological therapy for psychosis in the acute psychiatric inpatient setting. *Qualitative Health Research*, 29, 14: 2048–2056. https://doi.org/10.1177/1049732319843499

Woodward, S., Berry, K. and Bucci, S. (2017) A systematic review of factors associated with service user satisfaction with psychiatric inpatient services. *Journal of Psychiatric Research*, 92: 81–93. https://doi.org/10.1016/j.jpsychires.2017.03.020

Wright, N., Rowley, E., Chopra, A., Gregoriou, K. and Waring, J. (2016) From admission to discharge in mental health services: a qualitative analysis of service user involvement. *Health Expect*, 19(2): 367–376. https://doi.org/10.1111/hex.12361