Training in cognitive behavioural interventions on acute psychiatric inpatient wards

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Abstract

There has been a drive towards addressing the types of care and therapeutic interventions available to people with serious mental illness, which is reflected in the latest government mental health policy initiatives. Recent evidence strongly supports the implementation of psychological and social interventions for people with psychosis, and in particular the use of cognitive behavioural techniques. Until now, the main focus has been on people living in the community. This study examines the delivery of psychosocial interventions training to qualified psychiatric nurses and unqualified staff on seven acute psychiatric admission wards in London, UK. The approach had the strength of on-site delivery, follow-up role modelling of the interventions and clinical supervision. Despite this, in some cases the training was less successful, mainly because of staffing and leadership weaknesses. The impact of training in these methods and the implications for mental health education and practice development are discussed.

Keywords: cognitive behavioural interventions, psychiatric inpatients, psychiatric nursing education, psychosis, schizophrenia

Introduction

Schizophrenia is a serious, often lifelong and disabling mental illness. It strikes roughly one in a hundred people at some point during their lives (Kaplan 1992) and 1.6% of the entire NHS health care budget is spent on treating the illness (Davies & Drummond 1994). Along with the radical change in social policy in the last decade and the focus on caring for people in the community, the government has recommended strategies to improve the provision of care and treatment for this client group (Department of Health 1995, Department of Health 1999a,b). Despite these initiatives, the types of therapeutic interventions available to patients on acute psychiatric wards remain problematic. The Sainsbury Centre conducted a survey investigating quality of care in acute psychiatric wards. Over two hun- dred patients were followed throughout their stay on an acute ward. Investigators recorded how people were admitted, what treatment they received and how they were dis- charged. Ten key factors for the effectiveness and efficiency of acute care were identified and they concluded and recommended training in evidence-based practice for all clin- ical staff (The Sainsbury Centre for Mental Health 1998). Moreover, a later document outlined key capability skills that would be necessary for mental health practitioners to effectively deliver quality care related to the Government's National Service Framework for Mental Health (The Sains- bury Centre for Mental Health 2001). Even more recently, the National Institute for Clinical Excellence (2002) were explicit in their guidelines that all people with a diagnosis of schizophrenia should be offered cognitive behavioural interventions.

Traditionally, the main mode of treatment is medication. However, up to 40% of people with schizophrenia will relapse on medication (Johnson *et al*. 1987). Many people will continue to experience hallucinations and delusions (Curson *et al*. 1988, Kuipers *et al*. 1997). Furthermore, neuroleptic drugs can also produce unpleasant side effects which may drive recipients to cease taking medication alto- gether (Barnes & McPhillips 1999).

Of those people who continue to be affected by the ill- ness, some remain fairly well between episodes and may manage to work and continue with a reasonably fulfilling life in the community. However stressful events in their daily lives are likely to cause relapse and a resurgence of acute symptoms (Nuechterlein & Dawson 1984). Relapse often necessitates admission to hospital, primarily to main- tain the person in a safe environment and for treatment, which typically involves high doses of medication. Others have symptoms all of the time, although they tend to fluc- tuate in frequency, intensity and duration, with exacerba- tions prompted by stress (Tarrier *et al*. 1990). The permanent presence of symptoms may lead to serious social disability, and people at this end of the spectrum may need supported accommodation, specialist day care and daily help with self-care.

Among the most prominent symptoms of acute schizo- phrenia are delusions and hallucinations. If deluded, the individual may entertain strange beliefs with great convic- tion. If hallucinated, the person may hear voices that rein- force their delusional beliefs, or cause distress by berating and criticizing them. Each relapse the person suffers makes more tenuous their place within their social networks out- side of hospital. Long periods off work because of illness can lead to loss of a job. A long period in hospital can weaken ties with friends.

As a result of these issues, a range of complimentary approaches, often seen as adjuncts to pharmacological treatments, have been proposed. These include: control of auditory input (Birchwood *et al*. 1989); cognitive modifi- cation (Chadwick & Lowe 1990); enhancement of coping strategies (Tarrier *et al*. 1993). Other psychosocial methods include: early intervention strategies (McGorry *et al*. 1996, Birchwood & Jackson 2001); family interventions (Bar- rowclough & Tarrier 1997, Fadden 1998) and compliance therapy (Kemp *et al*. 1996).

Psychosocial interventions in schizophrenia

Up until the 1980s, the most effective treatment to reduce symptoms and the risk of relapse has been treatment with neuroleptic drugs. Although these drugs can make a sig- nificant improvement to the patients' lives, they do have unpalatable side effects, and the need to take them for many years leads to a degree of resentment, sometimes even rejection by patients. Several strands of research have made a significant difference to this picture, demonstrating that psychological and social interventions can reduce symp- toms and relapse too. Although it is unlikely that these treatment methods will replace medication, they do consti- tute a method of delivering significant additional benefits to patients in an adjunctive way.

The first strand of research demonstrating that this was possible focused on the family care environment. The illness of a family member with schizophrenia, and the perceived burden of care, can cause great stress and many potential misunderstandings (Brown & Rutter 1966, Vaughn & Leff 1976, Leff *et al.* 1985). In some families this leads to hos- tility and criticism of the ill person, and the additional stress generated by this causes more frequent relapses (Lam 1991). Research has shown that education of families about schizophrenia, combined with training in how to manage the many daily difficulties presented by living with a suf- ferer, can reduce the risk of relapse by up to a third (Leff *et al.* 1982, Falloon *et al.* 1984, Tarrier *et al.* 1989).

Later research successfully applied existing cognitive behavioural therapy techniques to the management of reduction of the symptoms of schizophrenia. This research showed that the intensity with which delusional beliefs were held, and the disruption caused by hallucinations could be reduced through a form of verbal questioning, belief modification, and experimental reality testing (Chadwick & Lowe 1990, Chadwick & Birchwood 1994, Had- dock & Tarrier 1998, Tarrier *et al.* 1998).

Education and training

These new methods, often called together ‘psychosocial interventions’, are being incorporated into community psychiatric nursing practice very rapidly (McCann 2001). Specialist courses have commenced in the UK, initially sponsored by the Jules Thorn charitable trust and known as ‘Thorn Courses’. Practitioners from various mental health disciplines can acquire specialist therapeutic skills in the management and care of people who are seriously men- tally ill, their families and carers. The main course com- ponents are: assertive case management, family work, psychological management and integrated approaches to care. Participants are encouraged to foster reflective, research based and evaluative approaches to practice. Research from medical, social and psychological perspectives is integrated with the experiences of users to develop person-centred approaches combined with techniques of cognitive behavioural therapy. These training courses have been evaluated and are known to have a beneficial impact upon the patients of those nurses and other mental health professionals who receive training (Brooker *et al*. 1994, Lancashire *et al*. 1997).

Application to acute psychiatric wards

The success of cognitive behavioural therapy in reducing psychotic symptoms of patients living in the community prompted researchers to test whether similar methods could be of benefit on in patient wards. A series of studies have now shown that these interventions can have a sig- nificant impact upon patients who have been admitted with a relapse of schizophrenia. Not only is there a beneficial impact upon the central acute symptoms, but that the effect generalizes to other symptoms of the illness. The overall impact is that, depending upon the definition used, cognitive behavioural therapy is associated with a 25–50% reduction in recovery time (Drury *et al*. 1996a,b). Up until now, these methods have been used primarily by psychologists and researchers who have seen patients on acute wards

(Nelson 1997). However there is a significant oppor- tunity for nurses to incorporate these techniques into the overall care of patients on their wards.

Practice development through on-site training

Given this context and these research developments, the time was considered ripe for an application and incorporation of these methods into acute inpatient psychiatric nursing practice. It was for this reason that in 1999 the Foundation of Nursing Studies, the Tompkins Trust, and City University agreed together to fund a 3-year project to develop the practice and skills of inpatient nurses in this area. It was hoped that this would lead to improvements in acute psychiatric care through the provision of a theoretical and practical framework for nurses' therapeutic interactions with patients. Additionally, because of the previously quoted research, it was hoped that the deployment of these interventions by nurses would have an effective role in the promotion of rapid recovery from acute psychotic episodes. Over the 3 years of the project, attempts were made to engage with, and develop practice on seven wards in three separate hospitals. Senior managers were first contacted, and the project explained to them. Once their support and permission were obtained, the managers holding responsi- bility immediately above the ward managers were consulted, then the ward managers on the site brought in, resulting in a number of wards volunteering to participate. A steering group was formed which included representatives from each area: clinical, research and education. Two wards were engaged with the project at any one time. Once these wards were identified, the Lecturer/Researcher (EM) would spend some time working on those wards, meeting with the staff, and explaining to them the nature, content and purpose of the project. Once the team were known and thoroughly committed to the project, training sessions would be organized on site, dates and venues set, and a programme of educational development rolled out. With those wards where the educational programme was completed, the Lecturer/Researcher then

worked once per week with staff on the ward, providing supervision and role modelling the application of the intervention techniques taught.

Training content and evaluation

The educational package was developed and delivered at three staged levels (Tennant & Hughes 1997): applicator, technician and specialist. The most basic applicator level of training was delivered to all staff on a ward, both qualified and unqualified, and included: development of psychological interventions for psychosis; the vulnerability/stress model and model of reflective practice; the engagement process; psychological and social assessments; coping strategies; medication compliance issues; and working with families and carers. Technician training was delivered to qualified staff only, and involved therapeutic strategies including motivational interviewing and creative ways of working with voices and thoughts. Specialist training was seen in terms of the development through *in vivo* supervision and practice involving one or two members of the ward team who were particularly enthusiastic and talented. The divisions between these three levels of training were not always rigorously upheld, as a result of pressure of circumstances, more details on which are provided below. The content also proved to be over ambitious at times, and was scaled back in the light of experience as the project continued. Training was delivered on site, either on the ward itself or nearby. The Trusts involved generously donated their staff time, and training was held during the afternoons. If staff stayed on beyond their rostered hours, they reclaimed their time at a later date. Because of the necessity of covering nursing duties on the ward with sufficient staff, many of the sessions were run repeatedly with small numbers of attendees. This ensured that there were many opportunities for all staff to attend.

At the outset it was hoped that the project could be evaluated via the comparison of wards where

staff received the training and supervision package, and those that did not. For a number of practical and ethical reasons, this proved to be impossible. Individual feedback took place at the end of each session. More substantial evaluation tools were utilized at the end of the training and involved structured and semi-structured questionnaires. All of the participants had an extremely positive experience and rated *strongly agree* or *agree* to 13 statements about the learning that took place. Overall, the feedback was very encouraging. All of the participants seemed to enjoy the learning experience and gained much from the sessions. The facilitator noted how the group developed over time and how people appeared more comfortable about sharing their own work within the group. The group as a cohesive unit were able to problem-solve clinical issues pertaining to their own work. One thing that did stand out was the valuable contributions made by the two members who were unqualified staff. They appeared to relish the opportunity to be part of the learning experience.

Judging from the individual feedback, staff involved in working in acute mental health settings found the training beneficial and important to their work with people with serious and enduring mental health problems. The training involved qualified and unqualified staff. This seemed to work very well and as the training progressed, participants spoke of having a greater understanding and appreciation of one another's roles within the team. Any issues that emerged were explored in a safe way within the group through careful and sensitive facilitation.

In this paper we provide a description of the seven wards where the project team engaged with the ward staff and delivered training. All were acute, sectorized general psychiatric wards, with similar staffing establishments, located within three different hospitals in the London area, UK. Table 1 summarizes how the wards responded to training, based upon the observations of the first author, and from information systematically gained through the feedback and evaluation of the participants. In addition, the Lecturer/Researcher kept a

reflective journal through- out the process and this was used in project development within the research team at the University. In all seven cases initial engagement with the project was enthusiastic, especially at middle manager and ward manager levels. Follow- ing a process of working alongside staff, frontline workers also expressed that enthusiasm. However difficulties eventually emerged with some wards. In three cases this was immediately the training started, in another when training was completed, and in yet another after a period of post- training supervision. In two out of the seven cases training and supervision was completed, with continuing use of the therapeutic methods taught. Valuable lessons have been learned from this process, both in its successes and its failures, and these have key implications for policy development in acute inpatient psychiatric nursing care.

Discussion

The two keys to enabling practice development in psycho- social intervention on acute psychiatric wards appear, in our experience, to be:

- effective leadership and management; and
- sufficient and stable staffing of the ward

The above factors have been evident in other practice development projects and have been documented in the literature (Lancashire *et al*. 1997, Fadden 1998, Leff *et al*. 2001). At the most fundamental level, effective manage- ment and leadership means that training can be organized and staff will attend. In addition, in these circumstances staff will be more motivated to work together as a team to implement the training and improve their practice. The importance of effective ward leadership is becoming more well recognized, and there are now leadership development programmes for ward managers in operation at many UK locations (Cunningham & Kitson 2000a,b, Cook 2001). Our experience in this project underlines just how critical these programmes are to successful improvement of care in acute psychiatry.

Effective ward management is unlikely to be present in the absence of effective middle management. Ward managers themselves need to be supported, supervised and led by their own line managers. If this is absent, they have no effective organization to fall back on or to rely upon. In this situation a ward manager is likely to feel isolated and powerless to effect meaningful change, therefore despite having a strong wish to see their ward improve, they may feel completely unable to make that happen when offered an out- side training resource. It can only be concluded therefore that good management across acute psychiatry is a prereq- uisite for good quality care, and specifically for practice development programmes.

Staffing was the other major factor that determined the successful engagement of wards with the training in psychosocial interventions. All the wards described here were in London Hospitals. Many had problems both recruiting to their establishment figures, and if they achieved them, in keeping staff in post. Some were more successful than others. In those that were failing, there was a reliance on temporary staff and a high turnover. These factors added to the general sense of instability and disorganization on a ward, and handicapped any efforts to make anything other than basic care happen. With few staff, it is more difficult to release

anyone for training, and those that do manage to attend find it difficult to psychologically disengage from the demands of the ward. In one case, as has been described, following huge investment in training, all the qualified staff left to other jobs, and the ward returned to its starting position. Where there is a high and rapid turn- over of staff, any investment in change evaporates swiftly, and eventually vanishing completely in a short space of time. In these circumstances, it is perhaps better to concentrate on equipping staff with usable skills during their basic nurse training, so that they can use them from the moment they arrive as qualified staff on an acute psychiatric ward.

It would appear that these two factors, effective leader- ship and stable staffing, often seem to go together. Staff drift to and stay on successful wards, because they are more comfortable and fulfilling to work on. This type of ward was where practice development functioned best, staff attended training, and stayed on in order to implement it in their daily work with patients. The consequence of this bifurcation between wards is that the good wards get even better with practice development activity, whilst the poorly functioning wards remain unimproved. It is difficult to see how this could be altered.

It therefore seems impossible to use training in psycho- social interventions to remedy the difficulties that some wards have with leadership and staffing. Training in psychosocial interventions can only benefit wards that constitute fertile ground. Those that are the equivalent of a windswept, stormy desert, need some other form of intervention to turn them round. This rule is likely to hold for the new Nurse Consultants who have been appointed to this area, and who have been charged with developing psychiatric nursing practice. They too are likely to find that they can work most effectively only with those wards that fulfil essential staffing and leadership requirements.

The responsiveness of unqualified nurses to this training opportunity was very marked. This was possibly because exposure to any training in psychiatry was a novelty, and possibly

because the training gave them a way to release some of their pent up frustrations with the limitations of their role and their lack of knowledge. It was very clear that there were many excellent and committed unqualified staff working on the wards. They represent an opportunity to recruit good calibre, experienced individuals into nurse training, as well as being a resource that can be used to rap- idly improve acute psychiatric care via investment in education.

Generally speaking, the qualified nursing staff were more jaundiced about the training offered as part of this practice development initiative, with rather less enthusiasm demonstrated overall. During *in vivo* role modelling and in subsequent supervision sessions, it often proved harder to engage qualified staff in structured therapeutic interactions with patients. Low levels of nurse–patient interaction have been reported in many pieces of descriptive research over the years (Altschul 1972, Cormack 1976, Higgins 1998, Sainsbury Centre for Mental Health and Mental Health Act Commission 1997). Although it was sometimes the administrative duties of qualified staff that made it harder for them to spend therapeutic time with patients, it was not consistently the case. This can feel, to the person trying to develop practice, like reluctance or some form of inertia. We were unable to come to a definitive conclusion about the reasons for this.

Conclusions

Overall, important lessons have been gleaned from the project. We recognize the strengths of the project in locally deploying and delivering training to all staff on the wards. This must be more advantageous, and can only have more chance of making a direct impact on patient care than sending small numbers, perhaps less than one per ward, on longer term academic courses at external academic institutions. Additionally, practitioners can encounter problems when they return to the ward and attempt to practise advanced skills. A recent example of

this would be the reported experiences of Thorn Graduates who attempt to continue to deliver a range of psychosocial interventions in the community (Gamble 1997, Leff *et al*. 2001). In the case of this programme, on the spot supervision was available to nurture the skills into practice. However, in some instances, the joint problems of staffing stability and leadership issues presented challenges to this practice development project. At this point, we are unable to say how typical of acute care were the problems we identified, however, it is possible that they are quite widespread. In future, it would be useful to conduct a more systematic evaluation of the interventions. It would be beneficial to carry out a comparison study between two or more wards and use measures to discover whether or not the interventions have any impact upon recovery and perhaps length of stay. It would also be helpful to hear the views and opinions of service users who were receiving the interventions. Nevertheless, important information has been gained from this study in terms of staff training needs and satisfaction with the delivery of these innovative therapeutic approaches.

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