

Rapid Recovery from Acute Psychosis

Keywords:

Schizophrenia, psychosis, cognitive behavioural therapy, acute psychiatric care, practice development

Duration of project:

April 1999 – April 2002

Report received for publication: June 2002

Project leaders:

Len Bowers, Professor of Psychiatric Nursing
Eddie McCann, Lecturer/Practitioner

Contact details:

Department of Mental Health
City University
London
E1 2EA
Email: L.Bowers@city.ac.uk or
e.j.p.mccann@city.ac.uk

Summary of project

This project focused on promoting rapid recovery for patients with acute psychosis by developing practice in acute psychiatric wards. There is growing evidence to suggest that psychological treatments can be complementary or even offer an alternative to traditional medical treatments for patients with schizophrenia and other serious mental illnesses. More recent evidence strongly supports the implementation of psychological and social interventions for people with psychosis, and in particular the use of cognitive behavioural techniques. Mental health nurses are developing the knowledge and skills to use these new approaches to caring for people with serious and enduring mental illnesses, but until now implementation of treatment like cognitive behavioural therapy (CBT) has been with people living in the community. This project explored the introduction of CBT to acute psychiatric inpatient care. The report provides detail of the development of a training programme, together with insights into the complexities of developing and changing practice.

Background

Schizophrenia is normally treated with neuroleptic drugs, and although 70% of patients show improvement, many still experience distressing and recurrent psychotic symptoms (Curson, Patel and Liddle, 1988). In a community survey, 47% of patients continued to experience persistent psychotic symptoms despite conventional neuroleptic drugs (Harrow and Silverstein, 1977). The newer 'atypical' antipsychotic medications appear to have fewer extrapyramidal symptoms. However, they still carry the risk of unwanted effects such as sedation, dysphoria, sexual dysfunction, weight gain, endocrine effects, autonomic and cardiovascular effects, anticholinergic effects and seizures, as well as extrapyramidal problems (Barnes and McPhillips, 1999). As a result, patients may be reluctant to accept drug treatments and some may even wish to stop taking medication altogether.

Treating a person with a psychosis can be extremely complex due to the range of difficulties, disorders and disabilities associated with the illness. For example, many patients have deficits in attention, concentration, short-term memory, motivation, planning, decision-making, and sense of pleasure (Sharma, 1999). Problems with unemployment, social isolation, healthcare and family dependency abound. There may also be chronic disabilities related to self-care, socialisation and work capacity (Haddock and Tarrier, 1998). Other problems encountered by people with psychotic illness include depression, anxiety and suicide. It has been proposed, that in order to address the heterogeneity of schizophrenia, a system of care is required which includes pharmacological and psychosocial treatment approaches.

Psychosocial treatments for schizophrenia take many shapes, all relying on interpersonal interaction for therapeutic gain (Birchwood and Tarrier, 1992). The 'new wave' of psychological treatment approaches

FOLDS

developed in the last decade have targeted people with enduring mental health needs. CBT is one such technique being used in the management of psychosis. This structured approach aims to reduce the distress and disability associated with residual psychotic symptoms, reduce emotional disturbance and promote the individual's active participation in preventing relapse and social disability (Fowler, Garety and Kuipers, 1995; Nelson, 1997).

Mental health nurses have taken the opportunity to learn these new approaches to caring for people with enduring mental illnesses, although until now the main focus has been on people living in the community. This project explored the introduction of these methods to acute psychiatric inpatient care. The project ran for three years: April 1999 – April 2002, and was located in North and East London.

Practice development implementation

The project was composed of two key activities; the development of a suitable training package and the establishment of a programme to deliver training and support to ward nursing teams.

The training package on cognitive behavioural techniques was devised for the preparation of inpatient psychiatric nurses, both qualified and unqualified. The package was devised to include three levels of skill (Tennant and Hughes, 1997). The most basic 'applicator level' of training was for delivery to all ward staff, both qualified and unqualified. It included the development of psychological interventions for psychosis; the vulnerability/stress model and a model of reflective practice; the engagement process; psychological and social assessments; coping strategies; medication compliance issues; and working with families and carers. 'Technician level' training was for delivery to qualified staff only, and involved therapeutic strategies, including motivational interviewing and creative ways of working with voices and thoughts. 'Specialist level' 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 plan was to deliver this training 'on site' to ward nursing teams, on an overlapping sequential basis. The implementation pattern is shown in box 1:

Box 1: Implementation Pattern

Negotiating with senior managers: Meetings were initiated with consultants, managers and the heads of each professional group to inform them about the project and gain their support.

Seeking support of ward managers: Several meetings were held with the ward managers to explain the training and its advantages, leading them in most cases to volunteer to participate.

Engaging staff through working with them on the ward: The project worker spent several shifts on the wards before starting the training, so as to become familiar to the staff on the ward and explain the rationale and benefits of the training.

Delivering the training on-site: This was done either on the ward itself or nearby. Sessions were repeated several times to allow all staff to attend. Staff attending outside normal shift hours were allowed to take the time back at a later date.

Follow-up: On-site supervision and role modelling was provided by the project worker, either via the working of shifts and demonstrating the skills, or via timetabled supervisory sessions on both a group and individual basis.

This model of implementation was felt to have several strengths: training was accessible to staff; there were clear links with practice; it allowed the development of an alliance between practitioners and trainer; it enabled follow-up support to ensure the taught material became embedded in practice. The training package was delivered to the staff of seven acute inpatient wards.

Outcomes

Despite the careful engagement with all those involved, on-site training, and supervisory support, in some cases the training failed to take hold. Only two out of the seven wards trained continued to use the material taught. In three wards, despite managers and staff making a positive commitment to the project, the ward manager either failed to secure venues for the training, or failed to allocate their staff to training sessions, or organise the off duty rota so that this was possible. In all three of these cases, attempts to resolve problems through offers of help, or through negotiation with senior managers, were a complete failure. On another ward, the training programme was completed successfully, but all qualified staff who had received the training left during the subsequent three months. This

led to failure to continue the intervention on the ward. In the last unsuccessful ward, participation in training was good, but the offer of follow-up supervision was refused, and as a result the outcome is unknown. On the wards where the training was positively received and successfully implemented, ward managers made a personal commitment to the project, organised their staff to attend, attended themselves, and facilitated the implementation of the skills taught. This success occurred within the context of a stable staff team and supportive managers.

So, in essence, staff on seven acute psychiatric wards have received intensive training and supervision in cognitive behavioural interventions for people with psychosis, although in only two cases did this continue beyond the project input. In many cases the staff have left to continue working in other areas of psychiatry, taking those skills with them and investing them elsewhere.

On reflection, the factors hindering the development of more advanced practice in acute psychiatric nursing were identified as:

- Unstable and/or inadequate staffing levels
- Weak or absent ward management
- Unpredictable crises on the wards, coupled with high staff anxiety
- Weak middle management control, leadership, support and target- setting for wards

Conclusion

Important lessons have been learnt which are critical to the success of further projects, both research and practice development. It is clear that successful changes to nursing on acute psychiatric wards require stable staffing and good leadership as a prerequisite. Without that being in place, training or practice development cannot be effectively engaged with, let alone implemented. Future quasi-experimental studies of acute psychiatric care should select their samples from wards that meet these criteria, or run the risk of failing to deploy interventions or collect outcome data. Adjustments have been made to several forthcoming studies at City University to take these factors into account. A further, and somewhat depressing, implication of these findings is that practice development can only produce effective change on wards that are already functioning at a reasonably good level.

These lessons are also important for the work of Consultant Nurses, many of whom are expected to develop the practice of psychiatric nurses working in hospital settings. The findings of this work suggest that they should carefully target their time to areas that are ready for change and development in nursing care. Perhaps practice development initiatives increase the difference in the quality of care provided on different psychiatric wards by helping the good to become better. If care is to be improved overall, great attention also needs to be given to the attraction, selective recruitment, and leadership training of ward managers.

As a result of this project and in response to substantial demand from healthcare service providers for training of staff in CBT, a curriculum has been devised and validated by City University, and a formal training course was initiated during 2001.

References

- Birchwood, M. and Tarrier, N. (1992) *Innovations in the psychological management of schizophrenia*. Chichester: Wiley.
- Barnes, T.R.E. and McPhillips, M.A. (1999) Critical analysis and comparison of the side effect and safety profiles of new antipsychotics. *British Journal of Psychiatry*. Vol. 174. Supplement. 38. pp 38-43.
- Curson, D.A., Patel, M. and Liddle, P.F. (1988) Psychiatric morbidity of a long-stay hospital population with chronic schizophrenia and implications for future community care. *British Medical Journal*. Vol. 297. pp 819-822.
- Fowler, D., Garety, P. and Kuipers, E. (1984) *Cognitive behavioural therapy for psychosis*. Chichester: Wiley.
- Haddock, G. and Tarrier, N. (1998) Assessment and formulation in the cognitive behavioural treatment of psychosis. In N. Tarrier, A. Wells & G. Haddock (Eds), *Treating complex cases the cognitive behavioural therapy approach*. pp 155-163. Chichester: Wiley.
- Harrow, M. and Silverstein, M. (1977) Psychotic symptoms in schizophrenia after the acute phase. *Schizophrenia Bulletin*. Vol. 3. pp 608-616.
- Nelson, H.E. (1997) *Cognitive behavioural therapy with schizophrenia: a practice manual*. Cheltenham: Stanley Thomas (Publishers) Ltd.
- Sharma, T. (1999) Cognitive effects of conventional and atypical antipsychotics in schizophrenia. *British Journal of Psychiatry*. Vol. 174. Supplement. 38. pp 44-51.
- Tennant, A., and Hughes, G. (1997) Issues in nursing care for patients with severe personality disorders. *Mental Health Practice*. Vol. 1. No. 1. pp 10-16.

Further Reading

A copy of the original full report: Bowers, L. and McCann, E. (2002) *The Promotion of Rapid Recovery from Acute Psychotic Episodes: the application of recent research findings to the practice of psychiatric nursing on acute wards*. Report to the Foundation of Nursing Studies and the Tompkins Foundation. London: City University can be obtained from the website:

http://www.city.ac.uk/barts/research/reports/pdf/bowers_/Rapid.pdf

McCann, E. (2001) Recent developments in psychosocial interventions for people with psychosis, *Issues in Mental Health Nursing* 22 (1): 99-107

Bowers, L. (2001) Conflict and containment in Psychiatric Nursing. 7th Network for Psychiatric Nursing Research Conference, Oxford, 27/9/01.

Bowers, L. (2002) Update on a five-year research programme. 21st Annual Nursing Research Conference, Royal College of Surgeons in Ireland, Dublin, 21/2/02.

Acknowledgements

To the Tompkins Foundation for funding the project.

To Mrs Elizabeth Tompkins for her interest and support throughout the project.

To the Foundation of Nursing Studies for funding the dissemination of the project.

How to reference this report

Bower, L. and McCann, E. (2003) Rapid Recovery from Acute Psychosis. In Shaw, T. and Sanders, K. (Eds) *Foundation of Nursing Studies Dissemination Series*. Vol.1. No. 6.

The Foundation of Nursing Studies Dissemination Series

ISSN 1478-4106

Editors: Theresa Shaw and Kate Sanders

32 Buckingham Palace Road

London SW1W 0RE

Tel: 020 7233 5750

Fax: 020 7233 5759

www.fons.org

Reg. Charity No 1071117