Using psychosocial interventions within a high-security hospital

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Psychosocial interventions have been used for many years in caring for people with mental health problems. The few interventions that have a recognised evidence base are cognitive behavioural therapy (CBT), family interventions, and education programmes for patients and carers. The process of implementing these interventions in a forensic setting will be described and recommendations will be made for future practice.

The State Hospital is a national resource for Scotland and Northern Ireland. It provides psychiatric care under conditions of special security and receives 50-60 admissions annually from other NHS facilities, prisons and the courts. The patients are considered likely to threaten themselves and others on account of their dangerous, violent or criminal propensities. The average age is 34, and about 70 per cent (n=169) of inpatients have a diagnosis of schizophrenia (Thomson et al, 2000). About 90 per cent of the patients are male. There are specialist services for female patients and also for patients with intellectual and developmental disabilities. On average, patients have had nine years of inpatient psychiatric care before admission to the State Hospital.

The advent of clinical governance, making clinicians more accountable for practice, alongside the introduction of mandatory clinical standards, for example *Clinical Standards for Schizophrenia* (Clinical Standards Board for Scotland (CSBS), 2001), have enforced changes in mental health practice. The drive to provide clinical practice based on sound evidence is becoming crucially important in our daily work and there is an increasing focus on adherence to guidelines. An example of how one of the guidelines for mental health, *Psychosocial Interventions in the Management of Schizophrenia*, (Scottish Inter-collegiate Guideline Network (SIGN), 1998) has been introduced into a forensic setting will be demonstrated.

**Treatment following diagnosis**

Despite antipsychotic medication being the recognised treatment of choice for patients with a diagnosis of schizophrenia, a substantial proportion of people remain troubled by symptoms (Roth and Fonagy, 1996). While medication remains central to treatment, pharmacological intervention alone is insufficient to help with the psychological and social impact of the illness on patients, their families and carers (Gillam, 2002). In the past decade there have been advances in the development of non-drug (psychosocial) interventions. Kane and McGlashan’s (1995) review of the treatment of patients with a diagnosis of schizophrenia confirmed psychosocial interventions (PSI) as integral components, rather than just worthy extras, in the management of this highly heterogeneous condition (Burns, 1997).

**Psychosocial interventions**

The SIGN document (SIGN, 1998) defines PSIs as ‘those interventions for which there exists firm evidence of effectiveness... (the term) does not aim to cover all of the wide range of PSIs which have been proposed as contributions to the management of schizophrenia’. In the SIGN guidelines, the PSIs that are recommended on the basis of having been systematically evaluated are:

- Educational programmes;
- Family interventions;
- CBT.

However, there are important interventions that would be regarded as ‘good practice’ when there is a diagnosis of schizophrenia, such as engagement, assessment, support and help with relationships and communication — that would not be included in a formal definition of PSI simply because they had not been evaluated rigorously. The contemporary evidence for the effectiveness of PSI has been comprehensively reviewed. See Padden (1997) for family work, Garety et al (2000) for CBT, and Atkinson et al (1996) for education programmes. However, caution is advised, despite the encouraging nature of this evidence, because it would be unwise to subscribe to it wholesale without some caveats. It should also be noted that the transfer of such research findings into routine service settings can be fraught with difficulty.

Three years ago The State Hospital funded a six-month research post to establish the means of introducing *Psychosocial Interventions in the Management of Schizophrenia*. This was the first guideline published by SIGN that focused on the adult mental health setting. The Department of Health equivalent is the National Institute for Clinical Excellence guideline: *Core Interventions in the Treatment and Management of Schizophrenia in Primary and Secondary Care* (2002).

**Methods**

An internal review was carried out over a six-month period. Contact was made with multidisciplinary team members from each of the 11 wards to establish baseline information about services within the hospital. Brief semi-structured interviews were carried out with
a number of carers (n=11) and patients (n=13) from the 11 wards. Essentially this was a means of eliciting views on the information people received about their illness from staff members within the hospital. All NHS trusts in Scotland with a mental health remit were contacted using formal and informal methods. Letters were sent to the nursing directors of each trust, and telephone calls were made to members of the Scottish Association for Mental Health – which is represented by people in every area in Scotland – as well as to members of the Scottish Forensic Network. Follow-up discussions with key personnel helped generate an overview of the current level of participation in PSIs. Trusts that were actively involved in the delivery of PSIs were visited, with the purpose of identifying good practice. A literature review was conducted to identify relevant published information on PSI for the management of patients with a diagnosis of schizophrenia. Several sources were used:

- Cochrane Schizophrenia Group (CSG);
- Clinical databases – PsychINFO (1985–2000);
- EMBASE (1980–2000);
- MEDLINE (1966–2000);
- CINAHL (1982–2000);
- SIGN guidelines reference list;
- Articles gathered via communication with authors.


Visits were made to key people (identified through the literature and by networking with colleagues) with specialist knowledge of PSIs. Various sources were contacted to identify information leaflets about schizophrenia that were suitable for use in the hospital, for example NHS Scotland (formerly Health Education Board Scotland), Scottish Association for Mental Health (SAMH), National Schizophrenia Fellowship (NSF), MIND and SANE. Pharmaceutical companies were also asked for their assistance to identify non-promotional literature.

Results

The main areas of need were as follows:

- More and better-trained staff – there is a shortage of staff trained in PSI (Tables 1–2 show the number of staff trained in 2000);
- There was minimal use of CBT for psychosis, probably related to a shortage of trained staff. At the time of the survey, multidisciplinary teams reported that 22 patients were receiving CBT for psychosis, out of 94 for whom this intervention was considered appropriate. No specific protocol for CBT was being followed at this time;
- There was a lack of educational provision for carers – relatives who took part in the survey expressed interest in obtaining more information about schizophrenia and were eager to take part in education sessions. Desired frequency for meetings varied from weekly or fortnightly to monthly. The suggested time for meetings was before or after visiting. There was a request for different health professionals to be available during education groups;
- A need for regular provision of educational programmes for patients was identified. A programme entitled ‘Coping with mental illness’ had been running since 1997. Although this had not been formally evaluated, feedback from people attending has been favourable;
- A need for one-to-one education programmes in addition to the group programme for patients was identified.

Many recommendations were made, which suggested methods for implementing the SIGN guidelines. The implications for practice were significant and it was evident that implementation would necessitate a measured approach given the resource implications. Despite this, many developments have taken place and the hospital now has a small yet growing service that provides two of the three recommended aspects of PSI.

Family interventions have been considered unmanageable to date, due to two main factors. First, there are no staff trained to deliver family interventions and second, research evidence suggests it is more effective if carried out in the family home.

If staff were to cover Scotland and Northern Ireland it would become resource intensive. However, it is important not to lose sight of this and reconsider this intervention at a later date.

Allocation of dedicated staff

One new clinical psychologist was employed to lead the PSI service. Two clinical nurse specialists were employed, one with a full-time remit to provide CBT for psychosis. The second was allocated to the education programmes for patients and carers and sessional CBT for half of the working week. The responsible medical officer who had developed and delivered the education programme for patients has continued the commitment on a sessional basis. In addition to core staff there is a pool of staff trained to deliver CBT for psychosis on a sessional basis, for example one or two sessions per week (Table 1).

### TABLE 1. STAFF IN THE STATE HOSPITAL DELIVERING CBT FOR PSYCHOSIS, BY DISCIPLINE

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Number of staff in 2000</th>
<th>Number of staff in 2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Occupational therapy</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Psychology</td>
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<td>11</td>
</tr>
<tr>
<td>Medical</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
<td>20</td>
</tr>
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### REFERENCES


This article has been double-blind peer-reviewed.

For related articles on this subject and links to relevant websites see [www.nursingtimes.net](http://www.nursingtimes.net)
Training

It has been necessary to send staff on training courses to increase the number who are competent to deliver CBT for psychosis. In the past three years five clinical nurse specialists, two ward staff and one forensic psychologist have been seconded to either of the following:

- A diploma in CBT at Dundee University;
- A postgraduate certificate in CBT at the South of Scotland Cognitive Therapy Course.

The course at Dundee requires a commitment of two days per week over a 10-month period, at the end of which it is possible to gain a diploma. This is known as ‘fast-track’ training. It is also possible to complete the course at the slower pace of one day per week over two years. The diploma can be upgraded to a master’s degree in CBT if a further year is completed.

The South of Scotland course has recently gained accreditation to certificate level. The commitment for this course is one day per week for a 10-month period. Trainees wishing to upgrade to diploma level are required to complete a second year.

The psychoeducation programme for patients was delivered only in group format up until 2000. Discussions with patients and key staff during the review of services highlighted the need to deliver it on a one-to-one basis. This was specifically for people who were unable to attend a group because they felt ‘too paranoid’ or ‘too anxious’. For this reason throughout 2002 and 2003, in-house training has been provided for five ward staff, one clinical nurse specialist and one consultant nurse to deliver the programme on a one-to-one basis.

On average it is possible to train three staff per year. Further training to develop group work skills is required for the ward staff if they are to consider delivering the programme in the group format. Having staff trained on the wards allows more flexibility in the delivery of the programme. The plan is to continue to train staff until there are at least two members able to deliver this intervention on each of the wards.

The group of four staff delivering the education programmes for carers (one consultant psychiatrist, one clinical nurse specialist, one social worker and one consultant nurse) have a wealth of experience in delivering groups of this kind, but have not yet had the opportunity to train others. The group programme is still in its infancy, having only been delivered on three occasions. Attention will be focused on refining the programme before encouraging the involvement of others.

Supervision

An external consultant (psychologist) was employed on a sessional basis to oversee the introduction and development of PSI. The consultant also provides monthly group supervision for all staff delivering CBT for psychosis. Another external supervisor was employed on a sessional basis to oversee the development of the education programmes for patients and carers.

Fortnightly supervision is now provided by existing ward psychologists for all staff who deliver CBT for psychosis. Supervision is also available for ward staff who are trained in the education programmes through the clinical nurse specialist who delivers the service to the group. This is essentially provided on an ad hoc basis.

A steering group was set up to ensure the entire PSI programme was coordinated. It was also important that good communication existed between the key people developing and delivering the service. The steering group includes leaders from CBT, education programmes, and external supervisors. Meetings are planned every two to three months.

Policy change

All clinical nurse specialists are required to gain a CBT qualification from either of the courses mentioned previously. They also have the option of becoming accredited with the British Association for Behavioural and Cognitive Psychotherapies (BABCP) within two years of completing the course. This is desirable but not essential.

Protocol development

A new protocol for the delivery of CBT for psychosis was developed specifically for patients in a forensic setting, because the existing protocols did not fully account for the special needs of this group. When developing the protocol key factors had to be considered, such as: this group being doubly stigmatised, having been identified as having mental disorder and offending behaviour; the presence of compulsory treatment procedures to follow, which sometimes made the development of a working alliance more difficult; and the high incidence of comorbidity, with many having a dual diagnosis of psychosis and personality disorder.

The protocol was formally piloted for a six-month period and amended in accordance with information gathered from patients and staff using it.

The existing protocol for the patients’ education programme was written up and is currently in the process of being updated.
rigorously evaluated. Many adaptations have been made to the original programme and it has now become a course called ‘Coping with Mental Illness’. It is a group psychoeducational programme consisting of 22 sessions over four modules:

- Module One. Foundation – basic knowledge of signs and symptoms of various mental illnesses, possible causes and models, such as ‘stress vulnerability’;
- Module Two. Living with mental illness – treatment, management and relapse prevention;
- Module Three. The legal system – the ‘ins and outs’ of The State Hospital;
- Module Four. Families and carers – difficulties in relating to others, looking at the impact on families.

A new protocol was developed for carers’ education, incorporating much of the same information that was in the patients’ course, but with a specific focus for carers. Carers are advised that the main aim of the programme is to offer an introduction to ‘Coping With Mental Illness’. It offers information on: legal aspects; signs and symptoms; possible causes of psychosis; treatments of psychosis and dealing with stigma; creating a low-stress environment; and managing disturbed behaviour. This course runs for four two-hourly sessions, once a month.

Provision of literature

Not all carers and patients choose or are able to attend the education groups. To provide access to information for a wider range of people, information leaflets on a range of mental illnesses are now available to all patients, carers and staff throughout the hospital. The distribution of these leaflets is coordinated by the practice development department. Before distribution each leaflet is subject to a quality check using a system called Discern as described by Charnock (1998) – a standardised index of the quality of consumer health information.

Research projects

There are three projects directly associated with the introduction and development of PSI programmes:

- CBT for psychosis in a forensic setting: results of a case series following The State Hospital pilot protocol (completed in 2003);
- An evaluation of the use of a CD-ROM-based psycho-education programme for people with psychosis in a forensic setting (work in progress, due for completion in July 2004);
- Evaluating the effectiveness of an education programme for people with severe and enduring psychotic disorder in a forensic setting (work in progress, due for completion in October 2004). The third project had the advantage of giving a member of ward staff the chance to become involved in the research process via a part-time secondment.

Future recommendations

There needs to be continued commitment from the organisation to carry out a rolling programme of training for staff, to enable them to deliver CBT and education programmes for patients and carers.

A training manual needs to be developed for staff undertaking training in the education programmes for patients and carers. Consideration also needs to be given to the process of adapting the education programmes for people with intellectual and developmental disabilities.

It is important that information gathered from the evaluation of both CBT for psychosis protocol and the education programme – when completed in October 2004 – is disseminated and sent for publication. Liaison with medium-secure units and other forensic facilities in Scotland is also under way, and it is important this continues in an effort to share and deliver consistent information to patients.

Staff involved in the development and delivery of the PSI service should continue to collate research upon which to base clinical practice. A potential development area is group CBT for people who hear voices. Another consideration is the introduction of alternative methods of delivering education programmes such as CD-ROMs, which could be used as an information resource.

Conclusion

The outcome of all these developments is an improved and more flexible service, which allows the organisation to provide additional interventions to a greater number of patients and carers. The commitment to deliver PSI is evident throughout The State Hospital, although the introduction of these interventions has not been rapid.

The argument for well-trained, properly supervised staff far outweighs the opportunistic approach of block training groups of 20 staff at a time, using short courses and leaving supervision to chance. Progress is good so far and the research projects that have been put in place to measure the effectiveness of these interventions will soon give an indication of their success.

There are a number of key factors that have aided the implementation of the SIGN guidelines. A vital factor has been the allocation of key individuals to lead the development and supervise the work in progress.

Second, the organisational support, in terms of accepting the need for the introduction of these interventions, has been vital. Financial support has been a necessary part of this and was essential for training purposes. Practical support was also essential, sometimes requiring ‘reorganising shifts’ and ‘sessional commitments’ to allow staff time away from their regular employment in order to undertake professional development.

Third, the concurrent introduction of the CSBS Clinical Standards Schizophrenia has ensured that many aspects of the SIGN guideline have been introduced, and are an integral part of clinical practice.

Finally, the positive attitude of clinicians towards change has been essential. This has been demonstrated by their willingness to become involved in training, which impacts heavily on their time.

One of the biggest challenges was setting up the carers’ education group. Organising suitable times and locations was problematic and finding time to carry out carer assessments remains a hurdle yet to be overcome.