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"Give us something to do"; Reflections on the challenges and opportunities in running a therapy group programme on an inpatient psychiatric triage ward

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“Give us something to do”; Reflections on the challenges and opportunities in running a therapy group programme on an inpatient psychiatric triage ward

Abstract

People on inpatient psychiatric wards often report feeling bored, and say that they would like access to therapy groups on the ward to help aid their recovery. However, there are many challenges to providing groups on wards, including lack of staff with the requisite time and expertise. This paper describes how a therapy group programme was designed and implemented on a psychiatric triage ward. The group programme was psychology-led, with involvement from the nursing team as co-facilitators. Challenges and opportunities arising from this approach are discussed, with some suggestions for areas of research and practice warranting further exploration.

"There are two sorts of 'boring' on the ward. One is caused by having lots of hours to fill and not having the things one usually has to fill them up with because one is not at home. The other is a side effect, or a series of side effects from the medication(s). It is possible to be bored on the ward even when there are activities planned every hour, and not to be bored when doing nothing. The trouble with boredom is it makes slow hours go even more slowly".

- Antoniou (2007, pg.33)

This quote by Janey Antoniou is from a chapter entitled "Bored on the ward", in which she wrote about her experiences of being a patient on an acute psychiatric ward. Her account of feeling bored on wards, and not having access to usual activities to pass the time, is sadly far from unique. Qualitative studies based on individual interviews with people who have been psychiatric inpatients frequently reveal themes around boredom, lack of access to therapies and activities on wards and over-reliance on pharmacotherapy alone (e.g. Lelliott & Quirk, 2004; Jones et al. 2010). These findings are consistent with several large service user surveys commissioned by mental health charities including Mind (Baker, 2000; Mind, 2011), the Sainsbury Centre for Mental Health (SCMH, 2006) and Rethink (The Schizophrenia Commission, 2012). Added to this, a Care Quality Commission (CQC) survey of psychiatric inpatients found that 35% of respondents said there were not enough activities available for them on weekdays, rising to 54% who said the same of evenings and weekends. Less than a third of respondents reported having access to any kind of talking therapy during inpatient admissions, and the majority of people who wanted to access a talking therapy during an admission were unable to (CQC, 2009).

Providing access to activities and therapies on wards depends upon the availability of trained staff to provide them. The vital role of mental health nurses in establishing good therapeutic relationships with patients through highly-skilled talking, listening and empathising is well-established (McAndrew et al., 2014). However, a recent review of 13 studies of nursing and patient

activities concluded that very little nursing time is spent delivering therapeutic interventions and may even be reducing over time (Sharac et al., 2010). Why might this be? Multiple factors are likely to be influencing this trend. Primarily perhaps, the large reduction in psychiatric bed numbers in the UK over time has pushed up the clinical threshold for inpatient admission, resulting in acute wards being filled with the most unwell, distressed and disturbed patients. At the same time, there is intense pressure to discharge patients as quickly as possible to free up beds as inpatient care becomes more and more of a scarce and expensive resource. The majority of nursing time may therefore be spent on responding to crisis and risk management, and on tasks such as paperwork and bed managements which do not involve direct patient contact (Mullen 2009; Rose et al., 2015). Some attempts have been made to counter this. In 2008, the Mental Health Act Commission recommended that inpatient wards implement a policy of daily protected engagement time, whereby all administrative duties and outside visitors are suspended in order to free up time for nurses to spent time directly with patients. However, implementation has been inconsistent across wards, and the benefits of this approach are as of yet uncertain (Nolan et al., 2011; McCrae, 2014).

In the current climate of inpatient care therefore, nursing staff usually do not have the time to provide activities and therapies on inpatient wards. Furthermore, inpatient multi-disciplinary teams (MDT) often lack specialist therapy staff such as psychologists or art therapists. Despite this, good practice guidelines for inpatient wards all include the provision of regular activities and therapies. This includes the Royal College of Psychiatry's Accreditation for Inpatient Mental Health Services framework (AIMS; RCPsych) and the service-user led initiative StarWards (www.starwards.org.uk). Where MDT group programmes have been implemented on acute inpatient wards, small-scale service evaluation projects have reported universally positive outcomes. These include increased levels of staff-patient interaction, decreased levels of violent incidents, and highly positive feedback from staff and patients (Gibson et al., 2008; Kemp, Merchant & Todd, 2011; Kerfoot, Bamford & Jones, 2012). However, a recent systematic review of group therapy for

psychosis in acute care highlighted the small number of studies published overall in this area, and in particular the paucity of randomised controlled trials in the literature (Owen et al., 2015). Given the considerable heterogeneity and methodological limitations of the existing studies they found, the authors concluded that much more research is needed in this area. Our aim in writing this paper is to reflect on some of the challenges and opportunities we experienced in running a MDT therapy group programme within this challenging clinical setting. We hope that by sharing our practice-based experience this might highlight areas warranting further research in the future, and potential areas for development in training and supervision of mental health nurses on inpatient wards in general.

Service Context

This paper describes how a new group therapy programme was designed and implemented on an 18-bed, mixed-gender, inpatient psychiatric triage ward in an inner London borough. Demand on acute psychiatric services within this borough is extremely high; the area has the highest incidence of new cases of psychosis in the UK, with incidence rates 3 times the national average (Kirkbride et al., 2013). The triage model was therefore implemented in response to increasing demand on inpatient services, high bed occupancies, and high re-admission rates. Psychiatric triage wards provide assessment, treatment and care for people experiencing an acute mental health crisis requiring hospital admission. They aim to assess and discharge patients within 7 days, either back home with appropriate support, or to a locality acute ward for patients requiring a longer admission. After being operational for 18 months, the triage ward expanded their multi-disciplinary team (MDT) to include a highly specialist clinical psychologist (PJ) and a support worker role dedicated to being an activities co-ordinator (CC). This afforded the unique opportunity to develop a completely new therapeutic group programme, and to include the nursing team and other members of the MDT in delivering the programme.

Developing the programme

The first step was to design an appropriate therapeutic group programme. We conducted a consultation exercise with both patients and staff to ask them what groups they would like to see provided on the ward. We also looked to emulate group programmes successfully implemented in other parts of the country (e.g. CBT service on Woodhaven Adult Mental Health Unit; Durrant et al., 2007). In addition, we made reference to good practice guidelines on the provision of activities and therapies on triage wards (AIMS-AT standards, 2014, 4th edition; RCPsych). Based on the recommendations of these various sources, we recognised the need for both *activity* and *therapy* groups. Patients can benefit from *activity*-based groups to provide meaningful occupation, enjoyment, relaxation and interaction; in addition they should also have access to *therapy*-based groups where thoughts, feelings and experiences can be explored more deeply within a safe therapeutic environment, with an appropriately skilled facilitator. We paid careful attention to issues around staffing of groups, both in terms of skill mix, and availability to run the groups. As highlighted in the introduction, the greatest threat to the successful and regular running of group programmes on wards is likely to be lack of protected time for nursing and other staff to deliver these groups, rather than lack of skills, or interest on behalf of the staff. With this is mind, we wanted to maximise the use of the activities co-ordinator in having a protected role of engagement and interaction with patients, rather than generic nursing duties. The final timetable included activity groups twice a day (e.g. yoga, music, art, smoothie-making) run during the week by the activities co-ordinator, supported by nursing staff. Weekend activities such as movie-night were timetabled to be set up by nursing staff, but not to require their constant presence throughout as we felt this would be an unrealistic expectation. In developing the therapy groups, we also wanted to make best use of the clinical psychology role in taking the lead on groups where needed, but also taking a more supervisory and training role in supporting other members of the MDT to deliver

groups. We did this with reference to the distinction made between high-and low-intensity therapies, as commonly used in training and competency frameworks (e.g. increasing access to psychological therapies, IAPT; Roth & Pilling, 2008). As the clinical psychology role was funded half-time, PJ could be directly involved in delivering groups on 2 days a week. We therefore designed a therapy programme with 2 high-intensity groups a week (emotional coping skills/understanding voices), led by the psychologist and supported by the activities co-ordinator, and 2 low-intensity therapy groups a week, led by the activities co-ordinator and supported by a member of the nursing team (coping with stress & anxiety/self-esteem). All groups were broadly CBT-based, with additional dialectical-behaviour therapy concepts (DBT; Linehan, 1993) used in the emotional coping skills group. PJ took the lead on training and supervision to support CC to deliver the low-intensity groups, and to ensure a high-level of fidelity to the group protocol at all times. An additional challenge was developing group protocols suitable to the triage model; standard group protocols could not be implemented on a ward where most patients would be unlikely to attend more than one session. We therefore designed all group protocols to follow a single-session format in order to accommodate short admissions and to make all groups accessible and relevant to all attendees. A therapy folder was established on the ward with standard protocols, worksheets and handouts for each group. We placed particular emphasis on establishing ground rules with patients at the beginning of each group, in order to create a "safe space" and a sense of community and mutual co-operation within the group. This included the flexibility for patients to enter or leave the group at any time, but also to show respect to each other, for example by not talking at the same time as anyone else and not directly challenging anyone else's experience or views. Groups were open to all patients, regardless of diagnosis, reason for admission or presenting difficulties.

Reflective section: Challenges and opportunities of MDT involvement in the group programme

This reflective section is written by CC from a first person perspective. CC worked in the recovery support worker post as activities co-ordinator for 15 months. Gibbs' (1988) six stage model of reflection has been used to support reflection and learning.

1) Description

My role as activities coordinator meant that I had protected time for patient interaction, and my main duties were to run daily therapy and activity groups and provide 1:1 emotional support outside of these set times. I came to this role as a psychology graduate with previous experience of running therapy groups in 2 different community settings. However, as I was unfamiliar with running inpatient groups, part of my training involved me observing the Clinical Psychologist (PJ) in the lead facilitator role for several weeks, with me as a co-facilitator. I then stepped into the lead role for 2 of the groups, with a member of the nursing team as the co-facilitator. Due to changing shift patterns, it was not possible to try to get the same member of the team to co-facilitate the group each week and so staff were allocated on the day.

2) Feelings

I found delivering the group timetable personally very rewarding. Often first thing in the morning the patients would ask me what groups were planned for the day. Patients often told me that the groups were the most 'useful' part of their care on the ward and in particular they valued the chance to keep busy, explore emotional issues and share experiences with others. I also noticed that patients were usually very kind and supportive towards each other in the group. This made me feel running the groups were worth-while.

Running the groups was challenging sometimes as well as rewarding. For example, I found it difficult when my co-facilitator was largely silent throughout the group. This brought up several feelings in me. I worried that they were anxious that they lacked the skills or knowledge to guide the group. Sometimes I wondered if they saw running groups as a worth-while use of staff time, which made me feel frustrated.

3) Evaluation

Working with the nursing team on the groups was a good experience in many ways. I felt it helped me to form closer working relationships and made me feel more integrated in the team. I also valued sharing a common goal with the co-facilitator in delivering the groups together. In general, nurses gave very positive feedback after co-facilitating a group and often commented it was valuable to get to spend protected time with patients that was explicitly set aside for listening and talking, rather than just interacting with patients during medication time or when assisting with physical care needs. Something I found particularly meaningful is that many nurses commented that they had seen a 'different side' to a patient in the group context. This supports previous accounts in which nurses reported contact with service users as the most satisfying part of their job (Baker et al, 2014).

A persistent challenge in running the groups often related to the allocation of co-facilitators. In practice, I found I had to always take the initiative to approach the nurse co-ordinating the shift to remind them to allocate someone. Sometimes the coordinator conveyed a sense of stress when I did this and as a result I felt like I was asking for something unreasonable, as though the groups were not an important or necessary part of the shift.

4) Analysis

Reflecting on the challenges of getting staff allocated to the groups each shift, and the participation of the co-facilitator in running the groups, I think this perhaps tapped into some underlying issues for me. For example, my feelings of frustration at times could have reflected my worries that the groups were not valued by the wider team, or that they were not seen as a priority on the ward. It has been argued that the primary model of inpatient mental health care is now one of observation

and behavioural management, rather that one of therapeutic intervention (Mullen, 2009). This could lead to therapy groups not being seen as a core part of the nursing team's work.

On reflection it seems likely that a significant factor in co-facilitator being very quiet in the groups might have arisen from a lack of confidence and training in running psychology groups. I had learnt most of the skills I used in groups during my observations of PJ in the first few weeks, supported by reflecting in supervision. Lack of staff training in psycho-social interventions has been identified as an ongoing problem on psychiatric wards (Baker et al, 2014). I also wondered if the nursing team lacked a sense of ownership of the therapy timetable. Although they had been consulted on the scope and materials for the groups, they might have felt more invested in the groups if they had had a larger role in creating the group protocols.

5) Conclusion

In terms of working most effectively with my co-facilitator of the groups, some things I did which seemed to work well included sitting down together 15 minutes before the group to discuss the therapeutic aims and intentions of the group. I also found it helpful to de-brief after each group, to discuss any challenges or questions arising from the group. I was well-supported in the development of my groupwork skills by receiving training and supervision from PJ, and it perhaps could have been helpful to extend this to the nursing team. There could also have been more of a role for peer supervision, and providing opportunities for the nursing team to share groupwork skills and expertise.

6) Action plan

- Deliver presentation to nursing team about scope and aims of psychology groups before the group programme is implemented

- Involve nursing team in the development of the group protocols, and group materials
- Discussion with ward manager about possibility of adding "allocation of co-a facilitator for psychology group" to the shift task list given to each shift co-ordinator.
- Suggest monthly group supervision dedicated to running the therapy groups. All facilitators would be encouraged to attend.

Feasibility and acceptability

A formal evaluation of the impact of the group programme for patients or the ward as a whole is outside of the scope of the paper. However, some reflections on the feasibility and acceptability of the group programme are pertinent here. A group record was kept for each therapy group, to record whether the group ran as planned, who facilitated the group, how many people attended and major themes arising. Overall, the groups were very well-attended, by a wide range of service users. Attendance varied from 1-8 participants, with an average of 4.5 people attending each group. As the therapy groups were solely run by the clinical psychologist and activities co-ordinator, there was inevitable disruption to the programme due to both planned (annual leave, study leave) and unplanned leave (e.g. sick leave). However, excluding planned leave, overall the therapy groups ran according to timetable on the vast majority of occasions (approx. 90% of the time). This was a very positive result, given the busy and challenging nature of the clinical environment on Triage ward.

Discussion

The aim of this paper is to share our experiences of the challenges and opportunities of developing and implementing a therapeutic group programme on the triage ward with multi-disciplinary input. We found that it was possible to provide a programme of both activity and therapy groups 5 days a week, which ran as scheduled around 90% of the time. This was achieved with specialist roles within the MDT who took the lead on planning and supervising (clinical psychologist) and delivering (support worker) the groups. Having core members of the team with protected time, and specialist skills in therapy and groupwork, then allowed the inclusion of the wider nursing team in the group work programme as co-facilitators.

Triage wards are still relatively novel within UK psychiatric services, and this paper is the first of its kind to describe the development of a group programme specifically designed for this kind of acute service. Our report of our experiences should of course be interpreted with the usual caveats that this may not be generalizable to other services, and we do not attempt to present any data at this time on efficacy of groupwork in terms of reducing symptoms, or reducing risk of relapse after discharge for example. Owen et al. (2015) call for larger, methodologically rigorous randomised controlled trials of inpatient therapy groups to address the gaps in the evidence base, and we are very much in agreement with this.

Reflecting on our own experiences of running the groups on the wards we certainly found that the challenges and opportunities of the programme were consistent with previous findings from surveys and service evaluation projects. Staff and patients were keen to have groups on the ward. Groups were well-attended, and a therapeutic space could be successfully created on the ward, even in the midst of a seemingly chaotic and disturbed environment. Nurses reported that co-facilitating the groups was a valuable experience, and they were pleased for the opportunity to interact with

patients in this way, rather than just during medication rounds or when attending to their physical health needs. However, some nurses appeared to lack confidence in their ability to co-facilitate groups, or to be able to respond appropriately to difficult thoughts or emotions that patients may express during groups. This highlights a need for more training and supervision for nursing staff in groupwork and therapies. If nurses feel they lack the skills and confidence to run groups they are likely to simply avoid it, or to view involvement in therapy groups as not an appropriate part of their role (Kemp et al, 2011).

Implications for Practice

The eminent US psychiatrist Irvin Yalom argued in his seminal book on inpatient group psychotherapy that group therapy was under-used and under-valued within psychiatric hospitals (Yalom, 1983). Given the limited number of studies rigorously evaluating inpatient therapy groups, it may be reasonable to suggest that this still applies to certain a degree 30 years on. Making and maintaining progress in this area will undoubtedly be challenging for staff, teams and services as a whole. It requires a cultural paradigm shift in how we think about and deliver inpatient care, in line with the recovery model being implemented more widely across mental health services. Yalom recognised that full MDT involvement for group programmes was essential, stating that; "*No inpatient group therapist can lead a successful group if the other members of the ward treatment team devalue group therapy*" (Yalom, 1983, page 9). The acute solutions report specifically recommended that ward activities must stop being viewed as added "luxuries" to be done if there are staff and time available (SCMH, 2006). In order for therapy groups to have true parity with medical interventions on the ward, they must be given the same priority. Ward rounds, medication rounds, and daily physical observations are never cancelled, even in the most demanding circumstances of staff shortages (and most would argue, rightly so). However, therapy groups are under constant threat of cancellation and disruption, and require high levels of energy and

commitment from staff dedicated to the provision of such interventions on the ward to guard against this. This paper describes a service which was successfully run by a psychologist, working closely with an activities co-ordinator, and with committed determination to include the wider nursing team as co-facilitators. Alternative models, for example, a nurse-led group programme headed by nurses with specialist therapy skills would be undoubtedly valuable. However, this model could only be implemented by giving nurses protected time to run groups, some regularity of shift patterns so that groups can run according to a predictable timetable, and support with further training and supervision for nurses. We would like to end this paper as we started it - with a quote from a service user. These voices are surely the most important to be listened to; although paradoxically, the least likely to be heard.

"All staff time and resources are spent to stop bad things happening but not make good things happen"

- Anonymous service user quote, MIND report (2011)

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