The theory of bio-psychosocial model

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The theory of bio-psychosocial model was introduced in 1977 by Mr. George Engel, a professor of psychiatry and medicine. It is a comprehensive model explicating a strong relationship between health and disease by integrating cultural, social, and psychological considerations (Engel 1977, p. 132). There has been a consistent effort since 1980s to examine the interconnectedness between social, psychological, behavioural factors and the functioning of immune system to explore their contribution in causing human illness (Karren, Hafen, Smith, & Frandsen, 2002; Kiecolt-Glasser, McGuire, Robles, & Glasser, 2002) followed by a bio-psychosocial model. The bio-psychosocial interventions are conceptualized to target the combination of biological, psychological and sociological factors that contribute in deteriorating human body functions thus producing illness. These interventions are the collaborative efforts with service users by integrating a number of evidence based practices by encompassing the medical, social and psychological paradigm with intent to accomplish swift recovery (Brooker & Brabban 2004). The main objective of these interventions is to analyze and identify the underlying causes of the disease by evaluating the causes of biological dysfunction, psychological problems affecting mental and emotional health and assessing the sociological issues including marital status, financial positioning, culture or religion that may serve as the root cause of sickness. The core elements of bio-psychological interventions are the management of medication, symptoms and relapses, the cognitive-behavioural therapy (CBT) for psychosis, collaborative assessments and structured family interventions. The effectiveness and responsiveness of mental health services rely upon the easy access of psychological interventions to the people diagnosed with severe and enduring mental health issues (Layard 2004). The Department of

Health has been consistently emphasizing on the need for Early Interventions in Psychosis Services (EIPS) and bio-psychosocial interventions specifically focussing on CBT, to be implemented across diverse clinical settings particularly in acute inpatient units (DoH 2001, 2002, 2004, 2006). The accessibility of such interventions facilitates in optimizing treatment concordance, reducing relapse rate and mental health problems and improves the overall clinical outcome which encourages resurgence of patient's wellbeing (Gray et al. 2001). However, it is significant to note that psychosocial interventions can only be effective when implemented with the help and support of adequately trained healthcare workforce.

1. 1 Rationale of the Study

In accordance with the fundamentals of bio-psychosocial models, it can be constituted that the core forerunner of an ailment belongs to the three vital elements including physical, psychological, and socio-cultural components. Stevens & Smith, (2005), in their study examined the bio-psychosocial model and constituted that it helps in comprehending with the interactive and reciprocal effects of environment, genetics, and mental behaviour (Stevens & Smith, 2005, p. 25). To support the validity of the bio-psychosocial model, several pragmatic evidences have been put forward advocating the relationship of social, psychological and immunological factors that produce negative impacts on human health conditions (Trilling, 2000). Over the last decade, the need for education and training of healthcare workers in order to develop their PSI skills has been amplified however, the literature suggests that the implementation of PSI in routine service provision is extremely challenging (Kelly & Gamble 2005). This paper is designed to examine the

role of psychiatric in an acute in-patient ward. Moreover, the study in intended to highlight the policy and research related to bio-psychosocial interventions that help in managing crisis and complexities of an acute ward. The study will also facilitate in identifying the barriers of implementing psychosocial interventions and thereby, propose effectual strategies to prevail over these difficulties.

2. NATIONAL POLICIES FOR MENTAL HEALTH

Mental illness along with cancer care and coronary heart disease were identified as the three national priorities in the year 2000 followed by which the UK government increased the funds for NHS up to 9% of GDP (Kings Fund, 2005). The budgetary limits for adult mental health services were also extended from £983m to £3, 770m in 2001-2002 and up to £4, 679m in 2005-2006 (Mental Health Strategies, 2006) and it was also constituted that maximum financial resources will be utilized to support the inpatient services (Mental Health Strategies, 2006). The evidences suggest that the acute inpatient units have been facing a tremendous amount of dissatisfaction (MIND, 2004) and therefore, numerous healthcare bodies including Department of Health (DoH), the National Institute for Mental Health England (NIMHE) and Care Services Improvement Partnership (CSIP) collaborated to institute acute inpatient programme (DoH, 2002). The collaborative efforts by these healthcare bodies resulted in the development of standard policies and guidelines for the betterment of acute inpatient services (Healthcare Commission 2007). Concerned with the conditions of mental health treatment, the national guidelines on acute psychiatric care were published in 2002 as the acute inpatient services were considered to be unsatisfactory

(Department of Health, 2002a: 3). The main objective to institute standard policies and guidelines in accordance with Mental Health Act Commission is to ensure that all the inpatient mental health services are consistent in providing their patients with adequate sense of privacy, security and absolute care (MHAC, 2005: 19).

ACUTE IN-PATIENT WARDS

In accordance with the description proposed by the Department of Health (2002), the main purpose of introducing acute wards is to offer high standards of humane treatment and care facilities readily available to the patients within a safe and therapeutic setting during the most acute and vulnerable stage of their illness (DoH, 2002a: 5). The acute inpatient services have been developed to ensure that the spread of diseases is lessened and maximum treatment and support is made available for the patients that are unable to be treated in an alternative, less restrictive setting (********). The acute in-patients wards are meant to facilitate both health care providers and service users however, a number of studies have illuminated on the difficulties of managing the acute in-patient wards. A series of issues has been outlined by various studies including leadership crisis, deficient clinical skills and poor risk management process (SNMAC, 1999). The robustness of interaction between nurse and patient and lack of therapeutic activities has also been questioned (Ford, Duncan and Warner, 1998); and a number of studies indicated a frequent state of confusion and chaos that builds up in the in-patient acute wards (SCMH, 1998). The effectiveness of CBT for psychosis is also challenged where there is a lot of complaint about non-therapeutic environment and non-cooperating overworked staff (MIND,

2004). Several studies also point out the dissatisfaction of patients due to surplus admissions in wards causing uneasiness and certain overly restrictive rules ended up in lack of privacy. The issues of in-patient acute wards also involved grievances of patients having less or no formation about treatment and which is considered to be unresponsiveness towards their civil rights (Walton, 2000). The study is therefore, focussed to critically examine the underlying issues and dig in the factors that aggravate them in order to suggest effective management strategies to improve the receptiveness of the nurses and open ways for easy accessibility to highly developed in-patient wards.

ROLE OF NURSE IN ACUTE IN-PATIENT WARDS

A critical care nurse working in acute in-patient ward has comprehensive mix of knowledge, skills and competencies required to fulfil the needs of a critically ill patient without having a direct supervision of a ward manager. The blend of knowledge, skills and competencies are not characterised by the therapeutic setting including intensive care unit or a high dependency ward instead, these blend of knowledge, skills and competencies must compliment the needs of psychotic patients. Psychotic patients need extensive care in order to reduce the chances of ill-fated crisis and complications. The level of therapeutic care can be enhanced by the careful interventions of experienced critical care nurses having advanced observational skills and holistic approach to deal with both the psychotic patients and their families. Following are some basic interventions employed by the critical care nurses in an acute in-patient ward to maximize operational efficiencies.

4. 1 Ensure Positive Alignment

Acute in-patient wards are critical in nature and therefore, a tactful and positive alignment of nurse-managers and nurse-patients is essential to maintain a functional ward. The role of nurse in an acute patient ward is to effectively respond to patient's requests and offer maximum level of help and information. Patients are entirely dependent on nurses as they are the key point of contact in a ward and therefore, it becomes imperative for the nurses to establish a respect element for their clinical ability. Working closely with managers and regular staff meetings are all part of positive alignment that ensures smooth work process of an in-patient acute ward.

4. 2 Supporting the Ward Manager

A high-quality therapeutic skill of the nurse is to understand the organizational hierarchies and respect the decisions of the ward manager. Ward leader is involved in the positioning and staffing and the most crucial element of ward manager's job description is to take prompt decisions. Acute wards are critical in nature so chaos and confusion adversely affects the mental health of patient and therefore, nurses are required to perform their duties by supporting the decisions and following the rules as set by the ward manager.

4. 3 Safety and Containment

Nurses in the acute in-patient wards are required to safe management system and prompt resolution of acute distress. The motherly relationship between nurse and patient supports the concept of containment by the benefitting the mental health of the patient. Physical restraint is the core element of containment which helps in the therapeutic progression. The role

of a nurse in psychiatric wards is fundamental in preserving the safety and containment as the skilful and qualified nurses are specifically trained to reduce anxieties and fears of the patients and supporting them to resume a balance between idealism and realism.

4. 4 Effective Communication

Nursing in general supports a holistic approach towards the service users and the role of nurses become even more significant in an acute in-patient wards where the patient's are extremely vulnerable. Nurses are the immediate point of contact to provide significant information about the patient's mental health to the interdisciplinary team and the family members of the patients. Moreover, it has been observed that a nurse-patient relationship maintain effective communication, achieves better results in terms of fast recovery.

4. 5 Observation & Improving Patient Outcomes

Acute in-patient wards require careful observations to reduce sedation and weaning from ventilation and to offer physical rehabilitation, and psychological support in a timely manner. Role of nurses in acute wards are required to be adequately skilful to monitor the dependence of patients on support equipment and to make proactive predictions and prevention of agitation by significant interventions in case of sudden deterioration. Recovery of a psychotic patient can be enhanced by using patient-centred care and vigilant management practices to cope with reckless events (Ball and McElligot, 2002).

CBT FOR PSYCHOSIS

Cognitive behavioural therapy is designed to evaluate the symptoms of psychosis and at the same time examine the relative impacts of illness on the patient's mental health. A psychotic patient experiences a number of difficulties in terms of isolation, societal rejection, feelings of aggression as a result of which there is an increased risk self-harm and substance misuse. The main purpose of adopting CBT for psychotic patient is to gain symptomatic and functional recovery of the patient however, in case of persistent symptoms due to disrupted developmental trajectory; it is advised to continue with the therapy. CBT develops enhanced understanding of psychotic disorders and promotes adaptation to disorder by initiating coping strategies in order to reduce the degree of secondary morbidity and prevent relapse (Trilling 2000). CBT aims to improve the emotional and mental wellbeing of patients by reducing distress and offering helpful strategies to manage the residual symptoms of psychosis in daily life. The treatment therapy for psychosis involves a number of key phases and management strategies to progress speedy recovery.

5. 1 Assessment & Formulation

The psychosocial intervention that involves CBT for psychosis primarily requires a therapeutic alliance between the healthcare provider and the service users. The initial phase of CBT involves engagement of therapist and patient in the assessment of the illness so that the patient's mental health can be analyzed and their psychotic experiences can be recorded. The assessment phase of CBT helps in identifying the problem areas, factors sustaining the problem areas and the underlying causes of the psychotic

disorder. Therapists strive to understand the nature, complexity and extent of the disorder by probing in the biological, psychological and social background of illness. During the assessment phase a therapist attempts to summarize the aetiology, development and maintenance of psychotic disorder and thereby, outlines the length and frequency of necessary interventions. Engagement of both therapist and the patient facilitates in the formulation phase where a specified course of action is established to undertake the therapy.

5. 2 Psycho-education

The early phase of psychotic disorder is identified by the onset of certain symptoms after which a the healthcare providers diagnose the ailment by taking into account numerous theories of psychosis and a number of individual explanatory models that helps in understanding of the precise form of psychosis. The patients are required to be informed about the impacts of substance misuse, compulsory medications and the inception of warning signs in order to keep them in the loop of the overall recovery process accompanied by CBT. The psycho-education also involves details about the helpful agencies and the nature of recovery which is usually conducted as part of a group programme. Educating the patients about facts and essential information is always useful however, it is imperative that the psychosis education programs are designed in a way that the patients comprehend the concept of these programs intended to restore their mental health. Depending upon an individual’s coping style and willingness to absorb the information, the reaction to such educating programs might differ.

5. 3 Adaptation to Psychosis

The theory of adaptation to psychosis entirely depends upon the patient's understanding of the disorder and how he/she addresses the recovery process by reacting to the underlying situation. The process of adaptation involves acknowledging the impact of psychotic disorder on patient's life by estimating the damages caused to the patient's self-esteem and his/her realisation of personal potential to combat with disorder. CBT helps the psychotic patients to identify their personal strengths and limitations to fight with ailment by expanding their coping skills and formulate realistic plans to facilitate the patient. The main objective of the CBT for psychosis is to enable the patient's to learn the concept of overcoming the negative aspects of life and focusing on positive things including healthy activities, friendly relationships and personal accomplishments in order to enhance their self-esteem. The psychotic patients are extremely vulnerable and cannot stand social fears which eventually deteriorate their mental health. CBT enables them in adapting to their psychotic conditions by making them realise their strengths and capabilities to prevail over internal fears and hence contribute significantly in the recovery process.

5. 4 Treatment of Secondary Morbidity

Failure in adaptation to psychosis results in secondary morbidity state in which the patient is unable to cope with internal and external fears and thereby, experiences extreme level of depression, anxiety and substance misuse. It is important that CBT for psychosis is continued and the nature of the secondary condition has to be explained to the patient. Failure in adapting to psychosis leads the psychotic patients to develop irrational

beliefs and assumptions which make it even more difficult and challenging for the therapists. However, an approach of cognitive challenging supplemented by group-based interventions for anxiety management or substance misuse is followed by examining the underlying beliefs and assumptions and replacing them with rational beliefs and assumptions.

5. 5 Coping Strategies

A number of behavioural and cognitive strategies have been formulated to help patients work towards improved functional outcome despite of psychotic symptoms. The functional and emotional problems that arise with the positive and negative symptoms of the psychotic disorder are controlled by coping strategies included in CBT for psychosis. It is however, necessary to identify the target symptoms to manage the recovery process. The most commonly used strategies in CBT include coping strategy enhancement, distraction and focusing techniques for voices after the identification of positive symptoms (Trilling 2000). Self-monitoring of behavioural activities, scheduling of paced activities, assertiveness training and diary recording of mastery and pleasure are some of the interventions used to cope with the negative symptoms.

5. 6 Relapse Prevention

The relapse prevention phase is amongst the integral phase of CBT in which the therapists are required to prudently monitor and intervene where there are early warning signs for relapse. It has been constituted that after the commencement of treatment approximately 80-95% of the psychotic patients experience the relapse prevention (*******). CBT incorporates several interventions to address the issue of relapse prevention including

cognitive restructuring of enduring self-schema in which there is an elevated risk of relapse.

BARRIERS TO IMPLEMENT PSYCHOSOCIAL INTERVENTIONS

The clinical effectiveness of psychosocial interventions has been emphasized in a number of evidence based studies as the significance of these interventions has exceedingly grown over the last 20 years. The growing awareness and enhanced need and inclination towards the espousal of psychosocial interventions suggest that these interventions should be routinely implemented (NICE 2002). However, there has been a considerable amount of literature indicating the potential difficulties and challenges associated with the integration of psychosocial interventions within the routine mental health service provision (Brooker & Brabban 2003, Forrest & Masters 2004). The challenges are multifactorial and are primarily concerned with the workforce development and education (Brooker et al. 2002, Brooker & Brabban 2004, Forrest et al. 2004); clinical and managerial leadership (Cook 2001, McCann & Bowers 2005); and the impact of limited resources on service development in the context of increasing demands (McCann & Bowers 2005).

6. 1 Education & Training

Mental health services are currently challenged by policy, service user and professional drives. In order to establish the early intervention in psychosis services a range of initiatives are required. The foremost requirement to entrench the bio-psychosocial interventions into all levels of service delivery is to maximise the number of trained practitioners (Brabban & Kelly 2006).

More importantly the integration of the principles of the recovery approach and evidence-based practice has to be included in the education and training of the healthcare workforce (Repper & Perkins 2003, Kelly & Gamble 2005, NIMHE 2005, DoH 2006). However, it is unfortunate that despite of consistently mounting awareness and need for the psychosocial interventions within the clinical settings and mental health service provisions, the fraction of PSI trained workforce is still inadequate (Layard 2004). The situation becomes more intricate when a segment of trained healthcare workforce is not practicing their PSI skills due to other contributing factors including excessive workload and lack of time, limiting the scope of implementing psychosocial interventions (Brooker & Brabban 2004).

6. 2 Managerial & Leadership Crisis

Management and the senior staff have a better understanding of the complex nature and clinical significance of PSI training and its implementation and therefore, the role of managers become crucial in determining the success and failure of implementing psychosocial interventions in acute wards. It has been observed that regular communication between managers and trainees and careful check and balance maintained by the programme leaders enables successful PSI implementation (McCann & Bowers 2005). However, the managers and programme leaders find it difficult to sustain the precision of PSI implementation due to workload pressures across the service (Cook 2001).

6. 3 Limited Resources

The most frequent complaints and issues regarding the failure of implementing psychosocial interventions in the acute wards have been identified by the literature and the most common issues are the unprecedented gap between theory and practice. Limited resources on service development in context of increased demand also tend to hinder in successful PSI implementation (Repper & Brooker 2002). In order to fill in the gaps between theory and practice of PSI implementation the aims and objectives of the interventions has to be illuminated so that the practicability of the interventions can be sustained. It is therefore, essential to improve ward-based information and clarify the ward rules for users (Flood et al, 2006). On the other hand, sufficient resources including caseload size, access to assessment and intervention materials are required to undertake the interventions (McCann & Bowers 2005).

6. 4 Staffing Issues

Excessive workload and staffing issues are the key problems of an acute in-patient wards where there is extreme need of practising psychosocial interventions. It has been observed that even after the completion of training and courses the trainees are compelled to resume the same job description. It is extremely unfortunate that the work overload doesn’t allow the trainees to utilize their skills and knowledge at an advanced level (Williams 2008). Managers of the in-patient wards also complain about the workload pressure as being the critical factor for not adjusting the job descriptions of the trainees after the completion of their relevant course. On the other hand,

trainees also complain about the excess workload and lack of time to focus on and practice their PSI skills.

6. 5 Excessive Workload

The most problematic barriers in the implementation of PSI are the emergency excessive and unpredictable admissions of the critical psychotic cases which require immediate attention. The presence of critical care nurse is therefore, extremely significant at any point of time which is one of the major staffing issue. Critical care nurses are already under immense workload pressures and conversely, the reduction in the number of beds has added to the situation (Williams 2008). The rise in demand due to high case loads has made it extremely difficult to effectively employ the structured PSI interventions into routine work.

REQUIREMENTS OFACUTE IN-PATIENT WARDS

The threshold of admission in acute inpatient wards has considerably increased and the role of critical care nurses has also become more complex. Systematic assessments by highly skilled critical care nurses by involving service users and their carer allows formulating a plan for significant interventions which are targeted to reduce the burden of in-patient wards provided if the necessary care and interventions can be continued at home (Royal College of Psychiatrists, 2006b). The complexity of the contemporary acute in-patient ward is enhanced by the reduction in the number of beds however, it is considered to be a small component of the multifaceted care system (Clarke, 2004). The most critical aspect of the decision making process is the comparison of psychotic patients awaiting the admission therefore, critical care nurses are required to carry out vigilant assessments

by making careful considerations about the individual's circumstances (Meehan et al, 2006). Patient's expect the nurses to function in a collaborative way and treat them with respect (Baguley et al, 2007) however, a number of studies indicates dissatisfied service users complaining about the services being intimidating, demeaning and often humiliating (NIMHE, 2007). To address the underlying issues and in order to maintain the accreditation standards for the acute in-patient wards a full multidisciplinary ward round, at least once a week has been recommended (Royal College of Psychiatrists 2006b). Moreover, the government has also introduced crisis management and home intervention teams in order to lessen the burden of admissions in acute in-patient wards with intent to focus on recovery by involving community efforts. A combination of psychological and social interventions by reintegrating the service users into the community can be achieved by adopting a holistic approach.

STRATEGIES TO OVERCOME THE BARRIERS

A number of strategic measures have been identified by the study which is likely to enhance the benefits of implementing psycho social-interventions in the acute in-patient wards. The main objective of the proposed recommended strategies is to address extensive issues encompassing diverse areas and segments related to the acute in-patient wards, to accomplish utmost advantages for both the practitioners and service users.

8. 1 Enhanced Flexibility

The level of emergency admissions and dependency of patients in the critical care unit cannot be predicted and may considerably vary in between allocated shifts. The complex structure and nature of the acute in-patient

units require flexibility in the number of critical care nurses per shift in order to effectively respond to changes in demand (******). Moreover, the critical care nurses are required to consistently examine the trends in elective patient admissions so that the capacity planning and nurse staffing may comply with the change in demand.

8. 2 Employment of Healthcare Assistants

Critical care nurses are highly skilled and trained to understand the needs of an acute in-patient ward. Therefore, while determining staffing levels, the recruitment of health care assistants must not interfere with the skill mix of critical care nurses. Considering the excessive workload pressure on the critical care nurses, it is beneficial to employ the health care assistants to facilitate in providing quality care services. However, to create a balance between critical care and general care services, it is advisable to specify the registered nursing hours so that the quality of critical care may not be compromised (Needleman et al, 2002).

8. 3 Definite Policies & Procedures

Clearly defined policies and protocols helps in maintaining a healthy work environment and organizational structure. It is imperative to clarify the roles and responsibilities with respect to the specified job title in order to ensure that smooth workflow has been maintained across the entire ward. Moreover, definite policies and protocols also facilitate in successful implementation of PSI and practising of CBT by the trained staff. Depending upon the past experiences as a critical care nurse and knowledge of working in the critical care facility it has been recommended that for at least 30 days nurses should maintain supernumerary position in the intensive care wards

(DHSSPS, 2000). To address the staffing needs, managerial support complying with policies and procedures, is required so that the chaos and confusion shall be avoided.

8. 4 Professional Development

Critical care services can be improved by consistent training and staff development programmes specifically designed to focus on the psychosocial interventions practice. It is highly recommended to incorporate evidence-based interventions in the curriculum of PSI-trained staff and their skills and knowledge must be employed in their respective job descriptions (Brabban and Kelly 2006). Moreover, the professional and developmental needs of the nurses working acute in-patient ward must be considered during staff appraisals to promote professional excellence of the critical care staff.

8. 5 Reduce Workload Pressure

Support of healthcare assistants shall be obtained to encourage superior care services by disseminating the excessive workload pressure. It has been observed that during PSI training, the staffing is greatly affected and therefore, it is advisable to utilize the replacement funds to relieve workload pressures in the critical care units. Moreover, rational strategies and centralized measures might be helpful in addressing the substitution arrangements in an effective manner.

8. 6 Training and Education

Development of leadership skills for critical care nurse is highly recommended for improving the PSI implementation, advanced patient care. It is also advisable to provide the critical staff with mandatory training

including essential fire training, manual handling and basic life support in addition to the training for psychosocial interventions (Brabban and Kelly 2006). Moreover, a tripartite structure for communication in between ward managers, program leaders and the trainees would help in successful implementation of the psychosocial interventions.

8. 7 Dissemination of Knowledge

The significance of the psychosocial interventions has to be widely encouraged and therefore, the content and levels of PSI programme shall be kept diversified which may involve modular provision and training specific to certain interventions e. g. family work, medication management or clinical areas including acute inpatient, forensic etc. (*****) To establish the efficacy and implementation of the PSI, it is imperative to disseminate the basics and core PSI knowledge and values to the healthcare staff across the clinical environment. Furthermore, the local training needs for PSI shall be regularly reviewed by the stakeholders to ensure that adequately trained and skilful staff is maintained at all times to provide extensive care in critical wards.

8. 8 Evaluating the Impacts of PSI

Psychosocial interventions integrate collaborative participation of service users and carers at every stage including planning of services, training programs, formulation and implementation of strategies and diffusion of the recovery approach therefore, the impacts of these interventions can be evaluated by collating feedback from both critical care nurses and service users.

8. 9 Regular Audits

To estimate the effectiveness of the evidence-based interventions regular audits are required to entrench withi