



SCENE

Enhancing social networks,
improving quality of life

SCENE Intervention Manual

Improving quality of life of patients with
psychosis through a new structured
intervention for expanding social networks



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The SCENE intervention

Background

People with psychotic disorders often live with small social networks and poor quality of life. Approaches to improve social networks indirectly through symptom control and social skills training have largely failed, whilst interventions directly targeting the social activities of patients have been more encouraging.

Informed by a successful trial of a simple intervention to increase social activities of patients with psychotic disorders in Italy, we are developing and testing an intervention in the NHS, that is relatively brief, generic (i.e. can be used by professionals with different backgrounds) and effective.

Aim

The aim of the SCENE intervention is to improve patients' quality of life through enhancing their social networks.

Type of intervention

The SCENE intervention consists of a number of one-to-one contacts between a patient and a mental health professional over a six-month period. Professionals encourage and help patients to engage in activities of the patients' choosing that involve social contacts.

Frequency and type of contacts

Professionals meet patients six times over the six-month intervention period, i.e. about once per month.

The intervention starts with two long meetings (about 60-90 minutes) in the first month to explore preferences, discuss options in detail and agree on the way forward. If possible, the two initial meetings should happen within a week's time. The following meetings discuss progress and provide support as required. They last at least 20 minutes and can be conducted face-to-face, over the phone or via Skype, though the first two meetings and the final meeting should be face-to-face. Further contacts of professionals with patients, as helpful via telephone, text message, Skype or other electronic means, are encouraged, but limited to issues directly related to the agreed action. They occur only shortly before, during or after an activity.

The location of the meetings can vary and depend on patient preference and local circumstances (including patients' homes, community places and offices of services).

Content of meetings

The meetings focus on the patient's motivation to expand social networks, their preferences for how to do this, local options and plans for how to achieve it in practice, and discussions of the progress made. This may include direct temporary support (e.g. reminders, initial accompanying). The planned activities should be a way to expand social networks, e.g. leisure activities in groups but not going to the cinema on their own. This will usually mean establishing new contacts, but could also be engaging in new joint activities with previous contacts (outside on-going friends and close family). The intervention will not address potential difficulties in already existing on-going relationships (e.g. with close family).

Following the approach of the intervention in the trial in Italy, options for activities are those that are available to all members of the local community, not those that are available only or primarily to patients of mental health services.

Follow-up meetings start with a review of progress and end with an agreement on actions to be taken. This will then be reviewed and possibly revised at further meetings. Normally, the agreement should not specify more than one type of concrete activity at a time. If a patient expresses interest in more than one activity, they are asked to choose one to prioritise. If there is no substantial progress after a maximum of three months with one type of activity, an agreement is sought to switch to a different activity. There is some flexibility about when exactly the switch is considered and agreed. The switch is agreed by both patient and professional during a face-to-face meeting. The content of the meetings is further specified in Annex 1.

Approaches used in the intervention

The meetings are guided by four main approaches:

A **patient-centred approach** is used throughout to establish and maintain a helpful relationship with the patient. The approach consists of the Rogerian principles of unconditional positive regard and empathy.

Components of **Motivational Interviewing** are used to clarify the patient's motivation, to encourage taking up activities and deal with ambivalence (for details see Annex 2).

Information is provided about available options for activities (for details see Annex 5). This is supported by different types of information material (printed lists of local options, web-based information) which is appropriate to the patient's interest and needs. The patient is guided in accessing and using the information, providing enough information without overloading the patient (for a list of potential types of activities see Annex 3). If required, the professional will seek and provide more information to support the patient's plans.

The approach of **Solution Focused Therapy** is used to emphasise the strengths of patients, reinforce their self-esteem and abilities, and help them deal with failure in engaging with planned activities (for details see Annex 4).

A model for how these approaches are linked is provided in Annex 6.

Professionals delivering the intervention

The intervention is intended to be generic and eventually to be used by professionals with different backgrounds. In the feasibility and full trials within the SCENE research programme, the intervention is delivered by specifically contracted staff with appropriate professional or academic qualification (e.g. psychologists, social workers, nurses, occupational therapists), preferably psychology graduates. During the earlier case series, qualified and experienced clinicians deliver the intervention.

Training of professionals

Professionals are trained in the intervention in one session of up to three hours, preferably delivered in a group format and by a member of the core research team.

During the training, they acquire knowledge of the structure and aims of the intervention, i.e. number of sessions, frequency of sessions and procedures to help the patients to reach out to social activities. They are also taught the relevant elements of the approaches used in the intervention, i.e. patient-centred communication with Rogerian principles, motivational interviewing techniques, skills for providing appropriate information and solution focused therapy. Scenarios in which barriers for the patient in engaging in new social contacts may appear and strategies to overcome them are discussed.

Professionals also obtain a good knowledge about the options for activities in the local area available to the patient that involve contacts with other people. Knowledge about the local context starts with a list of possible options which are provided by the research team. In addition professionals are encouraged to network in the given community to generate more options for relevant activities.

Learning progress is assessed during the training and in the subsequent supervision.

Professionals receive updates on changes in options for activities from the local research team and from other participating professionals through networking. They are supervised in regular phone calls either locally or centrally from the study team in London.

Annex 1 – Content of Meetings

Initial meetings

The first two meetings will cover the following steps:

1) Introduction

The professional and the patient introduce themselves.

2) Clarification of the remit of the intervention

The professional explains and discusses the focused remit of the intervention, i.e. that it aims to expand social networks and that all other therapeutic issues have to be addressed elsewhere.

3) Exploration of past and current activities

The professional explores past activities that involved social contacts; this should be done chronologically covering the adult life time of the patient from the age of 15 years onwards, and stepwise for periods of 5 – 10 years; each activity is documented. The professional comments positively on each activity (e.g. that it is astonishing how the patient kept up some activities despite concerns, difficulties, illness, and potential social advantages).

At the end of the exploration, professional and patient go through the list of activities (if any) and discuss to what extent the patient enjoyed each activity.

This ends with an exploration of the type and extent of all current activities, although they are often very limited (which is one of the main reasons for why the patient has been referred to the intervention).

4) Motivation for change

The professional explores and discusses the patient's motivation to change and expand their social networks, using Motivational Interviewing techniques (Annex 2) as and when appropriate.

5) Options for activities

Professional and patient discuss which new activities (or expanding existing ones respectively) the patient considers.

6) Information

Linked to the previous step, the professional provides as much helpful information as possible about actual options in the given locality. Professional and patient discuss the practicalities and sometimes decide to obtain further information. In this step, the patient is encouraged and supported to find information him/herself. Yet, if this is a substantial hurdle, the professional provides as much direct support as needed (the whole intervention is about helping patients to social activities, not about training patients in information finding).

7) Consideration and decision

Once options have been identified, the patient is asked to consider taking it up. If the patient is ambivalent, patients are encouraged to take time, e.g. a week until the next meeting or a phone call, to think about it. After that time, patients decide to take the activity up, or professional and patient discuss the situation again and re-consider. Throughout this step, professionals express their respect for the decisions of the patient and present realistic concerns and expectations.

8) Definition of task

Finally, the patient decides on the type of activity and some specification of the actual steps (e.g. twice per week attending a certain class, but not necessarily on which days), so that professional and patient can assess afterwards whether the activity has been completed or not. The task gets documented for the patient, e.g. written on a piece of paper that the patient takes along.

How much time each step takes and to what extent they are covered in one or two meetings varies. Whilst the first meeting should normally end with steps 5 and 6 (which are often linked), the two initial meetings always end with a documented decision on an activity that the patient is going to undertake – once or more often - prior to the next meeting.

Follow-up meetings

These can be done face-to-face or over the phone (or Skype or Whatsapp or similar other media).

Professional and patient discuss to what extent the task has been completed. Professionals provide positive feed back and – if required – deal with complete or partial failure using solution focused techniques (e.g. emphasising what went well, see Annex 4).

As required, steps of the initial two meetings may have to be repeated, in particular step 6, i.e. the provision and discussion of practical information.

Each follow-up meeting ends with an explicit definition of the task until the next meeting.

In case, professional and patient come to the conclusion that the originally planned activity does not work, a face-to-face meeting is arranged in which steps 4 to 8 of the initial meetings are repeated and a different activity is planned. In most cases, this is done before the first activity has been tried for a three months.

Between meetings:

Professionals and patients can be in contact between meetings (e.g. by phone, Skype or similar media. However the possibility for patients to contact the professional outside meetings are limited to time slots that have been agreed beforehand and are shortly before,

during or after an activity. And the content of the contacts is focused on issues directly related to the activity.

If professionals become aware of additional relevant information (e.g. about the availability of a certain activity), they can communicate that to the patient at any time.

Final meeting:

At the end of the six month period, there is a final face-to-face meeting. Professional and patient discuss the achievements during the intervention and the plans for the future. Plans for the future are about continuing the current activities as well as ways to find and take up new or additional ones if the patients wanted that.

Patients will always be given or sent a letter in which the achievements are summarised and future plans specified, if and as appropriate.

Annex 2 – Motivational Interviewing

To be used when there is ambivalence or resistance to change.

The four central principles of motivational interviewing

1. Express empathy using reflective listening to convey understanding
 2. Develop a discrepancy between values and current behaviour
 3. Sidestep resistance by responding with empathy rather than confrontation
 4. Support self-efficacy by building confidence in the possibility of change
-
- Change talk – Elicit any talk that indicates motivation to change. Where change talk is expressed, respond to it by summarising and reflecting it back. Use evocative questioning to get the client to elaborate on this; ask for more detail and give reinforcement.

e.g. “What is it about having few social contacts that concerns you the most?” and “So you’re saying that you think it would be good to have more people to chat to?”
 - Ambivalence – Elicit any concerns the client may have, reflect this back and acknowledge the ambivalence. Move on to the reasons for change, giving more attention to change talk and attempting to elicit more.

e.g. “I’m hearing that you’re worried you might get overwhelmed if it’s a big group” and “Is there anything at all about being in a group that would be helpful?” or “So you’re saying that you feel nervous about going along to the activity but you also feel that you want to meet some new people?”
 - Self-motivational statements – Try to pick up on any statements that suggest ambivalence is diminishing such as recognition of the problem, explicit expression of intention to change or optimism about ability to change. Elaborate on these through open questions and reflection.

e.g. “So you said you think that something needs to change, why do you think this is important?”
 - Resistance – Acknowledge the emotion behind and resistance and demonstrate understanding. Sidestep resistance by avoiding confrontation. Move on by shifting the focus to reasons for wanting the change; elicit these from the client rather than giving oppositional statements.

e.g. “You’re angry that the last groups of friends you had disappeared when you became ill. I’m sorry you didn’t get the support you needed. Can you think of anything that might be different this time around?”

- Giving advice – Avoid giving the client information without their permission, always elicit from them whether this would be useful and allow the opportunity for them to give feedback.

e.g. “What do you already know about the teams in your area? What do you think you would need to know to be able to give this a try? Shall we have a look at some of the information I have on this? What do you make of that?”

Annex 3 – Potential Activities

Arts & Creativity

- Choirs
- Craft groups
- Creative writing groups
- Dance
- Drama/Theatre
- Drawing classes
- Gardening
- Karaoke
- Knitting/Sewing classes
- Painting classes
- Pottery classes
- Woodwork classes

Classes/Educational

- Baking classes
- Language classes
- Computer/IT classes
- Cooking classes
- Music lessons
- Courses

Clubs

- Bingo
- Book club/Reading clubs
- Chess club
- Comedy club
- Film club

Sport & Physical recreation

- Badminton
- Basketball
- Canoeing/Kayaking
- Climbing clubs
- Cricket
- Cycling groups
- Darts

- Fishing clubs
- Football
- Gymnastics
- Martial arts
- Meditation
- Mountain biking
- Nordic walking
- Pilates
- Rugby
- Running clubs
- Swimming
- Table tennis
- Tai Chi
- Tennis
- Walking groups
- Yoga

Health & Lifestyle

- Healthy eating groups
- Slimming groups
- Vegan groups

Interest/Discussion groups

- Science discussion groups
- Philosophy discussion groups

Speciality groups

- Carers groups
- Cultural groups
- Religious groups
- Women's groups

Volunteering

- Animal and natural conservation charities
- Other charities
- Community projects
- Libraries
- Voluntary work in shops or other organisations

Annex 4 – Solution Focused Therapy

To be used when there are setbacks or challenges.

- Compliments – Keep the focus on the positive, acknowledge and praise what has been done well. Where there have been challenges, acknowledge the difficulties and show understanding while emphasising and complimenting the effort put in.

e.g. “I can see that you have really tried to give this a go. Even though you didn’t manage to stay for the whole session well done for going there in the first place and putting in that effort.”

- Previous solutions – Emphasis a patient’s ability to solve their own problems. Most people will have faced similar difficulties in the past and may have found ways to overcome them. Asking what has worked before may help a person to come up with their own answers for the current difficulties.

e.g. “When you’ve had this problem in the past, what has helped?” or “Are there times where you have been able to overcome this problem? What did you do then?”

- Exceptions – Look out for exceptions to the rule i.e. times when a patient could have had this problem but didn’t. Identify a recent example of when this problem didn’t occur and establish what was different.

e.g. “I remember you saying that the last time you went to this group you didn’t feel particularly anxious. What do you think was different on that day?”

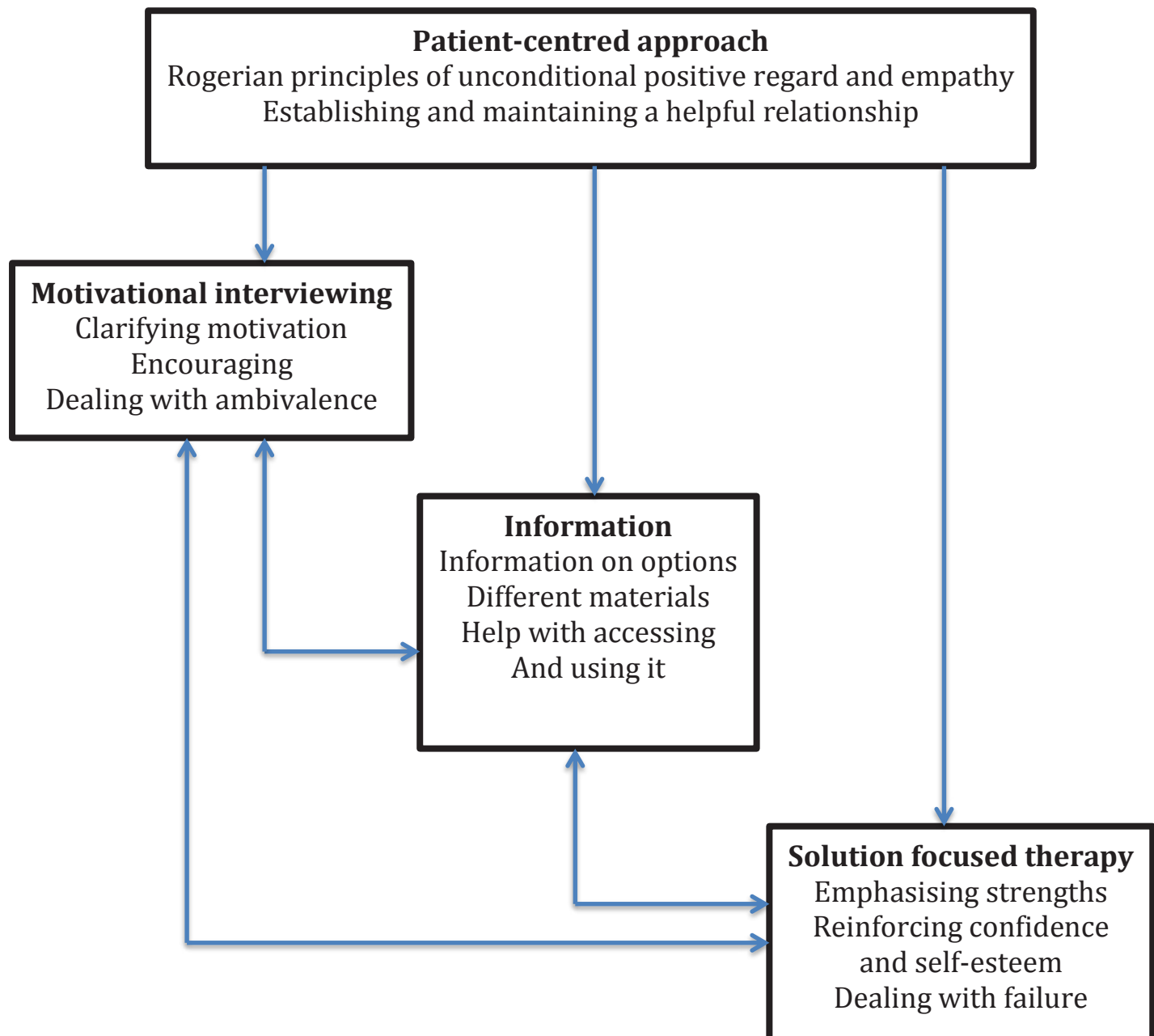
- Do what is working – Keep the focus on the positive by building on what the patient is doing already. Use the compliments, previous solutions and exceptions to frame positively what is being done well. Discuss how these skills can be put in to practice going forward.

e.g. “You’ve done really well to come here today even though you didn’t really feel like it. How did you manage to do that? How can you use those things to help you attend the group next week?”

Annex 5 – Information giving

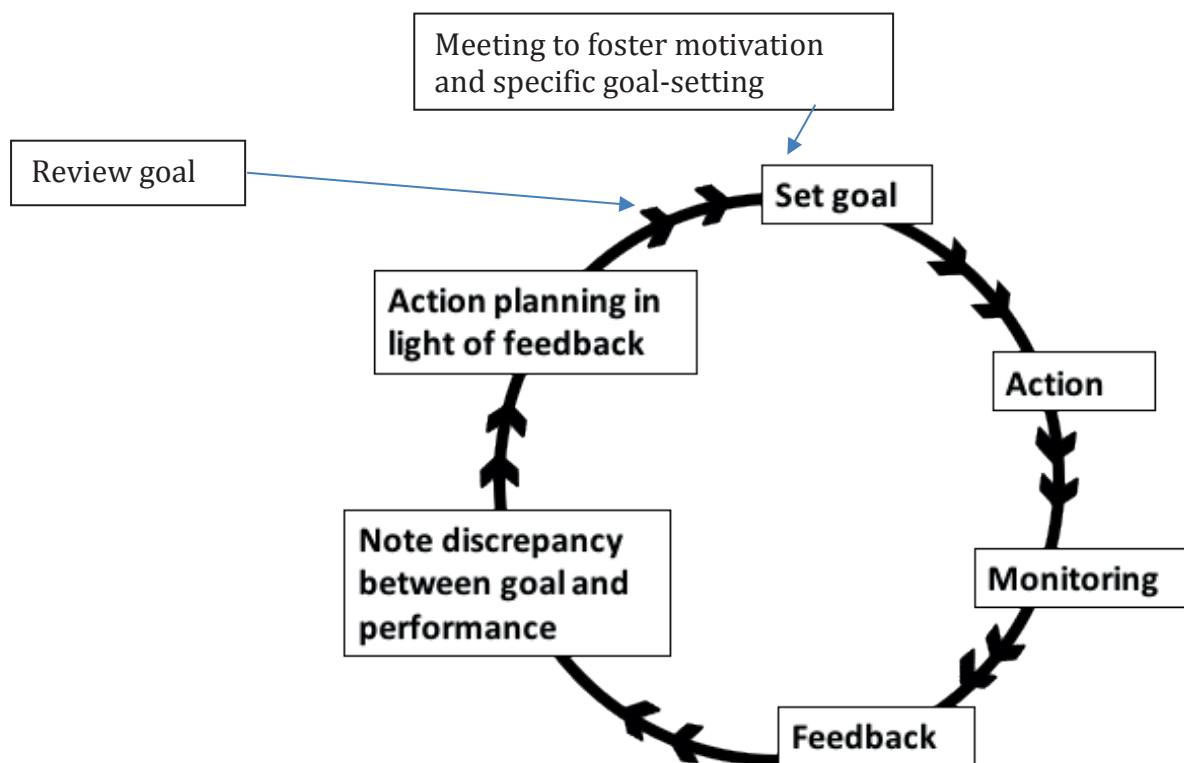
- Professionals have comprehensive information about available activities in the given locality, including their costs
- They utilise study materials and web searches to explore further what is available, depending on the patient's preferences
- They ask before giving information (elicit-provide-elicit)
- They ask what patients already know and what they think it would be helpful for them to know
- They provide information at a level and pace that is appropriate and understandable for the given patient, avoiding overload and checking patient's preferences for how much information would be helpful
- If required, they clarify that patients can ask for more information at any time
- If additional information is needed, professionals will either support patients in seeking that information or find that information themselves, as required and helpful; the additional information can be provided outside meetings.
- Patients leave the meeting with a documentation of the agreed action and with all relevant information in a form that can be checked at any time (e.g. printed or sent as text message)

Annex 6 – Approaches used in intervention



Annex 7 - Theoretical model of intervention processes

Based on an iterative model of self-regulation (Carver & Scheier, 1998)



Reference:

Carver CS, Scheier MF: On the Self-regulation of Behavior. Cambridge: Cambridge University Press; 1998.

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A brief training and supervision programme has been developed to accompany the manual.

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