

Cognitive behavioural therapy and family intervention for psychosis – evidence-based but unavailable? The next steps

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National Institute for Clinical Excellence updated guidelines for schizophrenia (2009) recommend two psychological treatments – cognitive behavioural therapy for psychosis (CBTp) and family intervention for psychosis (FI). Despite these recommendations being in place for nearly a decade, implementation problems remain, particularly for FI. It is argued that these problems can be overcome, if services prioritise improving access to psychological therapies for psychosis, and that carers in particular need their own services to be developed.

The NICE (National Institute for Clinical Excellence) updated guidelines for schizophrenia were published in 2009. This was the first time a mental health guideline had been updated. The process involved looking again at high quality randomized controlled trials that had been completed since 2002, completing meta-analyses and cost effectiveness analyses, integrating the new evidence with the previous evidence and then making recommendations based on the whole of the evidence. The NICE process requires new evidence to be substantial if a recommendation is to be overturned or a new recommendation made.

As has been published (NICE, 2009), the guidelines looked at the treatment and management of schizophrenia and related disorders in adults with an established diagnosis, and made four main recommendations.

1. Better access and engagement for Black and Minority Ethnic (BME) groups;
2. Medication tailored to people's individual responses and preferences;
3. Family Intervention (FI) and Cognitive Behavioural Therapy for psychosis (CBTp) continue to be recommended, arts therapies should be considered; and
4. GPs should monitor physical health and conduct checks at least once a year.

Of these recommendations, I will focus in this paper on FI and CBTp, both psychological therapies for psychosis that I have been involved in developing and evaluating. The issue is that despite being recommended for nearly a decade,

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neither of these therapies is widely available. Access to them depends entirely on local training initiatives (e.g. MERIDEN www.meridenfamilyprogramme.com in the West Midlands). FI in particular has been seen as 'nobody's job' and carers of those with psychosis have needs that are routinely ignored by services (Kuipers, 2010). As Insel (2009) has noted, implementing such therapies remains a problem: 'we have powerful, evidence-based psychosocial interventions, but they are not widely available' (p. 131). 'A serious deficit exists in training for evidence-based psychosocial interventions' (p. 131). As a result, people are not receiving the evidence-based psychological therapies that they need in psychosis. I and others have argued that we need an Improving Access to Psychological Therapy (IAPT) not just for anxiety and depression in primary care, but for severe mental health problems. In the current financial climate this seems unlikely, but the IAPT model has been funded by Central Government, and the potential remains for expanding this model to other conditions; it would be likely to be similarly cost effective.

We know that service users and carers would like more access to talking therapies in psychosis, at least partly because of the established evidence base which shows that outcomes improve. This evidence now spans 30 years for FI, which reduces relapse rates in psychosis, and 20 years for CBTp where symptoms improve. We also have evidence from the 2009 NICE update that these therapies do not do harm; they do not lead to increased death rates or poorer outcomes. Further, unlike antipsychotic medication, psychological therapies do not have an unpleasant range of physical side effects.

The definitions of these therapies used in the updated guidelines are described below: CBTp is a discrete psychological intervention where service users establish links between their thoughts, feelings or actions with respect to the current or past symptoms, and/or functioning; re-evaluate their perceptions, beliefs or reasoning in relation to the target symptoms. In addition, a further component of the intervention should involve the following: service users monitoring their own thoughts, feelings or behaviours with respect to the symptom or recurrence of symptoms, and/or promotion of alternative ways of coping with the target symptom, and/or reduction of distress, and/or improvement of functioning.

FI is a discrete psychological intervention where family sessions have a specific supportive, educational or treatment function and contain at least one of the following components: problem-solving/crisis management work; intervention with the identified service user.

The NICE process requires that interventions have an impact on the following critical outcomes, which include mortality (suicide), global state (relapse, rehospitalization), mental state (total symptoms, depression), psychosocial functioning, family outcomes (including burden), quality of life, leaving the study early for any reason, and adverse events. Thus studies have to show that they make a significant difference to these outcomes, not just on measures of interim processes, such as improvements in attention or memory but not symptoms or functioning. Finally, all studies included in NICE meta-analyses have to meet

pre-defined quality checks regarding their methodology, such as adequate randomization procedures, sample sizes and percentage of those followed up.

The resulting evidence base for CBTp was 31 randomized controlled studies ($n=3052$), 22 of them being new trials. The results showed a small but clear effect on symptoms, including depression, but not on relapse rates. For FI, the evidence base was 38 randomized trials, of which five trials were follow-ups ($N=3134$). Some 32 trials were then included in the updated meta-analysis (19 new trials) ($N=2429$) and the results showed that FI reduces relapse in schizophrenia consistently. The recommendations, which follow on directly from the evidence base, were to offer CBTp to people with schizophrenia, which can be started in the acute phase, and should consist of more than 16 sessions. FI was recommended to be offered to families of people with schizophrenia who are living with, or in close contact with the service user. FI can also be started in the acute phase, should last between three to 12 months, and consist of more than 10 sessions.

Unfortunately, the NICE evidence base and recommendations for psychological therapies does not of itself ensure implementation. NHS Trusts are asked to consider NICE findings and there is an increasing emphasis in the NHS for funding to be focused on evidence-based treatments. However, implementation requires different skills and changes in management practice. Unlike medication, where quality control is the responsibility of the manufacturer, psychological therapies require high levels of training and continuing supervision to be set up by local services. It is this that takes time, energy, funding, and persistence. The gap between recommendations for those with schizophrenia and implementation in services remains challenging (Prytys, Garety, Jolley, Onwumere, & Craig, 2010). There is a shortage of trained therapists and a lack of effective systems for ensuring therapy competencies in CBTp and FI (Pilling & Price, 2006).

At the South London and Maudsley (SLAM) Foundation NHS Trust, there has been an ongoing piece of work to look at the barriers to implementation of CBTp and FI for psychosis, and to try to develop management systems, training programmes and local community team practices that support and enable such therapies to become more available. This description uses as an example ongoing work by Professor Garety, Dr Suzanne Jolley, Dr Juliana Onwumere, and myself, some aspects of which are reported in more detail by Prytys et al. (2010).

Eight local community adult mental health teams were audited initially to clarify demand and develop appropriate local criteria (based on NICE recommendations) for identifying service users who should be offered these therapies. SLAM has a population of around one million, mainly living in inner city, South London Boroughs, extremely high indices of social deprivation, and substantially raised rates of psychosis, especially in BME populations (between four and nine times higher). At the time of the initial audit, there was a striking lack of clarity about who should be offered psychological therapies. Reasons given by staff for considering service users unsuitable for these therapies included poor insight, good insight, no symptoms, too many symptoms, family difficulties, family has too few problems. There were no systematic information

systems to identify service users with psychosis, and few staff with any relevant training, particularly few with any family intervention skills.

After a considerable amount of work with the teams, a similar audit completed with 16 teams in 2008, revealed that between 9–12% of eligible service users were being offered a course of CBTp over a two-year period, but fewer than this were being offered FI for psychosis. Some 90% of therapy was delivered by clinical psychologists, and service users were more likely to be offered therapy in teams that had a full or part-time clinician, i.e. a therapy post. However, CBT was much more likely to be offered than FI.

The processes that had been put in place to make even this progress included case registers of suitable clients in teams, identifying trained clinicians, offering new training courses for clinicians, routine monitoring of outcomes, specialist clinical supervision and annual targets set for staff; 10% of those eligible for CBTp to be offered it and 5% of those eligible for FI. A 10-point charter incorporating these requirements was drawn up with the teams and made widely available.

The barriers to implementation of psychological therapies into routine practice are predictable. ‘Lack of protected time, heavy case loads and role confusion were key factors preventing implementation of psychological interventions by those with relevant training’ (Prytys et al., 2010). When services are under pressure, or crisis driven, these longer-term more preventative interventions are inevitably not prioritized. It seems to be the case that service organization does not in itself ensure the delivery of complex therapies. If the output required is for more service users to have access to such therapies, then staff need to have this as their primary goal and staff support, supervision and management systems need to be geared to this.

More seriously, care co-ordinator pessimistic attitudes to service user recovery and the primacy of biological treatments were reasons why service users were still not considered for psychological therapies (Prytys et al., 2010). For people with psychosis, while intermittent, crisis focused care needs to be available, it should only be one part of more long-term preventative approaches, in which psychological therapies are demonstrated to have a primary role. Care for those with psychosis needs to include a range of comprehensive services, such as medication, vocational help, recovery plans, help with housing and activities, benefit advice and importantly, hope.

FI in psychosis appears to have even more entrenched challenges than CBTp. At least for CBTp staff are used to seeing service users individually. Trying to see families, often out of hours, with two staff members together (Kuipers, Leff, & Lam, 2002) can be felt to be unfeasible. Seeing carers is in any case ‘nobody’s job’, they are not prioritized (Kuipers, 2010) and ‘patient confidentiality’ can prevent contact, despite the well-evidenced arguments that many service users may want carers involved in some aspects of their care, and decisions made when acutely unwell to exclude a carer, may not be permanent (Slade et al., 2007). There is thus an argument for offering carers intervention in their own right. One aspect of FI for psychosis is to help carers’ emotional

processing of grief, loss, anger, shock and denial, as well as how to negotiate problem-solving with service users. 'It is now time to consider theory based interventions focused on improving carer outcomes' (Kuipers et al., 2010).

A final part of the NICE guideline update was to look at the evidence for Early Intervention Services (EI). This had not been done previously by NICE. Interestingly, the evidence now suggests that such services do have an impact on outcomes for those with schizophrenia and that such services seem to be helpful. Four randomized trials were included in the meta-analyses ($N = 800$). EI reduced hospital admission and relapse rates, reduced symptoms and increased engagement with services. As found before, used alone, FI reduced relapse rates, and CBTp alone reduced symptom severity (Bird et al., 2010). I have previously argued that EI is a good model of the kind of care we should be offering to those with psychosis, but that service users need 'high quality, comprehensive needs led services at all stages of presentation early, medium or later' (Kuipers, 2008, p. 159).

Conclusion

It would seem that in contrast to the late 1980s when there was considerable pessimism about the usefulness and appropriateness of offering psychotherapy to those with psychosis, there is now a clear evidence base that CBTp and FI are efficacious with these conditions and do not have adverse effects. There is new evidence that EI services can be helpful and that offering such input has promise of at least improving subsequent service contact. Implementing such therapies as routine parts of care remains problematic, particularly the demands of FI in routine services. However, there are some pointers as to how to overcome these problems and perhaps try new ways of offering help directly to carers.

As Dr Tony Garelick discussed in Dr Richard Lucas's obituary, he 'was constantly trying to find meaning in the most disturbed patients and looking and searching for ways about how to make contact with them and find a mode of communication with patients they could relate to and use' (Garelick, 2009, p. 158). While Dr Lucas's psychoanalytic training and therapeutic orientation came from a different tradition, both CBTp and FI also attempt to find meaning to 'make sense' of what has happened with service users and carers. The fact that such psychotherapies are now becoming more generally part of the treatments that can be offered to those with psychosis, does seem like progress.

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