

Psychiatrists, psychological therapies for schizophrenia and training.

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Section 1: Psychological therapies and psychosis

Introduction

“Psychological treatments should be an indispensable part of the treatment options available for service users and their families in the effort to promote recovery”

(NICE Schizophrenia Guidelines 2002 p 16)

The NICE Guidance is intended to be a comprehensive guide to the delivery of effective treatments for schizophrenia. It prescribes the principles of care across stages of the illness, describes how care should be initiated, the treatment of the acute episode, the promotion of recovery, and audit measures to assess the extent to which the guidance has been implemented.

The guidance also analyses and grades the evidence for specific interventions across phases of the illness. These include working in partnership, pharmacological interventions, psychological interventions and service level interventions. The evidence base for psychological approaches is substantial, but implementation of such approaches has been much slower than adoption of drug treatment guidelines.

Implementation of the NICE Guidance in routine service delivery will require a change in the training of psychiatrists and other mental health professionals to deliver across the range of recommendations.

Service background

At the same time as the NICE guidance was being prepared there were far-reaching changes in the way services are organised for service users with schizophrenia. The introduction of new functional teams, (Assertive Outreach, Early Intervention and Crisis Resolution Home Treatment Teams: NHS Plan, 2002) in all mental health services has created new forms of community based treatments. These teams may provide psychological interventions, but this paper draws out explicitly the levels of skill needed in various modalities of psychological therapy to make these functional teams consistent with NICE guidance. This part of the document is intended as a focus for consultation with other disciplines involved in the delivery of psychological therapies within functional teams.

The new functional services rely on a team-based approach (rather than just individual case work) to delivering a range of bio-psycho-social interventions to

people suffering from schizophrenia and other types of severe mental illness. These team skills need to be seen within the framework of the NICE guidance to make both aspects of policy consistent. The core skills required by the psychiatrist and other professionals working within these teams need to increase in range (numbers of staff trained in each team) and depth (an appropriate mix of basic, intermediate and more advanced skills in each modality for the style of work undertaken) to meet the demand for effective care delivery. We have suggested that these 3 levels should be taken to be congruent with levels A,B and C as recommended in the Review of Psychotherapy Services (DH 1996)

Implications for psychiatric training

Postgraduate medical education is currently facing a major revision with the advent of the Post Graduate Medical Education and Training Board (PMETB), the introduction of Modernising Medical Careers (MMC) and the European Working Time Directive (EWTD). The training pathways leading to the new CCT (Certificate of Completion of Training) are likely to differ from the current structure. Whatever changes are eventually adopted, the assumption made in this paper is that psychiatrists in all specialties need to be aware of the implications of the NICE guidance. General and older adult, rehabilitation and psychotherapy specialists will need training to become proficient in the knowledge and skills delineated in the NICE document. The skills include specific treatment approaches, but go considerably beyond these in including a sophisticated understanding of how the treatment system works.

Appropriate training for psychiatrists helps to produce effective consultants and this, in turn, is important in improving the quality of services. Training should produce consultants capable of overviewing the system, to ensure the development of therapeutic environments in which psychological therapies can be delivered safely and effectively.

Not all consultants can (or would wish to) become therapists, but they should be capable of enabling the treatment environment so that psychological interventions can be delivered effectively by other team members.

Focus of the document

This document deals with psychological and service level interventions that facilitate changes in practice. The focus is on training for family interventions and CBT for which there is the best evidence graded at levels 'A' or 'B'. There is also a section on Psychosocial Interventions (PSI) in its own right. Although PSI courses subsume elements of CBT and family interventions, they also take an overview of effective case management and its component skills.

The paper also includes sections on psychodynamically-informed supportive therapy, arts-based therapies, and systemic therapy, which are supported by weaker levels of evidence, but are nevertheless in wide use in mental health services.

The document describes the skills needed for effective practice within NICE guidelines by taking the high level skills needed for effective practice, followed by a development based on the *10 Essential Capabilities*, and finally a more detailed description of the skills and training for each of the main modalities.

After describing the skills in each modality, they are then applied to the different functional teams, suggesting whether the skills should be at basic (Level A), intermediate (Level B) or advanced level (C). The modalities are divided into three key areas that have the strongest evidence (CBT, family interventions and Psychosocial interventions) followed by three additional areas (dynamically informed supportive therapy, arts therapies and systemic therapy).

General skills needed for effective practice

These high-level skills form a framework within which more specific approaches can be described. The skills required are in six areas:

1. Understanding the indications and potential benefits of the range of psychological therapies available, their delivery within an effective therapeutic alliance, and the match between individual patients, therapists and therapies
2. Understanding the psychological and organisational factors that work for and against the delivery of effective psychological therapies
3. Understanding the role of the psychiatrist in multi-disciplinary teams to facilitate the successful delivery of psychological interventions

4. Understanding the factors in inpatient settings that promote and work against the creation of a therapeutic environment
5. Ability to train other psychiatrists in the acquisition of these skills.
6. For some psychiatrists, delivering specialist psychological therapies themselves.

These six approaches provide the background within which more specific skills can be described. A list of the core competencies for practitioners undertaking psychological work with service users and their families is listed below. The working group agreed these and they are consistent with the *10 Essential Capabilities* described by NIMHE working with the Sainsbury Centre and proposed as core generic skills for the mental health workforce.

Core competencies

These are divided into four characteristics describing the required 'Mind set' or attitudes, and a further four Core Treatment Skills required by all mental health professionals including psychiatrists, plus organisation and inter-disciplinary skills.

“Mind Set” skills

These describe the fundamental approach from which treatments can be delivered.

1. Maintaining psychological awareness including the ability to contain, reflect and think about the self, other and the system.
2. Recognising the psychological meaning of symptoms, illness and the situation.
3. Maintaining a positive attitude to recovery with the service user and those closest to them (families and carers)
4. Being sensitive to the context including culture, gender, age, religion and the institutional culture of the treatment setting

Core Treatment Skills

5. Capacity to engage and maintain engagement with service users, families and professional networks, by addressing fears (which may be expressed as hostility or suspicion) and systemic resistance

6. Working with the therapeutic alliance using collaboration, negotiation and working towards ending
7. Working as an effective part of a team through understanding the group dynamics of a treatment team and having the necessary communication skills to express that understanding
8. Being able to engage in supervision and/or reflective practice

Organisational understanding and inter-professional skills

9. Maintaining appropriate psychological boundaries and reflective space whilst assessing the impact and meaning of the treatment setting on the self, service user, staff and carers
10. Understanding 'expressed emotion', 'malignant alienation' and 'regression' in an individual and institutional context

Additional skills in psychiatric assessment and case formulation

A psychiatrist should be familiar with cognitive, systemic and psychodynamic approaches to psychoses, and be able to integrate them into the overall assessment. This should be conducted with the service user, and, where appropriate, with family members.

The psychiatrist should also be able to decide when to invite specialist input in any psychological intervention.

Core modalities

Cognitive Behavioural Therapy for individuals

The NICE guidelines for the management of schizophrenia in primary and secondary care (2002) state that CBT is to be made available for patients with schizophrenia. A meta-analysis of the relevant research stated that grade A evidence existed that CBT was an evidence-based treatment for patients whose symptoms of schizophrenia had proven resistant to treatment with anti-psychotic medication.

CBT will, therefore, need to be made much more widely available in general psychiatric practice and in rehabilitation. Patients with chronic symptoms linked to co-morbid conditions such as substance dependence, alcoholism and personality disorder were not specifically covered by this guideline, and it is likely that each of

these conditions may attenuate effectiveness of therapy, but the disability caused by these co-morbid conditions means that the interventions are often used in practice.¹

A lesser degree of evidence (B) was attached to the recommendation that CBT should be made available for those patients with problems with concordance with antipsychotic medication regimes.

A further recommendation at level C related to CBT for patients lacking insight into their condition. Taken together these indications probably indicate a need for a CBT intervention for the majority of patients with schizophrenia being managed in general psychiatric and rehabilitation settings.

Patients should receive not less than 10 sessions of CBT over at least a 6-month period. This leads to a significant gap in skills across all professions. Psychiatrists can help to narrow the gap through the opportunity to learn at least basic level CBT as applied to service users with psychosis.

Over the past few years, opportunities for training have increased in the UK. Previously there were books and articles published on the broad range of psychosocial interventions, particularly cognitive behaviour therapy, but there was little opportunity to develop skills unless you worked alongside the specialist practitioners and researchers within the area, most of whom are clinical psychologists. Many of the main CBT courses focused on treatment of depression and anxiety disorders, but some CBT courses have now developed modules on managing psychosis.

Specialist Courses in CBT for psychosis.

New specialist courses have also developed, for example, as multi-disciplinary Masters Degrees in CBT for patients with severe mental illness in Manchester and Southampton Universities. These are two-year courses, with the first year focusing on CBT and the second year on research and development.

Students still learn the general model of CBT in the first module before learning techniques for working with patients with severe mental illness in the second module.

¹ Attempts to develop combined approaches, such as the combination of motivational interviewing for substance misuse with generic CBT have led to further models, which are currently being evaluated.

Severe mental illness in a family context is covered specifically in the third module with material on family level interventions.

The courses were first established in 1997 and 2000 respectively, but are limited in availability of places, access to appropriate local clinical supervisors, and also by travelling restrictions for many potential trainees.

A new course is currently being established at the Institute of Psychiatry / South London and Maudsley Trust as a post-graduate diploma in CBT for Psychosis; it also runs for two years, has a strong emphasis on therapeutic skills and theoretical understanding, and aims to develop independent practitioners in CBT for psychosis, competent to deliver therapy as recommended in the NICE guideline.

CBT training is also available as a component of PSI training as described later.

Supervision for CBT

Supervision is fundamental to developing skills in CBT, especially for patients with psychosis. Supervision allows the trainee to adjust techniques to the realities of everyday clinical practice and to a very varied group of patients. The goal of supervision can be described as modifying in-therapy behaviours by support and training.

In addition, it enables therapists to step back to reflect on their practice and to prepare for the next session.

Supervision complements the workshops and lectures and is of equal importance, but as it is time and skill intensive it is often the practical limit on the size of courses. Although generic supervision is often readily available within trusts there is a distinct lack of specialist supervision for CBT with schizophrenia. Receiving the appropriate clinical supervision is imperative to the continuing development of the therapist and the safety of the therapy offered.

Most supervision occurs in face-to-face interviews and this is still the default position. However, the use of telephone supervision, telephone conferencing, email case discussion or even correspondence can overcome the distance problem. Audiotapes of interviews can be valuable but it is difficult to compensate for the lack of reflection on non-verbal communication.

The use of video technology has helped to some degree and it has become more widely available. Web cams have been used but the quality will be poor until broadband is more widely available. Once the improved technology is more widely available in the NHS, it may well become the most viable medium for long-distance supervision (Kingdon and Turkington, 2002).

Family interventions using CBT techniques

These should be offered to any family who lives with or is in close contact with a family member with schizophrenia, especially where the individual has persisting symptoms, has had a recent relapse or is considered to be at risk of relapse (NICE guidance, 2002).

These concepts have been developed and researched within the context of Psychosocial Interventions (PSI) training. The evidence base refers to the psychoeducation and behavioural family management components of PSI training although the NICE evidence review drew on Family Interventions most often delivered alone, not as part of a PSI package. A meta-analysis of six studies (Mari de Jesus and Steiner 1994), which all took a PSI approach to family work, confirmed that service users increased their adherence to medication and families were more able to deal with some of the difficult emotions aroused by the illness. Relapse and re-admission rates were reduced. See also full review in NICE meta-analysis (REF).

Training Opportunities

There are a range of training opportunities beginning with the PSI based family work (see section on PSI training), as part of a diploma course. The interventions taught on these courses are usually manualised to improve consistency, and include supervised family assessments and practice.

Further training through degree courses providing extended supervised practice is available at many centres, including London, Manchester, Birmingham and Southampton. There has been a consistent problem in the impact of these courses in that the practitioners tend not to use the interventions they have learned when they return to their previous post. There is also emerging evidence from audit that service users who could benefit from CBT are not referred appropriately because of lack of awareness of the benefits conferred. (Kingdon personal communication 2005)

The West Midlands Family Programme has addressed this problem in part by involving local management structures, and requiring managers to take ownership of the training. This has involved creating job plans for the trained professionals to implement their practice or to become trainers themselves when they complete the course.

There are important lessons in this approach generally. The principle applies to psychiatrists already in consultant posts, in that their job plan can be adapted to allow attendance at the course and subsequently become part of programmed clinical activities (or in some case supporting professional activities as the consultant becomes a trainer).

The principle of adapting the future job is harder to apply for Specialist registrars as the link between the training and subsequent job plans as a consultant are difficult to anticipate. Posts stating dedicated time for psychological therapies are still rare, and it is often the post holder who has to negotiate programmed time as a consultant, rather than these approaches being part of the medical workforce plan for a trust.

In any case, it is uncommon at present for psychiatrists to undertake this type of training, but a shift in training experience for both SpRs and consultants is required to ensure a broad implementation of family work across disciplines, and to provide “champions” for these approaches at a senior clinical level.

PsychoSocial Interventions

Core competencies

PSI is a ubiquitous term that covers a range of interventions for work with people with a psychosis. It provides a comprehensive psychosocial model for case formulation, promoting consistency in the approach that a multi-disciplinary team can take to an individual service user and their family. The model can also be used in combination with a therapeutic community style approach in in-patient settings. It can make a significant contribution to engagement and therapeutic benefit. (The core competencies to support PSI are covered earlier.)

PSI may also include CBT for individuals and CBT-based family interventions, often at a basic level, both of which have been covered in their own right earlier.

Interventions

Support and educational function of PSI

Individual and Family Psycho Education Programmes raise awareness and knowledge through education of individuals and families.

Specific Skills for individuals included within PSI programmes

The programme for PSI trains practitioners in some practical skills that are of direct relevance to service users and also assist service users to engage with the process.

The skills include:

- Life skills
- Skills of everyday living such as budgeting
- Behaviourally based assessment of social and interpersonal skills
- Vocational Skills
- Pre vocational training (preparing someone for work) and
- supported employment.

Problem solving and symptom management skills

A more advanced set of skills is available which practitioners who do not necessarily have advanced assessment and formulation skills can use. These are skills conceptualised as a basic “tool box” of manualised skills for practitioners who may not fully understand the theoretical models behind their actions. The “toolbox” approach also includes more advanced skills where practitioners provide complex formulation-driven and individually adapted interventions. The service user is closely involved in the collaborative effort of drawing up these plans and the “tools” are described in everyday language to aid engagement.

Some of these more advanced tools overlap with the specific CBT and family intervention skills described earlier.

Other CBT skills used in PSI

These involve enhancement of coping strategies, developing a rationale to explain symptoms, realistic goal setting, modification of delusional beliefs, and modification of dysfunctional assumptions.

Concordance (adherence) therapy

These skills are used to promote adherence to medication specifically, but can be used for a broader range of issues where engagement and persistence with agreed goals is considered crucial

Cognitive rehabilitation and remediation

These approaches are used to compensate for some types of cognitive dysfunction that may impair the individual's ability to plan and to cope with the demands of the world.

Family Interventions

These include family sessions to address the problems agreed between family members and also to build on strengths identified, as well as to provide support to the family. More specific interventions may be used to work with high levels of critical expressed emotion in a family setting.

Groups

Groups can be used for analysis of strengths, to identify problematic relationship style and functioning, with the group being used to suggest and reinforce changes in response changes in behaviour that may exacerbate conflict.

Educational opportunities

'Thorn' courses and other courses in psychosocial interventions (e.g. in Sheffield) are available around the UK.

These courses were originally set up in the early 1990s with a remit that was initially case management and family interventions, but the original courses at London and Manchester soon began to include some elements of CBT for psychosis, and courses established since (e.g. in Nottingham, Hackney, Bournemouth and Gloucester) have followed this pattern.

In the past, these have mainly recruited nurses and occupational therapists rather than psychiatrists, but there is no reason why they should not be used more widely by doctors, particularly with "New Ways of Working" and the move towards more consultative modes of practice.

The national PSI implementation group with NIMHE recently commissioned a scoping review of PSI training. It was able to confirm a number of well conducted RCTs and cross sectional studies of PSI training programmes.

Many PSI programmes have been established, ranging from short introductory

courses through to diploma and MSc level programmes.

Training is provided in house (generic, family programme and courses for individual intervention) or undergraduate (generic and family courses).

There are postgraduate programmes (Sheffield, Birmingham, Manchester, Sunderland and London).

All types of PSI training resulted in trainees adopting a more optimistic “recovery” models of mental illness. It was generally well received by trainees who improved their knowledge about psychosis. In terms of outcome for service users and their families, a period of improved engagement with individuals and professionals was apparent.

It is however difficult to measure skill acquisition across the varying PSI courses. In addition there is no agreed “benchmark” for “expert level skills”.

It is therefore difficult to reach any general conclusion about the type or length of training that is required to achieve any particular skill. The final outcome measure of training is a change in behaviour i.e. implementation of PSI. This has been difficult in routine practice.

The improved period of engagement with individuals was not maintained unless the training was delivered to teams (Baillie 2003) and there was management support for structural change to enable continuing work (e.g. reduction in caseload size).

Access to local and skilled supervision is probably one of the most important determinants of positive outcome for service users and staff.

PSI related casework is likely to be the preferred model of working for functional teams (AOT's and EIT's).

Although PSI training is well received and has advantages for users and families, more research is required to develop validated measures of PSI skills. For example, it is not yet established that PSI training alone leads to competence in the practice of CBT for psychosis. PSI training however ought to be available to psychiatrists in training.

Interventions important in clinical practice, but not currently included in the NICE Guidance.

This section deals with three approaches that are used widely in practice, but where there is insufficient evidence of efficacy to be included in NICE guidance.

Psychodynamically informed psychotherapy

“Counselling and supportive psychotherapy are not recommended as discrete interventions in the routine care of people with schizophrenia where other psychological interventions of proven efficacy are indicated and available. However, service user preference should be taken into account”

(NICE guidance)

Psychodynamically-informed supportive therapies are feasible for many patients with severe and enduring mental illness, but they are relatively costly (in terms of time and experience) compared to some other effective interventions, so they should mainly be used as an adjunctive therapy with patients who need the opportunity to reflect on the meaning of symptoms which may have content linked to specific traumatic events or where there are other indications that a therapeutic conversation may allow the service user to be more resilient to disturbing psychotic experiences.

Also, not all service users engage with evidence-based approaches and here the alternatives may be psychodynamically informed supportive psychotherapy. This intervention may be helpful, delivered across the phases of recovery, by a professional in long term contact with the service user. In practice this is often the consultant or CPN (Davenport 2000, Van Marle and Holmes 2002).

There is now better evidence for the effectiveness for other non-specific supportive interventions such as befriending (Sensky 2002). In this context, we have subsumed befriending therapy within dynamically-informed supportive therapy.

Therapeutic aims of dynamically-informed supportive therapy

- a) Establishing a therapeutic alliance or “engaging” the patient; this often involves thinking about the barriers to engagement, which may be psychological or practical
- b) Psychological holding and containing, including the provision of a safe, secure and reliable setting to provide a structure for the work.

c) Understanding transference and countertransference issues and their impact on the therapeutic relationship (and within the setting/team, as re-enactments often take place).

Specific techniques used in dynamically-informed supportive therapy

a) Specific types of communication, including empathic validation, praise and advice, affirmation, and confrontation where appropriate.

b) Environmental interventions such as gaining input from another professional (e.g. occupational therapist, educational link worker, housing support officer, general practitioner or solicitor). Recommending attendance at a vocational support service or undertaking voluntary work may also be relevant. Practical support sometimes needs to be organised.

c) Psychoeducation to promote a better understanding of the nature and personal impact of the mental disorder and its social consequences. Early warning signs recognition and relapse prevention plans can be negotiated and built in to the therapy.

d) Handling defences and promoting adaptive coping techniques to gradually improve social function and contribute to reducing social exclusion.

It can be seen that the specific competencies described for this form of intervention are similar to those described as generic core competencies at the beginning of this paper.

Systemic Therapy

Effective treatment of patients with serious mental health problems requires a coherent service from a multi professional group. Treatment modalities are more effective when they are provided as part of a planned multidisciplinary and multi-agency service collaborating between the different elements. This requirement includes medical, social and psychotherapeutic input. Systems-based approaches focus on these complex interactive systems to formulate difficulties and to intervene.

Psychiatrists and other professionals need to be aware of systemic theory and practice at four levels:

- Management of professional systems
- Management of personal and professional systems connected to service users
- Involving the service user's personal and family network and practitioners

- Ability (for some practitioners) to work in a systems-based therapeutic approach with service users and their families

All of these levels involve recognising the practitioners' limits and making appropriate referrals to specialist systemic therapists where appropriate

Management of Professional Systems

Involvement of the different professional groups that form the care team working with service users, is a shared responsibility between senior professionals and the team manager, and in practice the consultant psychiatrists will often have a key role to play in co-ordinating multi-disciplinary input to service users.

Management of Professional & Family Systems connected to service users

Psychiatrists and other professionals need to take account of the context that shapes a patient's experience. People displaying psychotic behaviours are often linked to complex personal and professional networks. A well-functioning system can promote recovery, but conversely a badly functioning system can lead to counter-therapeutic approaches including at its extreme institutional abuse.

Professionals also need to understand the impact of inequalities arising from gender, race, ability, sexual orientation, ethnicity, religion, age, social class, socio-economic status and employment to ensure that these are taken into account in developing effective care plans.

Psychiatrists need to ensure that they and the team are confident in containing the apparently contradictory views of professionals and family members involved in the service user's life whilst finding ways to help them work together coherently.

Involving the service user's personal and family network

Families with a psychotic member often feel blamed for the illness. Psychiatrists need to be sensitive to this perception and take steps to ensure that family members are supported and included in developing the treatment plan. The complexity of this work makes systemic family therapists important members of teams.

Psychiatrists, as part of their child psychiatry training, will often have had experience of working as part of a systemic team that operates using a live supervision model. In

adult services the same skills apply and competence in “live” supervision is an important skill within therapeutic teams.

Skills in conducting a therapy session include developing hypotheses to take account of the wider system, and asking open and relational questions.

It is important to understand and take account of the different responses from different family members, and work with the service user and family members to generate practical ways of resolving the different problems that confront them.

Psychiatrists should have an awareness of the influence of their personal experience on their practice and be responsive to the feedback they receive from their colleagues and patients.

Ability to work therapeutically with service users and their kin

Not all psychiatrists will be experienced in working therapeutically with patients and their families, although these skills are becoming more common. However, psychiatrists do need to take account of the potential confusion for service users and their networks when they adopt a number of differing roles in relation to the same service user.

Educational opportunities

Systemic therapy training is available in all parts of the UK. Standards for the profession are held by the Association for Family Therapy and Systemic Practice (AFT), a member organisation of the United Kingdom Council for Psychotherapy (UKCP).

Higher trainees can undertake intermediate level training in adult services as members of a systemic family team employing a live supervision model (one session per week for 1 year) This is underpinned by theoretical seminars, and working with one or two training patients and their families under supervision.

Arts Therapy

It would be unrealistic to expect that many psychiatrists would be able to train in one of the arts therapies. However, a basic understanding of the level and depth of training undertaken by arts therapists is useful to inform referrals for this intervention from all team members, and to understand the role of arts therapists within the overall team.

The creative arts therapies include art therapy, dance & movement therapy, drama therapy and music therapy. They are psychological treatments and are often called the non-verbal psychotherapies. They need to be distinguished from the valuable, but fundamentally different, use of arts to promote engagement and social inclusion

All the arts therapies offer a creative approach for communicating feelings that may be difficult to talk about or to put into words. The arts therapists work with a variety of creative methods and approaches, including making use of drawing and painting materials, body movement and voice work, role-play, music and improvisation.

Arts therapists are experienced practitioners in their chosen art form and are trained specialists in combining art, drama, music and dance movement with therapeutic models.

Arts therapists offer individual and group therapy in regular weekly sessions, where the overall therapeutic aim is to alleviate emotional distress and improve quality of life through using creative processes as an expressive and communicative channel.

The role of reflective practice

The NICE guidance recommends that

‘psychoanalytic and psychodynamic principles may be considered to help professionals to understand the experience of individual service users and their interpersonal relationships’.

Reflective practice is included here as it is fundamental to all of the approaches described above. It is not a psychological intervention for service users but for practitioners who need to make sense of the complex interactions within teams and institutions, and the bewildering experiences evoked when working with someone with a psychosis.

Psychodynamically informed reflective practice is helpful for psychiatrists and other professionals working with people suffering from schizophrenia. Reflective practice and supervision may enable care staff to recognise and manage their own difficult feelings when working closely with people who are very disturbed or distressed over long periods. This applies equally to doctors. Working with an awareness of the psychodynamic issues that affect the patient, and those closest to him/her, including

professional carers, helps to overcome those factors opposing therapeutic engagement (Davenport 2002).

Reflective practice is usually best facilitated by a professional with psychodynamic skills who does not work within the same service.

Reflective practice can also mean the team reflecting on the quality of the service that they offer as part of a clinical governance agenda.

Section 2: Psychological skills required by functional teams

This section is different in style as it attempts to summarise the key information about how the NICE guidance links to the development of a modern, team-based approach to the treatment of psychosis. It is intended as a vehicle for consultation with other professions in relation to the skills required within the whole team approach. A number of factors determine the skills required by functional teams, most importantly their client groups and the length of contact. The client group for Assertive outreach (AO) is likely to have severe positive symptoms and high levels of co-morbidity with substance misuse and personality disorder leading to disrupted social networks and an unstable life style.

In contrast an Early intervention in psychosis (EI) population may have lower levels of co-morbidity, more social stability and less prominent symptoms of psychosis. These assumptions will need to be tested in specific areas, as there may be variation attributable to social deprivation and other mediating factors.

Crisis resolution and home treatment teams (CRTs) will work on a short term basis with clients limiting the interventions that can be offered whereas rehabilitation and recovery teams will have an indefinite, possibly life-long engagement making the provision of long-term therapies essential.

Generic community mental health teams (CMHTs) will still continue, but they will manage a more stable population than some of the other teams, and there will be greater emphasis on individual case work rather than team-based working. The skills required in generic CMHTs will vary according to the local population, but for many service users the required interventions will be covered by the NICE guidance on CBT and family interventions.

Each section referring to a different team follows the same structure:

- Primary task
- Population
- Timescales
- Skills required according to basic (level A) intermediate (level B) and advanced (level C)
- Key interventions
 - PSI
 - CBT
 - Family interventions
- Additional modalities
 - Dynamically-informed supportive therapy
 - Systemic therapy
 - Arts therapies

Assertive Outreach (AO)

Primary task:

The main task is to work with individuals to improve their engagement with appropriate services.

Population:

The population has severe and enduring mental illness, are difficult to engage with services, have high levels of co-morbidity with substance misuse and personality disorder and have disrupted social networks and chaotic lifestyles. They may belong to marginalised communities either through culture or through poverty and social deprivation.

Timescales:

open-ended but with an aspiration to return to general CMHTs or specialist rehabilitation and recovery teams when stability achieved, although this may be over several years.

Skills required

Key modalities

PSI [basic, A]

PSI principles will be important in informing working style but will only be needed at a basic level, although these skills come into greater prominence when the individual begins to engage with the team.

CBT [basic and intermediate and advanced, AB&C]

Whilst the client typically has significant symptoms of psychosis, the chaotic nature of the engagement makes formal CBT unlikely. Although difficult to engage, where a client presents with very distressing symptoms, the provision of CBT can be of great value but needs to be undertaken by a practitioner with advanced skills.

Family Interventions [basic A, intermediate B and advanced C]

This group will have disrupted social networks and may be particularly vulnerable to stress. Although difficult to engage with family interventions, these would need to be from someone with considerable skills if such an intervention is undertaken.

Medication Management requires motivational interviewing skills

Additional modalities

Psychodynamic and reflective practice [advanced C]:

Psychodynamic principles are useful to understand the multiplicity of difficulties (Including social alienation) experienced by services users, and in supporting the team in working with them long-term.

Arts therapies

These are not normally possible as the population is unlikely to engage with formal structured creative therapies, although arts-based approaches to increase social inclusion may be used.

Systemic therapy [advanced C]

This group presents with multiple problems, interacts with many other systems and has difficulty with maintaining engagement. Supervision should be with an advanced practitioner.

Early intervention (EI)

Primary task:

To prevent the progression of illness and secondary disability in young people with a newly diagnosed psychosis.

Population:

Service users have early onset psychosis, possibly with only prodromal symptoms². As the population will be earlier in their illness trajectory, the secondary problems of disruption of social networks and functional disability will be less and co-morbidity

with substance misuse and personality disorder will be at a lesser degree than for some other services. However, a significant proportion of young people with psychosis of recent onset develop medication-unresponsive symptoms, frequent relapses and social disability.

Timescale:

timescale for involvement is predicted as having a median of 3 years but with considerable variability.

Skills:

Key modalities

PSI [advanced C]

These will be applicable to this client group in maintaining and increasing functional ability and promoting social inclusion.

CBT [basic A; advanced C]:

As many of the population will have minimal or well-controlled symptoms, only basic knowledge will usually be required, but access to more advanced CBT should also be routinely available, especially for the sub-group of clients with high morbidity.

Family Interventions [basic A and advanced C]:

Much of the focus for intervention will be in enabling family and social networks to be maintained and engaged in minimising the impact of psychosis on the service user.

Additional modalities

Psychodynamic and reflective practice [basic A]:

Again as the team is dealing with a population early in their illness, a basic understanding of psychodynamic principles as applied to developmental difficulties is necessary; supervision for more difficult patients may be helpful, but this is not a core therapy for EI services.³

Arts therapies [not routine]:

Arts therapies in this context are envisaged as primarily engaging those who are unwilling or unable to communicate through a primarily verbal therapeutic medium, usually due to disabling effects of long-term psychotic illness, they are therefore not

² Skills required for working with pro-dromal illness are being developed, but the Early Intervention teams described here deal mainly with service users where there is a clear diagnosis

³ There is a body of evidence for the use of psychodynamic therapies in first onset psychosis, particularly from Scandinavia, but this is not a model currently being widely adopted in the UK.

generally applicable to EI services, although arts-based approaches may be used in increasing social inclusion and engagement with the service. Some service users with previous exposure to this way of working may prefer to continue.

Systemic therapy [basic A]:

This population will usually have more intact social networks and less co-morbidity.

Crisis Resolution Teams (CRT)

Primary task:

To support service users and their families through short-term crises and to assist in their resolution.

Population:

Services users with major mental illness, including affective disorders, experiencing a period of crisis due to exacerbations of illness or social factors.

Timescale:

Short term to avoid hospital admission and to resolve the crisis.

Skills required:

PSI [basic A]:

These are helpful in addressing some problems, but formal, planned interventions are not provided due to the short timescales.

CBT [basic A]:

These will be helpful in addressing symptoms and can often build on previous interventions, but formal, planned therapy is not provided.

Family Interventions [basic A]:

Much of the team's work will be around mobilising support from social networks during crisis periods.

Additional modalities

Psychodynamic and reflective practice [basic A]:

This may be useful in understanding problems and engagement, but is not generally a planned intervention.⁴

⁴ Some models of crisis intervention draw on psychodynamic understanding, but in the main these have not included crises in this population.

Arts therapies:

not required due short timescales of intervention.

Systemic therapy [basic A]:

short term nature of work and 'resolution' cases.

Rehabilitation and Recovery Community Teams (R&R)

Primary tasks:

These community teams work long term to provide ongoing support and promotion of recovery.

Population:

Service users will be suffering severe enduring mental illness that is often treatment resistant, with severe positive and negative symptoms and associated functional and social disability.

Whilst they will usually have co-morbidity with other conditions such as substance misuse, personality disorder, cognitive impairment, or mild to moderate learning disability, they will be more engaged with services and more stable than the Assertive Outreach population.

Time scale:

The time scale needs to be long-term, possibly life long if the service user still requires services.

Skills required:

Core modalities

PSI [advanced] :

This long-term population, able to be engaged with therapeutic approaches would seem to be the group, *par excellence*, for whom PSI was designed.

CBT [advanced C]:

This group will have severe positive and negative symptoms and timescales support long-term psychotherapeutic work, although engagement maybe difficult.

Family interventions [basic A and advanced C]:

There will often be stresses in family or carer networks that can be addressed through family interventions.

Additional modalities

Psychodynamic and reflective practice [advanced C]:

There are usually multiple severe problems, difficulties in engagement and perceived lack of progress leading to demoralisation in teams. Long term psychodynamically informed supportive therapy can help service users to make sense of their profound difficulties.

Arts therapies [advanced C]:

This group will be able to engage in longer-term interventions due to their greater stability but may be inaccessible to verbal therapies, and so arts therapies may be used as an alternative, but they need to be at advanced level.

Systemic therapy [advanced C]:

There are complex conditions with fractured social networks, and systemic approaches may be difficult to use. When they are used they need to be at advanced levels of skill as they may involve complex interactions with neighbours, other residents, the wider social care system as well as family members.

Rehabilitation and Recovery Inpatient Teams (R&RIT)

Primary tasks:

Containment of risk and promotion of recovery.

Population:

Inpatient rehabilitation and recovery services, including forensic rehabilitation, serve the most disabled group within adult mental health services. The service users suffer severe enduring mental illness with profound positive and/or negative symptoms and multiple treatment resistance. Co-morbidity with other conditions will be typical and the service users will often have histories of high risk behaviours including violence (including in some cases sexual violence), self-harm, self neglect, fire setting, and many will have also experienced trauma such as childhood sexual abuse or adult sexual assault and violence.

Their needs will not have been successfully met by other services including acute inpatient and Assertive Outreach services.

Timescales:

Timescales will vary from a few months to life-long.

Skills required:

Key interventions

PSI [advanced C]:

As with community rehabilitation, this is the long-term population for whom PSI was designed, but there may be significant difficulties in maintaining engagement.

CBT [advanced C]:

This group will have severe positive and negative symptoms and timescales support long-term psychotherapeutic work, although engagement maybe difficult.

Family interventions [basic A and advanced C] :

Prolonged in-patient care may make family interventions less relevant, but it may be useful in re-engaging families who have been estranged from the service user, particularly prior to discharge.

Additional modalities

Psychodynamic and reflective practice [advanced C]:

complex conditions, high levels of disability and high levels of risk, often to staff. Formal, planned psychodynamic therapies may be indicated for patients who can engage long-term with an experienced therapist.

Arts therapies [advanced C]:

This group of patients will be able to engage in longer-term interventions due to their greater stability but may be inaccessible to verbal therapies and benefit from creative and arts-based therapies.

Systemic therapy [advanced C]:

The complex pathology, prolonged patient contact, high levels of disability, containment of risk, and complex and interacting institutional dynamics mean a systemic approach is indicated, but a high level of skill.

Acute Inpatient Teams

Primary Task

To provide a high standard of treatment and care in a safe and therapeutic setting to people with acute severe mental illness who at that time cannot be safely managed in an alternative setting.

Population

Acute inpatient units serve individuals with severe mental illnesses who become acutely unwell. Typically they have schizophrenia, affective disorders and co-

morbidities are common. They usually present with features suggesting high risk of self-harm, disturbed behaviour and/or violence. Because of these risks some will be detained under the Mental Health Act.

Timescales

The median length of stay is about 15 days. Some service users, usually those with more complex illnesses, require much longer admissions to reach a level of stability to enable discharge from hospital.

Skills required:

Key Interventions

PSI [basic A]

PSI skills will play a part but given the acute nature of the illnesses formal PSI interventions would not be routine.

CBT [advanced C]

Even though full formal CBT programmes would not usually be appropriate due to the short-term nature of the majority of admissions, a high level of skill in the range of cognitive-behaviour interventions will be very useful in inpatient settings. For example they will provide useful therapeutic means of addressing positive and negative symptoms of schizophrenia, allow the initiation of problem solving and symptom management skills along with work on concordance with treatment on discharge.

Family Interventions [basic A]

Some family work will be beneficial in supporting families and educating them about severe mental illness.

Additional modalities:

Dynamically-informed supportive therapy [advanced C]

Psychodynamic principles are useful in understanding the difficulties experienced by the service user and are helpful to inpatient teams who manage a high level of disturbance. Dynamically-informed supportive therapy will be useful in engaging users and promoting a better understanding of their problems.

Systemic therapy [advanced C]

The inpatient service manages service users who often have multiple, complex problems so interaction and understanding of other systems is vital.

Arts Therapy [basic A]

For service users who have difficulty expressing themselves verbally arts therapies will be useful in providing an alternative means of communication.

Section 3: Training implications for psychiatrists

Psychiatry training is being re-designed in the light of Modernising Medical Careers and the new role of PMETB. Some of the detailed competencies described here are subsumed within the overall curriculum.

This paper deals specifically with the competencies needed by psychiatrists arising from the NICE guidelines on schizophrenia and the discussion in this paper.

Training in core competencies

- These core competencies at a basic level should be part of the skills of all psychiatrists. They are key skills for all psychiatrists working with patients with schizophrenia and their families.
- MRCPsych training programmes should reflect the need to increase the availability of psychological treatments for people with schizophrenia.
- All psychiatrists involved in the delivery of psychological therapies for psychosis need to acquire at an intermediate level the mindset, core treatment skills, organisational understanding and inter-professional awareness through training and supervised practice.
- Consultants need to acquire flexible formulation skills to ensure appropriate referrals are made for specialist psychological interventions.
- The availability of supervisors for all modalities of training should be audited on a Divisional basis. The results should be included as training opportunities with each Deanery Training Programme prospectus and also circulated as part of CPD support arranged at Divisional or College level

Key Psychological Intervention skills including CBT and family interventions and PSI

- At a basic level, all psychiatrists should be aware of the range of interventions available for the treatment of schizophrenia, and how they are relevant to the functional teams with which they work.
- Trainees at the higher level and consultants should be encouraged to train in PSI based family interventions and CBT through one of the many accredited training courses and to undertake supervised practice to the level where they are able to practise the skills at a basic level and to have advanced knowledge

of how the various treatments can be linked as part of an overall formulation and treatment plan.

- Medical managers should ensure that systems promote rather than resist the implementation of new forms of practice for consultants and the teams they work with.
- Specialty training committees and programme directors should raise the profile of PSI training and training in CBT and family interventions through local training programmes so that the skills become widely available to higher trainees.
- Some trainees will access intermediate or advanced training in PSI skills, CBT and family interventions as part of their training programme. This level of skill is necessary for some general adult, rehabilitation and psychotherapy trainees (particularly those following CBT as their main modality). Training at this level supports a future role as consultant working with one of the functional teams.
- Some trainees will follow a specific training in family interventions or CBT for psychosis whilst others may follow the broader route offered by PSI training courses.
- Higher trainees in general adult psychiatry should be expected to undertake further training in psychological therapies by using flexible training sessions (special interest), or in some programmes they can spend a year working in a psychotherapy department gaining CBT and / or family intervention skills.
- Consultants should consider psychological intervention training as a realistic component of Continuing Professional Development.
- Medical managers should consider psychological intervention skills in medical workforce planning, and specifically in job planning for individual consultants, and support consultants gaining additional PSI, family intervention and CBT skills relevant for their role. These should be monitored through appraisal.
- Psychiatrists who have undertaken advanced training in CBT can register as independent psychotherapists in the CBT modality through British Association for Behavioural and Cognitive Psychotherapy (BABCP).
- Psychiatrists with specialist training should be involved in supervision of other team members.

Educational Opportunities in additional modalities

Dynamically-informed supportive therapy

- Higher trainees in general adult psychiatry can choose to undertake further training in dynamically-oriented psychotherapy, either by spending a year in one of the specialist psychotherapy placements on a general rotation, or by using their special interest sessions for supervised practice.
- Trainees in general adult psychiatry should be encouraged to gain further experience in dynamically-oriented psychotherapy as part of their higher psychiatric training.
- Dynamic psychotherapy can be undertaken as a main modality leading to independent registration as a psychotherapist through the United Kingdom Council for Psychotherapy (UKCP) or the British Confederation of Psychotherapists (BCP)

Systemic training:

- A basic understanding of systemic approaches to complex systems is needed for all psychiatrists.
- Application of this understanding is needed at intermediate level to provide effective leadership of complex systems, and so further training tailored to the needs of higher trainees and consultants needs to be developed, preferably as a national initiative given the scarcity of specialist systemic resources applied to work with psychosis
- Systemic training at advanced level can be the main modality for a psychiatrist training in psychotherapy, although this is uncommon. Systemic therapy can be undertaken as a main modality leading to independent registration as a systemic psychotherapist through the UKCP

Arts based therapies

- All psychiatrists need to have a basic awareness of arts-based therapies and their role, and to understand the distinction of arts-based specialist therapies from art as a medium to improve social inclusion and engagement.
- Arts based therapies (creative therapies) are widely available in many mental health services, although they have often been located with in-patient rather than community settings.

- Many of these services provide introductory awareness sessions for non-specialists. These can be useful to increase awareness about the methods used and the range of applicability of the different modes of creative and arts-based therapies.
- Some services and training organisations run longer introductory courses which provide skills at a basic level for psychiatrists and other professionals, but these do not provide the advanced skills necessary for independent practice.
- Arts based therapies can be undertaken as a main modality leading to registration as a psychotherapist through the UKCP

Recommendations re reflective practice

- Service delivery and job planning for professional staff should take account of the need for reflective practice, which should be timetabled and prioritised.
- There should be increased availability and funding for external facilitation of reflective practice groups.

Conclusions

To be developed after wider inter-professional consultation, but suggest reference to New Ways of working and

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