

Providing Psychosocial Intervention: the role of non-medical practitioners

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Introduction: a rationale for Psychosocial Intervention

It is recognised and accepted that psychological and social approaches have much to offer in the management and treatment of serious mental illness, such as schizophrenia, complementing psycho-pharmacological treatment (NICE (1)).

Psychosocial Intervention (PSI) refers to an approach that includes individual, family and group work, provided alongside the psycho-pharmacological treatment of psychotic illnesses (2). More specifically, whilst acknowledging the core principles of systematic assessment, care coordination, assertive outreach and early intervention in psychosis, PSI may best be considered an umbrella term that refers to the use of a structured, collaborative, cognitive-behaviourally orientated approach to working with service-users and families, which incorporates a number of important therapeutic components: engagement and outcome-orientated assessment; psycho-education; psychological approaches to managing symptoms, such as stress management, coping strategy enhancement, structured problem-solving and cognitive-behavioural intervention; medication adherence strategies; and, structured relapse prevention planning (3,4,5,6).

The varied benefits of PSI-related approaches have been well-reported within the literature, as: improving the service-user's knowledge and understanding of their illness; increasing self-motivation; promoting self-management; reducing symptoms and levels of distress / disturbance; enhancing positive coping strategies and problem-solving skills; enhancing skills in changing unhelpful behaviour and balancing unhelpful thoughts; improving treatment adherence; identifying the potential triggers and early warning signs of illness episodes; and, managing early warning signs and thus reducing the likelihood of relapse (4,5,7,8,9,10,6,11,12).

One of the major advantages of providing PSI as a routine component of care is the high level of active engagement and involvement of the service-user within their own care, through a collaborative and skills based approach (6). Mental health nurses and social workers, amongst others, are well placed to provide a number of these practical therapeutic interventions because of their active and close involvement in the care of service-users (13,6).

In this short paper, following a consideration of some of the evidence that supports the provision of PSI approaches by non-medical practitioners, the local Trust's approach to providing PSI will be briefly described.

Supporting Evidence for the Provision of PSI

It is generally accepted that there is sufficient evidence to support the effectiveness of PSI approaches for NICE (1) to conclude that family intervention and cognitive behavioural intervention (CBT) should be routinely available for service-users and their families / carers (5,1).

There is now a wealth of evidence supporting the provision of family intervention approaches (14). In their review of 32 randomised controlled trials involving 2,429 participants, NICE (1) concluded that there was robust and consistent evidence for the efficacy of family intervention, when compared to standard care or any other control, reporting the following outcomes: a reduction in the risk of relapse by the end of treatment and up to 12 months follow up; a reduction in hospital admission during

treatment; a reduction in symptom severity during treatment and up to 24 months follow up; with some, though limited, evidence of being effective in improving social functioning and the service-user's knowledge of the disorder.

Furthermore, in comparison to standard care, NICE (1) have reported that there is consistent evidence that CBT is effective in: reducing re-hospitalisation rates up to 18 months post treatment; reducing the duration of hospitalisation; reducing symptom severity by the end of treatment and up to 12 months post treatment; and, with some evidence for improvements in social functioning up to 12 months.

Considering the role of the non-medical practitioner, Turkington et al (15,13) investigated whether the provision of a programme of brief cognitive-behavioural intervention by community mental health nurses (CMHNs) could produce clinically important outcomes for people with schizophrenia in secondary care settings. In their multi-centre, pragmatic, randomised trial with 422 patients and carers, a brief cognitive-behavioural intervention that involved the provision of 6x one-hour sessions over a 2–3 month period, was compared with treatment as usual. To support this intervention, the CMHNs had access to a treatment manual and psycho-educational materials (based upon: Kingdon & Turkington (16)). Those receiving brief cognitive-behavioural intervention demonstrated favourable outcomes when compared with treatment as usual, highlighting improvements in overall symptomatology, insight and depression for the treatment group. Turkington et al (15) concluded that CMHNs, following their completion of a 10-day intensive training programme in the use of cognitive-behavioural intervention, can safely and effectively deliver brief cognitive-behavioural intervention to patients with schizophrenia and their carers.

In their one-year follow-up study, Turkington et al (13) reported a durable, statistically significant improvement in insight and negative symptoms for those receiving brief cognitive-behavioural intervention compared with treatment as usual. Furthermore, they highlighted that this intervention protected against depression and relapse, with a significantly reduced time in hospital for those who did experience a relapse.

In a scoping review of 37 papers in which the provision of training in generic PSI or family intervention approaches was evaluated (based upon 14 controlled studies, 11 cross-sectional studies and 12 uncontrolled studies using a pre and post measure design, published since 1990), a number of positive findings were consistently demonstrated: high levels of satisfaction with PSI training, though less satisfaction with available supervision; an increased level of knowledge following training, irrespective of the length or type of training provided (which included educational programmes varying from 18-hours to two years); the development of targeted skills for implementing evidence-based PSI; promoting a 'recovery-focused' perspective; a series of positive benefits for service-users, such as a reduction in symptoms & improved general and social functioning, and a positive impact on the experiences of service-users and carers (5,17).

The expectation that services and practitioners will make evidence-based interventions more available to service-users and families is increasingly emphasised within the national guidance (for example: NICE (1)), though this presents a challenge to services, requiring that various obstacles are managed / over-come: limited access to educational programmes; case-work pressures; conflict between care coordinator and PSI practitioner roles; lack of time for prioritising and organising the provision of PSI sessions; resistance from those who feel threatened by the changing nature of the practitioner's role; the unrealistic expectations of other team-members; problems in accessing support from the team manager or supervision from an advanced practitioner; a lack of confidence in providing PSI; and, a feeling of isolation (12,18,19,20,21).

Providing PSI within a Mental Health Service

Brooker & Brabban (5), Sin & Scully (22) & Mullen (6) have highlighted a number of critical ingredients for the successful implementation of PSI approaches, as:

- the provision of an appropriate educational programme;
- training sufficient numbers of practitioners within a team;
- ensuring access to high quality, skilled supervision;
- supporting and enabling practitioners to provide PSI as an expected component of their role;
- supporting practitioners in developing enough skill to apply interventions flexibly; and,
- achieving organisational ownership and support, for example, through the work of a steering group.

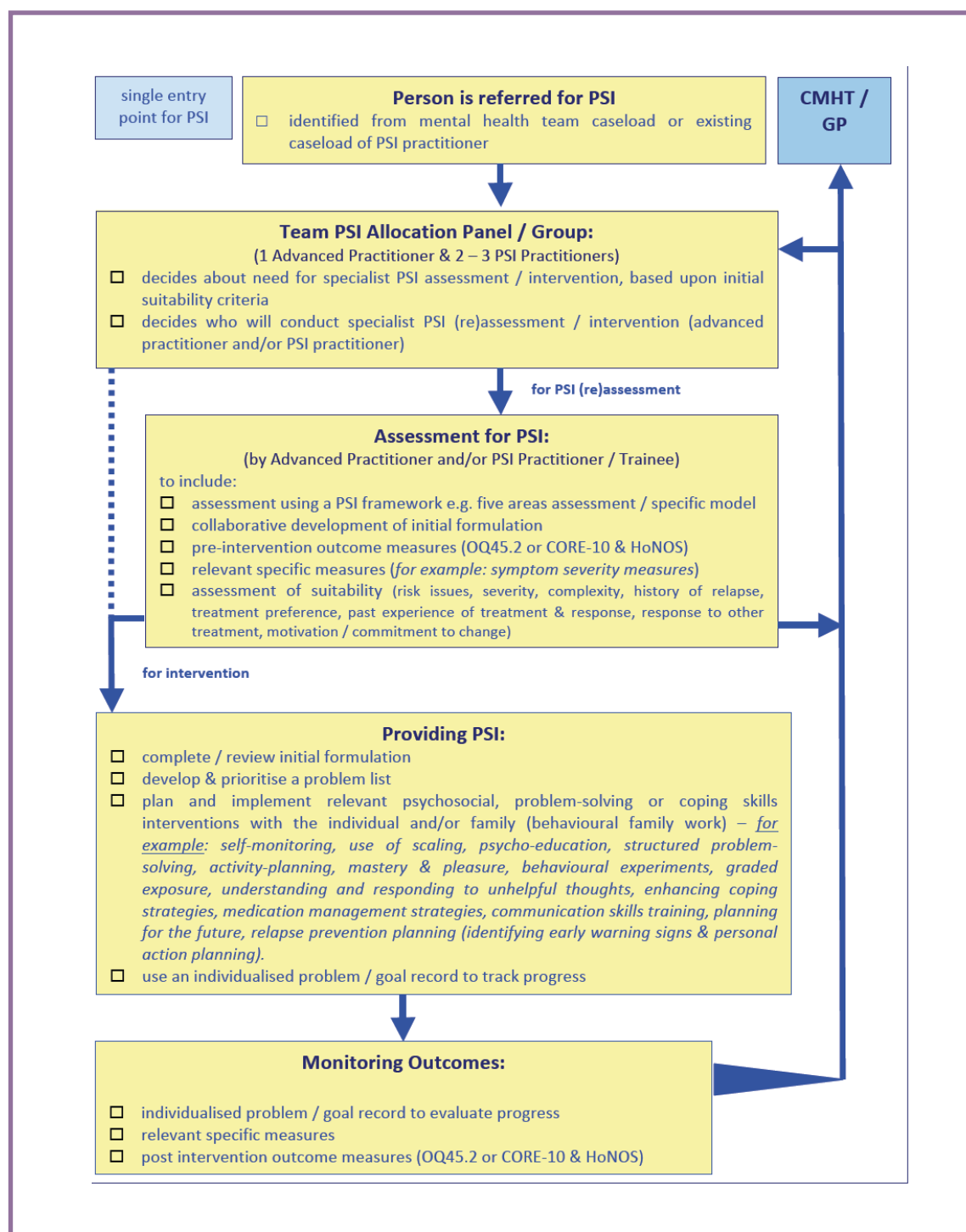
Within Bedfordshire and Luton, a stepped framework for providing PSI and related approaches was developed, acknowledging that service-users / families will have different needs, depending on the characteristics of the illness, personal and social circumstances, and responses that are needed from services. Stepped care involves making decisions about intervention which are informed by the systematic monitoring of progress and outcome – thus, some service-users may require a more or less intensive form of intervention or intervention from a more skilled practitioner / therapist (23,24).

In the context of the mental health team, it is acknowledged that some team-members will possess an awareness and basic level of knowledge and skill, being able to provide some basic cognitive and behavioural intervention strategies. At the next level (or step), a smaller number of team-members who have undertaken specific training in PSI will have developed skills in conducting a specific PSI assessment, collaboratively developing a formulation of the service-user's problems, difficulties and needs through use of a generic framework, as the basis for planning and providing a series of meaningful behavioural and cognitive interventions over the course of a structured series of therapeutic sessions. At the higher level, the team's clinical psychologist and, in some cases, other practitioners will have completed their formal training in a therapeutic approach.

Over the past few years, a significant number of mental health practitioners, primarily nurses and social workers, have undertaken one and/or two PSI educational programmes that have been developed with the University of Bedfordshire: a degree-level module in PSI, and from 2008, a Post-Graduate Certificate in PSI. Furthermore, a series of short in-house educational programmes on Medication Management (Concordance Approach) and Behavioural Family Therapy / Intervention have been provided. These programmes are intended to prepare practitioners for providing structured and collaborative PSI sessions to the service-user and/or family, and focus upon the acquisition / enhancing of practical skills.

Within the local mental health teams, practitioners who have completed a recognised and accredited educational programme in PSI are expected to provide PSI within their team under the supervision of an advanced practitioner, such as the team clinical psychologist. The PSI practitioner follows a practice pathway (see Fig. 1), which ideally involves participating within a team-based PSI practice panel / group meetings to discuss those service-users being referred for PSI.

Fig. 1: PSI Practice Pathway



For those completing a PSI educational programme, a standard for PSI practice has been established: for each PSI practitioner to provide structured and collaborative PSI sessions with at least two service-users (or families), supported by skilled practice supervision.

In recognising the impact and value of PSI within practice, a concurrent service audit has been designed and introduced as an expected component of practice by PSI-trained practitioners. In providing an overview of the outcomes being achieved by local mental health nurses or social work practitioners, though not limited to just working with people with schizophrenia, outcome-monitoring with those receiving time-limited structured PSI sessions to date (N=61), has demonstrated a reduction in psychological distress as measured using the OQ45.2 self-reported outcome measure (Lambert and Burlingame (25)), and a reduction in practitioner-rated HoNOS total scores (26). Upon further considering OQ45.2 findings, 65% of service-users have shown a statistically

significant and reliable improvement, primarily associated with a reduction in symptom distress at post intervention, though a small number also achieved a reliable improvement in problems associated with interpersonal relations and social role. It is proposed to continue to gather and build upon this outcome data-set in determining the value of this intervention approach for different client groups.

Conclusion

The model for promoting the implementation of PSI within the local Trust reflects the recommendations of national guidelines and the literature in ensuring that many of the critical ingredients are provided: the provision of an educational programme (the local accredited degree-level module in PSI; the more recent PGCert PSI course programme); the provision of skilled clinical supervision by advanced practitioners (most usually by team clinical psychologists and therapists); advocating a stepped model in delivering PSI as a service resource within a mental health team. This model serves to promote access to PSI approaches.

Whilst it must be accepted that providing PSI is most likely to form only part of a wider care package designed to address the specific needs of the service-user, this should be considered as an important therapeutic component of the integrated care-plan for those with schizophrenia or other serious mental illness.

Though not limited to those with schizophrenia, the outcomes of providing short-term PSI within the local mental health service are viewed as very encouraging and demonstrate the value of both promoting the implementation of evidence-based interventions and integrating outcome monitoring as a routine component of service provision.

GP comment

What have I learned from this paper?

1. The psychosocial intervention (PSI) practice pathway incorporates the various aspects of patient needs and is carried out considering individual patient's needs. This pathway helps us to understand how PSI practice works.
2. Psychosocial intervention can be a valuable part of the patient's care package.
3. There is evidence to show that psychosocial intervention can improve the patient's knowledge about the illness, improve self-confidence and reduce distress.
4. My expectations of a good schizophrenia service will include not only psychiatrists who will manage the medication competently but also professionals that can provide appropriate, targeted psychosocial intervention.

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