DEVELOPING PSYCHOLOGICAL APPROACHES IN OXLEAS NHS TRUST

1. Background:

Psychological approaches need to be further developed within Oxleas NHS Trust for the following reasons:

- In common with every other Mental Health Trust in the country, insufficient resources are available to enable staff within the Trust to meet the psychological needs of the care groups they serve.
- Gaps in psychological service provision have been identified as a major concern by service users and their carers.
- Department of Health guidance and Healthcare Commission standards emphasise the need to develop this area.
- Provision of psychological approaches in Oxleas is currently driven by local and historical factors. As such, not all client groups have equal access to therapy through a systematically applied service delivery model.
- Patient choice is central in psychological therapy making it a key element of the Trust's Service Development Strategy.
- It is therefore imperative that we embrace national guidelines and move towards offering equitable access to evidence-based approaches for all those who use the Trust's services.
2. Major Areas for Development.

Oxleas Trust needs to carry out two major developments in relation to psychological approaches in order to promote the delivery of effective mental health interventions:

1) Improve all staff’s understanding of the importance of psychological factors in mental health care.

2) Increase the availability of formal psychological therapy treatments.

The contribution of the Trust’s entire workforce – administrative, corporate and clinical - is essential in effectively engaging with service users. Psychological approaches are at the core of mental health services in this regard and the Trust has a good basis for developing work in this area. This paper begins by considering how psychological processes impact on the care offered by all staff and then looks in more detail at a service model for psychological therapy provision. The application of this model to working age adults with psychosis is then highlighted and the paper ends with an examination of the actions which need to be taken to develop the Trust’s capacity in this area.
3. Broadening staff understanding of psychological approaches

It is now widely acknowledged that an understanding of psychological processes is integral to the effective planning and delivery of mainstream NHS mental health care (see appendix 1 for details of national policy guidance). Psychological processes not only underpin a number of effective stand-alone treatments, they are a crucial component of all interactions between staff and those who use their services.

People who use mental health services have frequently experienced major and enduring difficulties in their relationships with others. They have frequently suffered various forms of abuse or experienced sudden traumatic separations which make them highly sensitised to apparent lack of consideration and/or rejection by any member of staff from within the Trust. Thus, all staff need an awareness of effective ways to facilitate positive engagement and maintain continued interactions with those who use our services.

This point can be made using three examples:

- The consideration shown by reception and administrative staff can substantially impact on service user engagement.
• Service user compliance with medication can be radically improved by the timely provision of clear and concise information about potential side effects.

• Delivery of the Care Programme Approach can be made a genuine partnership by paying attention to the psychological processes involved in setting up and conducting care planning meetings.

4. Provision of Psychological Treatments

In addition to improving day-to-day interaction with service users, the Trust needs to build on existing skills to increase its capacity to deliver the range of mainstream generic and formal psychological treatments. These psychological therapy treatments (appendix 2) are relevant for all care groups regardless of diagnosis or severity of their difficulties and can be applied in primary, secondary and tertiary settings either as stand-alone treatments or as part of a comprehensive multi-disciplinary package of care. Local needs assessments (appendix 3) indicate that there is a large mismatch in terms of Trust capacity and local need.
Therefore we need to ensure:

- Senior staff are signed up to the general model of psychological therapy provision described later in this paper.
- All staff have an awareness of the importance of psychological processes in mental health care
- All clinical staff have training in basic psychological therapy treatments
- Sufficient specialist psychological therapists are available to work with complex problems and supervise and train other staff.

5. A Psychological Therapy Service Model

We need to agree a generic model for psychological therapy which can be adopted for use within all care groups served by the Trust. This will ensure safe and equitable access to the major types of psychological therapy

The model is predicated on the assumption that certain basic organisational support structures are available within a given service/team context.

The service needs to have in place:

- Clear service management and professional support structures
- A single point of entry
- Integrated care pathways
- Workload management systems
- A clear commitment to training
- Multi-professional working
- Strong clinical governance arrangements
- Supportive supervision structures
- Strong team leadership

Within this context, the psychological service model depends on every service user having a comprehensive assessment from a mental health professional who can enable them to make an informed choice about the type of psychological approach which is most appropriate for them given their current difficulties. The assessment may also lead them to conclude that the provision of psychological approaches does not currently represent their most pressing need. The person making the assessment needs experience and understanding of all the major forms of psychological therapy, enabling the service user to make a decision about their treatment within the context of a clearly articulated and individually-based psychological formulation of their difficulties which considers cognitive-behavioural, psychodynamic and systemic aspects of their situation.
The model may be represented diagrammatically:

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Referral for Psychological Therapy

Skilled assessment allows informed choice

Psychological Therapy from the Trust not an appropriate current option
Psychological Therapy to be provided by the Trust

Assessment waiting list

Treatment waiting lists
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This model allows the precise calculation of waiting times for different types of psychological approaches using a specialist assessment framework.

The model allows us to:

- Be confident in our governance arrangements
- Ensure informed user choice
- Measure demand and capacity in an accurate way
- Protect individual staff from inappropriate levels of stress
- Make clear predictions about training and workforce issues
6. Applying the Model to Psychological therapy for people with psychosis.

This is a major three-borough initiative focusing on the NICE guidelines for working age adults with schizophrenia and includes the following elements:

- Examining current access to psychological therapy for people with psychosis across the Trust
- Completing the existing survey of clinicians with psychological therapy skills within the Trust, in the areas of CBT and family therapy
- Developing training programmes and supervision structures tailored to the differing levels of expertise in clinicians identified as possessing skills in CBT and Family Therapy
- Setting out a training strategy for staff new to such approaches

This approach is described in detail in appendix 4 where implementation proposals are set out describing the roll-out of the approach within the Trust.
7. Key Action Points for the Trust: Psychological Approach Implementation

- Agree service model at Board level
- All directorates to set priorities as part of Annual plan
- Establish a Project Board to cost the approach and drive it forward
- Reconfigure existing posts to increase number of psychological therapists
- Produce co-ordinated training strategy

Keith Miller, Director of Psychological Therapy

December 2005
APPENDICES

Appendix 1: National policy

There have been a number of policy documents in the previous ten years indicating the importance of establishing comprehensive psychological therapy services.

These include:

- *NHS Psychotherapy services in England – Review of Strategic Policy* (NHS Executive 1996). This report made recommendations about both type of provision as well as structure of such provision. It reviewed the evidence noting “psychological treatments can help in many mental health problems including severe, enduring mental illness, to promote significant change in symptoms and functioning.”

• *National Service Framework for Mental Health*. Several standards in this key document highlight the necessity for psychological assessment and treatment to be made available. For example, standard seven aims to reduce suicide and highlights the need for patients most at risk to have access to specialist psychological services as part of an overall coordinated care and treatment approach.

• *Psychological Therapies Working in Partnership* (NHS Executive 2000). This makes recommendations for the organisation and delivery of services “in primary care, in secondary care, in CMHT’s and in specialist tertiary settings.”

• *Treatment Choice in Psychological Therapies and Counselling. Evidence-based Clinical Practice Guideline*. (Department of Health 2001) This document summarises the evidence base for psychological therapies and includes a number of recommendations about building a comprehensive service.

• *Choosing Talking Therapies*. (Department of Health 2002) Information leaflet for patients
• *Nice guidelines for Schizophrenia.* (Department of Health, 2002) A requirement to provide cognitive therapy and family interventions for all clients with schizophrenia.

• *Personality Disorder - No Longer a Diagnosis of Exclusion* (NIMHE 2002). Recommends the availability of specific psychological therapy treatments for patients with personality disorder particularly specialist behavioural therapy (DBT) and group psychotherapy approaches.

In summary there is now a strong evidence base as well as a raft of policy directives indicating that a key requirement for all Mental Health Trusts is the provision of a range of psychological approaches.

“Psychological therapies are an important part of mainstream NHS mental health care. They are one of the two main approaches to the treatment of the mentally ill (the other being physical treatments such as medication and ECT).”

(NHS Executive 2000)
Appendix 2: What are the mainstream psychological therapy treatments?

Psychological therapies comprise a range of treatments that should be “routinely considered as an option when assessing mental health problems” (Department of Health, 2001). They are highly acceptable to patients and many prefer them to physical treatments such as psychotropic medication and ECT. They are appropriate throughout the life cycle and can offer significant treatment gains for the entire range of client groups served by the Trust including children, working age adults, people with learning disabilities, those in contact with forensic services and older adults. They can be of use and of relevance for patients regardless of diagnosis or presenting problem and at all levels of severity.

The range of procedures that are categorised as psychological treatment is very broad with over 450 forms of psychological therapy identified. Richardson (1997) notes that this apparent diversity and potential for confusion can be dealt with by grouping forms of psychological treatment into six major categories. All these treatments are provided at an advanced level of expertise by practitioners within the Trust. The six major types of psychological therapy are:

- Cognitive-behaviour therapy;
- Psychodynamic therapy;
- Family/Systemic therapy;
- Counselling;
• Integrative approaches;
• Group Therapy.

These approaches may be provided separately or as part of an integrated multi-disciplinary package. The medium used is usually verbal but some specialist non-verbal therapies such as art therapy have an important part to play with patients who find it hard to put their difficulties into words.
Appendix 3: Needs assessments

Several needs assessments in relation to psychological therapy provision, both internal and external to Oxleas, have been conducted in the last five years. These include:

- Oxleas assessment of need (Walker 2000)
- Bexley, Bromley and Greenwich Health (Lawson 2001)
- London Regional Survey (NHS London regional office 2002)
- Greenwich Primary Care Trust (Lawson, 2003)

All these surveys indicate that there is an extremely large shortfall when the demands of the population in Greenwich, Bexley and Bromley are compared to the capacity of the Trust to deliver psychological therapy services.

Lawson (2001) examined the population of working age adults in Greenwich, Bexley and Bromley and their requirements for psychological treatment by extrapolating from the OPCS psychiatric morbidity survey (HMSO 1995).

This assessment concluded that an extremely large number of people - over 75000 - across the three boroughs were suffering from a neurotic disorder (e.g. depression, anxiety, or obsessive compulsive disorder) which could potentially
benefit from psychological therapy. It was estimated that this group of people would require the services of in excess of 600 whole time equivalent psychological therapists to meet their needs.

These 600 + staff (if available) would only meet the needs of working age adults with neurotic disorders. The importance of psychological approaches for adults with psychosis have recently been enshrined in Department of Health treatment guidelines; these have pointed to the evidence base which strongly indicates the importance of providing cognitive behavioural therapy and family-based interventions for all those experiencing psychotic difficulties. There are also increasing demands for psychological treatment for those with personality disorder. Both these would significantly increase the number of staff required to deliver psychological approaches to those of working age.

Walker (2000) undertook an assessment of need based on current referral rates and estimate of demand/need by referrers within Oxleas in contrast to the epidemiological approach undertaken by Lawson. This produced a more conservative estimate. It suggested 86 specialist staff were needed to meet demand in secondary and tertiary Oxleas adult mental health services.

It is important to emphasise that other Trusts, both regionally and nationally, also struggle to provide sufficient psychological therapy for working age adults with mental health problems.
The other major care groups served by the Trust include children, people with learning disabilities, older adults and those within forensic services. No specific locally-based needs assessments for psychological therapy exist for these client groups although clearly demand is high. It should be emphasised that people in these other care groups have an equal right to psychological input to meet their needs.
Appendix 4

Increasing Access to Psychological Therapies for working age adults with Psychosis

1.0 Policy Context
Over the last decade national policy guidance has increasingly placed psychological therapies at the heart of modern mental health provision (e.g. NHSE, 1996; DOH, 2001; NSF for Mental Health, 1999; NHSE, 2000; NICE, 2002). The growing evidence base for the effectiveness of a range of psychological therapies in the treatment of common and complex mental health problems, has contributed to the importance placed on services providing access to ‘talking treatments’. Furthermore, psychological therapies are extremely popular with service users and carers. However, demand outstrips supply and mental health service users consistently place access to psychological therapy at the top of their list of unmet needs (DOH, 2004).

There is concordance nationally and locally about the need for services to provide a full range of psychological therapies to all sub-groups of clients. Kosviner (2000) highlighted the need for services to provide access to all mainstream psychological therapies at different levels of expertise. Furthermore, DOH (2004) emphasises the importance of having a psychologically literate mental health workforce, who are supported by a co-ordinated training strategy, which facilitates continuing professional development.

The Department of Health and NIMHE recently launched a policy (Our Choices in Mental Health, 2005) highlighting the importance of offering greater choice in treatment options for mental health service users, including improved access to psychological therapies. In Oxleas we are committed to improving access to evidence-based psychological approaches for service users and carers. However, in common with every other Mental Health Trust in the country, insufficient resources are allocated to meet the needs of the population we serve. Our approach to address the challenges presented by increasing access to psychological therapies has been to establish an Access to Psychological Therapies group “to promote and develop a systematic service delivery plan to provide increasing access to a range of psychological approaches and therapies for all service users” (Miller, 2005).

A first stage in developing psychological approaches as a key component of the Trust’s core business, has been to achieve agreement for an overall service model for psychological therapy provision. Kosviner (2000) provides a robust framework for delivery of a full range of psychological approaches, at different levels of expertise (Appendix 1), and we will be basing our service development strategy on the main tenets of this model. Furthermore, the group has
identified a series of tasks that will be necessary to improve access to psychological approaches. These include reviewing relevant NICE guidelines, auditing of existing skills, development of training for and supervision of all mental health staff in psychological approaches, and identifying areas for priority development.

Given the scale of service development required to improve access to psychological therapy for all sub-groups of clients, it has been necessary to identify which clinical group should be prioritised in the first wave of service development. In line with national imperatives (NICE, 2002), improving access to psychological therapy for psychosis was identified as a priority. SELSHA provided funding to initiate this project, as part of the South East London Choice and Mental Health Programme.

2.0 Increasing Access to Psychological Therapies for Psychosis: Proposal for development

2.1 Background

The NICE guidelines for Schizophrenia (2002) state that: ‘psychological treatments should be an indispensable part of treatment options for service users and their families’. The guidelines recommend that Cognitive Behavioural Therapy (CBT) and Family Intervention (FI) should be routinely available to this client group. Implementing the guideline can present services with a host of challenges, both in terms of having a critical mass of staff skilled to provide these therapies, and in understanding the range of approaches covered by the terminology. Within Oxleas, we have included CBT and FI activity carried out by appropriately skilled clinicians under supervision, as meeting NICE guidelines criteria.

Earlier this year, a cross-directorate audit (Mel Bunyan, Naomi Horton and Jane Moore), and a detailed mapping exercise within adult mental health services (Marina Richards) were conducted. They demonstrated that a significant shortfall exists in CBT and Family Therapy expertise within adult mental health. Furthermore, for clients with a diagnosis of schizophrenia, access to therapists who have the skills and capacity to deliver CBT and FI, in line with the NICE guidelines for schizophrenia is at best minimal, and frequently non-existent. The reasons for poor access to CBT for Psychosis and FI differ across the three boroughs for reasons of service configuration and variability in resources. However, none of the boroughs have sufficient numbers of skilled staff to improve access in a meaningful way at this stage. It is possible however, to make recommendations to improve access in the short term within existing resources, and identify strategies to facilitate NICE guideline implementation, requiring restructuring within teams, in the longer term.
In addition to the provision of sophisticated psychotherapeutic interventions required by the NICE guidelines, we need to be providing a range of CBT informed interventions at different levels of expertise. Delivering this agenda will require resource allocation and senior clinical management support. This proposal is consistent with recent guidance from NIMHE (Brooker and Brabban, 2005) which identifies the need for mental health services to provide a span of evidence-based psycho-social interventions (PSI) requiring different levels of skill and proficiency.

To avoid confusion in terminology, PSI is a ubiquitous term that covers all non-pharmacological evidence-based interventions used in work with people with psychosis and their families. Core values of PSI include therapeutic optimism and an appreciation of a philosophy of recovery (Brabban and Brooker, 2005). CBT for psychosis, CBT informed interventions (e.g. relapse prevention, psycho-education, concordance, coping skills enhancement), and FI constitute different components of PSI.

The draft recommendations to follow focus predominantly on improving access to CBT for Psychosis and CBT informed interventions, at different levels of expertise. This is described in relation to the overall service model we are aiming to adopt for developing psychological approaches across the Trust. Recommendations are also made that the core value base of PSI that should be at the heart of team based trainings, and our in-house induction programme. This value base is complementary to the development of psychological approaches to working with people with psychosis. In addition, current projects within adult mental health pertaining to Family Therapy provision are described.

3.0 Context and Strategic Vision for Increasing Access to CBT for Psychosis and CBT informed interventions

3.1 Therapists skilled to deliver CBT for Psychosis at different levels
The ‘Psychological Therapies Working in Partnership’ document (Kosviner, 2000) recommends that a full range of psychological therapies, at different levels of expertise should be available to all sub groups of clients. It advocates that three different ‘types’ of therapy are provided in services. This conceptualisation offers a framework for understanding the way in which psychological approaches can be embedded in services as a whole, rather than only being the province of specialist teams and practitioners. To follow is an outline of our interpretation of how these recommendations relate to the different levels of CBT practice for psychosis.

- Type A (integral therapeutic skills): General therapy skills, informed by a range of psychotherapeutic approaches, which should be provided by any mental health worker
within a multidisciplinary care package. With regard to working with people with psychosis, this would specifically include the application of CBT informed interventions (e.g. relapse prevention work, concordance, coping skills enhancement). Type A therapy would include the capacity to build a sound therapeutic relationship, and embrace the core values of PSI (described previously) into everyday practice. Currently there is considerable diversity in teams’ capacity to deliver evidence-based type A approaches. Practitioners who have completed Thorn training or similar, are most likely to provide CBT informed interventions to clients on their own caseload, however such approaches are neither widely available, nor systematically applied.

- Type B (single model therapists): Practitioners would be able to assess, formulate and provide interventions based on a single model in which they had expertise. As a service it is important that we make available to patients the full range of major psychotherapies, irrespective of diagnosis. With regard to CBT for Psychosis, practitioners could come from any professional background, and would have completed a reputable course in CBT which specialised in Psychosis. In addition, we would expect that CBT therapists should have an appreciation of the main tenets of the other major psychotherapies.

- Type C (highly specialist psychological therapists): Practitioners at this level would have completed training which provided a solid grounding in all the major therapy models. They would be able to assess the individual needs of clients and make recommendations for treatment, based on a broad, thorough and sophisticated understanding of psychological theories and therapies. These highly specialised psychological therapists are crucial in facilitating client choice in psychological therapy, in that they can enable clients to make informed decisions about the kind of psychotherapeutic intervention that might best meet their needs. In addition to the generic psychotherapeutic skills of therapists in this category, practitioners may have additional specialist skills in a single modality therapy (i.e. psychodynamic, systemic, CBT, integrative). With regard to CBT for psychosis, this involves completing an advanced CBT for psychosis training, or receiving CPD and supervision on the application of CBT for psychosis, over a number of years.

Increasing access to CBT for psychosis involves ensuring that clients have access to practitioners performing at levels A, B and C. The NICE guidelines for schizophrenia (2002) state that all clients with schizophrenia should have access to CBT for psychosis, however not all clients will require, or be suitable for intensive cognitive behavioural psychotherapy. It is therefore essential that teams have access to an experienced type C clinician who also has specialist skills in CBT for psychosis. Practitioners at this level can competently assess/give advice on who may
or may not benefit from the various levels of CBT practice, and re-direct clients to other therapeutic modalities where necessary.

We have accurate data relating to the number of Type B and C therapists in adult mental health delivering CBT for psychosis (appendix 2). Furthermore, Clinicians who have completed PSI courses can deliver CBT informed type A interventions (relapse prevention, concordance, coping skills enhancement). However, lack of supervision to this group has resulted in patchy utilisation of their skills, and at this stage few practitioners are delivering type A CBT based interventions in a systematic way.

4.0 Actions to promote service development
To follow are a series of recommendations with action points, to develop different levels of CBT for psychosis expertise, CBT informed approaches, and integral psychotherapeutic skills pertinent to this client group over the next 2 years. They include:

4.1 increasing access to highly specialist psychological therapists (Type C interventions)
4.2 increasing access to single model therapists (Type B interventions)
4.3 developing focused integral approaches (Type A CBT-informed interventions)
4.4 Embedding recovery and PSI within team cultures

4.1.0 Increasing access to highly specialist psychological therapists (Type C interventions)
4.1.1 The Rationale
In Oxleas, Type C therapeutic interventions in relation to CBT for psychosis are exclusively delivered by clinical psychologists. It is important that teams have access to a psychologist who is able to make advanced, theory driven CBT formulations. Furthermore, the unique contribution of clinical psychology involves the ability to draw on a sophisticated theoretical base to devise an individual strategy for complicated problems (Lavender, 2004). This is important for the following reasons:

- The research evidence base behind the NICE guidelines for schizophrenia, which promotes CBT as a treatment of choice, does not account for more complex presentations. In clinical practice clients with a primary diagnosis of schizophrenia often have additional problems, including: cognitive deficits, personality disorder, substance misuse, and deep-rooted underlying influences. Such cases require practitioners to
formulate using a range of models, not just CBT and have a sound understanding of developmental psychopathology.

- Teams need to have access to an experienced clinician who can provide supervision and training in psychological approaches to psychosis, and provide guidance around the appropriateness of a client receiving different types of psychotherapeutic intervention.
- It has been identified that teams without a psychologist are less likely to engage in psychosocial interventions generally, even when team members are qualified in CBT and other psychosocial interventions (Garety and Wellington, pers com).

4.1.2 Actions to improve access to ‘Type C’ interventions

- Clinical Psychologists within existing long term teams in Bexley and Bromley to allocate 50% of their direct clinical time to seeing clients who have a schizophrenia spectrum diagnosis. This would immediately improve access to ‘type C’ CBT for psychosis.
- In Greenwich adult community mental health services, new psychology posts, which focused on long term clients, would need to be created to provide meaningful access to ‘type C’ psychological intervention for psychosis. The number of posts generated would need to reflect the population covered by the teams. Lavender (2004) provides guidance about the estimated numbers of Clinical Psychologists required based on local populations of 250,000.
- Clinical Psychologists with the appropriate expertise, to take the lead in enabling other team members to identify clients who may be suitable for therapy, thus increasing referral rates in teams which have access to a psychologist.

4.1.3 Barriers to Implementation

- Lack of funding for new posts in areas without access to a psychologist will inhibit service development.
- Teams that currently have an appropriately experienced psychologist, predominantly refer clients with personality disorder. Increasing access to clients with psychosis will have a knock on effect for the management of clients with other disorders.
- The role of a team psychologist is diverse (supervision, research, teaching, team work) and so potential demand will outstrip supply.

4.1.4 Strategies to facilitate implementation

- Vacant psychology posts could be filled by psychologists with skills in CBT for psychosis, or those with an interest in developing expertise in the area. This is of greatest importance in localities without psychologists with these skills.
• Team leaders to enable psychologists to provide greater access to clients with psychosis, by supporting other team members in the management/holding of clients with other disorders. Furthermore, team psychologists already provide consultation to team members regarding the management of clients who present challenges to the service.

4.2.0 Increasing access to single model therapists (type B interventions)

4.2.1 The Rationale
The unique contribution of clinical psychology in providing ‘type C’ interventions has been described above. However, it is proposed that we should provide the opportunity for other professions to develop high level skills in providing CBT for psychosis. This would involve commitment to train on an advanced CBT for Psychosis programme, and would need to be supported internally by role reconfiguration and funding for training. It is imperative that we invest in the development of type B therapists if we are to improve access to CBT for psychosis in a meaningful way. Currently, Trust wide there is only one type B therapist skilled in delivering CBT for psychosis.

Clients and teams would benefit from having greater access to therapists competent in providing CBT for psychosis as outlined in the NICE guidelines. Furthermore, it is proposed that the combination of clinical psychology and CBT specialist from another profession would enhance the overall functioning of the team regarding psychosocial approaches more generally. Type B practitioners would be well placed to supervise and train other team members in the application of integral (type A) CBT based interventions (e.g. relapse prevention, CBT orientated groups, concordance, coping-skills enhancement). Furthermore, practitioners experienced in CBT for psychosis, could provide supervision to other qualified CBT therapists wanting to diversify their experience.

4.2.2 Actions to improve access to ‘Type B’ interventions
• Identification of one or more professional(s) within each CMHT, who could be supported in developing higher level CBT skills under supervision, with a view to applying for substantive training next year. SLAM CBT for Psychosis course, or Southampton Cognitive Therapy Training, would be the recommended courses, as they are the only courses in the country which provide the training required to reach a high level of expertise in CBT for psychosis.
• The clinician(s) identified for skills development in CBT for psychosis could come from any professional background, but would need to be in a position to meet the entry criteria for post-graduate training in CBT for Psychosis. It is recommended that these posts should be formally reconfigured, should the clinician successfully complete further
training. This would include management agreement about the number of sessions that should be dedicated to therapy. Successful completion of training should be reflected in Agenda For Change banding. This proposal is consistent with the Draft Service Development Strategy (7.3 Enhancing Psychological Therapies Services), which acknowledges the need to reconfigure posts to increase the number of existing psychological therapists.

- Vacant posts could be filled by clinicians with the skills/potential to develop the skills to meet the access to therapies agenda. This would be particularly important in teams unable to identify anyone to develop higher level CBT skills. This should be a priority in the directorates with very limited skills in this area.
- Development of an in-house programme of academic/skills based sessions to support clinicians identified for higher level skills development. Administrative and financial support would be necessary to augment current resources.
- We wish to foster a culture of mutual respect and understanding between therapists of single model approaches. With regard to CBT practitioners this would involve attending training days on both Psychodynamic and Systemic approaches, the aim being to familiarise CBT therapists with the main tenets of those approaches. (We would also expect Psychodynamic, Systemic, and Art therapists to attend workshops on therapeutic modalities other than their own).

4.2.3 Barriers to implementation

- Most team leaders support the idea of greater access to psychological therapy for psychosis in theory, however in practice, most would not support the idea of reconfiguring existing posts. The primary concern being that this would heavily impact on the care co-ordination burden of other team members.
- CMHT configurations in Greenwich do not have therapy posts dedicated to working with psychosis/SMI. Within current resources there would be little opportunity to develop the service further.
- Very few psychological therapists (Appendix 2) Trust wide are able to provide the supervision/mentorship necessary to develop the skills of other team members in CBT for psychosis. At this stage all resources to develop this service would need to come from clinical psychology. Furthermore, providing supervision would reduce the time for psychologists to offer direct clinical work.

4.2.4 Strategies to facilitate implementation

- Half-day workshop for psychologists working with clients who have psychosis to identify strategies to meet the challenge of providing mentorship to staff identified for skills
development. Consideration would also need to be given to how we can respond to the need for supervision in areas that do not have a psychologist experienced in CBT for psychosis, e.g. cross locality or cross directorate supervision – temporarily until an appropriate person is recruited.

- Establish a steering group to develop a programme of skills/academic training in CBT for Psychology for staff identified for skills development. This will comprise senior clinicians across the Trust who have expertise in the area and will be contributors. The training programme will be embedded within Learning and Development to ensure that there is coherence to the CBT programme we are offering within Oxleas.
- The greatest challenge to increasing access to psychological therapy within existing resources will be in supporting team leaders to change the profile of their teams. Post reconfiguration within teams will not be achieved without senior management support and facilitation.
- Financial provision to re-grade clinicians following successful completion of higher level training should be made. This would act as an incentive to remain in the Trust following training.
- Introductory workshops in all the major psychotherapies to be organised internally. CBT therapists would be expected to attend Systemic and Psychodynamic teaching, Psychodynamic and Art therapists to attend teaching on CBT and Systemic therapy, and Systemic therapists to attend teaching on CBT and Psychodynamic therapy. This initiative would be rolled out to all single model therapists working in adult mental health services.

**4.3.0 Developing focused integral approaches (CBT informed type A interventions)**

**4.3.1 The Rationale**

Oxleas’ draft service development strategy (2005) has identified skills development in CBT as a priority for all clinical staff. This guideline readily translates into aspects of PSI activity when considering the application of CBT to psychosis. Furthermore, the systematic development of CBT informed ‘type A interventions’ (e.g. relapse prevention, concordance, problem solving) would facilitate NICE guidelines implementation. Professionals who have already completed Thorn or other PSI trainings are well placed to deliver these interventions. However, due to caseload size and lack of supervision, skills learned during training are not systematically deployed even within their own caseload. Furthermore, there is no scope to disseminate knowledge to other team members and initiate projects that would be of value to the team as a whole.
Ideally, all team members should be well trained in focused integral approaches, relevant to working with clients who have severe and enduring mental health problems, and in some Trusts it is expected that all qualified staff complete Thorn/PSI training. The proposals to follow are intended to provide a structure to support clinicians who have already completed Thorn/PSI training. The proposals are intended to represent a first wave in the development and dissemination of focused integral approaches.

4.3.2 Actions to improve access to focused integral approaches (CBT informed ‘type A’ interventions)

- Identification of clinicians currently using approaches informed by PSI (predominant group will be Thorn trained staff)
- Examination of how current team structures support CBT informed PSI activity
- Set up borough/cross borough based PSI networks that can provide support/peer supervision for current practitioners, and stimulate impetus for new team based initiatives (e.g. relapse prevention groups).

4.3.3 Barriers to implementation

- Isolation of individual practitioners within teams may lead to demoralisation and lack of opportunity to initiate projects.
- For some practitioners, lack of PSI focused supervision since training may have affected confidence and competence in skills and knowledge previously gained.
- No time to invest in focused, CBT based interventions due to high generic caseload.

4.3.4 Strategies to facilitate implementation

- Stage one would involve focus groups with practitioners who use approaches which draw on PSI, the aim being to develop a network of support and good practice initiatives.
- Development of facilitated peer supervision groups across the Trust. Initially, this would focus on existing practice, with a view to enhancing skills and applying PSI more systematically within caseloads. A longer term goal would be for Thorn clinicians to provide interventions and support that other team members can benefit from (e.g. PSI clinics/groups). In localities where PSI commonplace, other practitioners could benefit from learning about how this has been achieved.
- Input from University of Greenwich PSI staff in conjunction with existing expertise in Oxleas may give this initiative higher profile.
• Greater links with basic nurse training courses to advise course directors about the basic PSI skills we expect in newly qualified nursing staff.

4.4.0 Embedding Recovery based interventions and PSI within team cultures

4.4.1 The Rationale

National guidance (DOH, 2004) has emphasised the importance of all mental health workers becoming more psychologically literate. Recovery orientated practice and PSI, which are the bedrock of modern mental health provision for clients with severe and enduring mental health problems, are concordant with mental health workers developing enhanced integral therapeutic skills. Within Oxleas, there are areas in which recovery orientated practice is being developed and systematically incorporated into everyday practice. Similarly, some practitioners draw on PSI in their day to day clinical practice. However, neither recovery based practice, nor PSI are routinely available across the Trust.

As a Trust we seek to promote a culture of recovery, evidence based practice, holistic care planning and improved communication between clients and practitioners. To achieve these aspirations, it is proposed that a training programme is either developed or commissioned, to provide training to all staff in recovery based practice, relapse prevention and concordance (the latter two being basic components of PSI). These approaches should be viewed as integral to generic case management and not stand alone ‘treatments’. However, it is clear that training alone does not improve PSI activity in teams (SLAM internal document, 2005; Brooker and Brabban, 2005). As stated previously, issues pertaining to supervision, access to highly skilled clinicians, team culture and role reconfiguration are essential to support positive change in team activity.

4.4.2 Actions to embed recovery orientated practice and PSI within team cultures

• Team based training on basic components of PSI (relapse prevention and concordance)
• Training in recovery orientated practice in boroughs where this initiative has not begun

4.4.3 Barriers to implementation

• Lack of support and value for PSI at a team level, making it difficult to impact on team culture.
• Teams being polarised in their conceptualisation of PSI and recovery e.g. ‘we all do it anyway’ (nonchalance leading to a lack of systematic, high quality delivery), OR ‘can’t do any of it without dedicated posts’ (obstructive and non-progressive approach).
• Practical difficulties associated with organising Trust wide team based training

4.4.4 Strategies to facilitate implementation
- CPA training to be used to introduce recovery principles and effective communication with clients. The aim being to harmonise different aspects of case management.
- Recovery based practice and principles of relapse prevention to be introduced into the Oxleas induction programme/mandatory training.
- Closer partnership with the University of Greenwich to agree minimum standards for nurse training in relation to recovery based practice and PSI.
- Borough based initiatives to address training needs on basic components of PSI, as different boroughs and teams have different training needs.
- Financial support to be made available to purchase external facilitators/user consultants.
5.0 Summary

Access to CBT for Psychosis at all levels of expertise is limited in the Adult Mental Health Community Services across the Trust as a whole, with some Boroughs demonstrating significantly lower levels of potential access than others. To improve access in a sustainable and meaningful way, we need to invest in increasing the numbers of practitioners delivering types B and C interventions. This may involve a combination of role reconfiguration and active recruitment of staff with those skills. Such highly skilled practitioners are essential both for the delivery of direct clinical work, and the promotion of CBT based PSI activity in teams. They are able to provide supervision to other team members, thus disseminating skills and facilitating culture change.

To complement service developments at the ‘highly skilled’ end of CBT, and to provide access to CBT-based initiatives to a wider number of clients, we need to support and appropriately supervise PSI activity undertaken by staff who have completed Thorn training and similar. Furthermore, professionals trained in these approaches, can readily transfer their skills to other client groups. Therefore, should the Trust redirect attention to other complex client groups (e.g. personality disorder/dual diagnosis), then professionals skilled in different levels of CBT practice, could support future service developments.

In addition to investing resources into developing practitioners who have existing PSI skills, and increasing numbers of skilled therapists, it is essential that we are equally committed to improving the integral therapeutic skills of the workforce as a whole. Training initiatives in basic PSI and recovery based practice could facilitate this process. Implicit in these approaches is the centrality of forging a respectful working alliance with service users and carers. Introducing these approaches through CPA training, induction programmes, nurse training, and customised team based training where necessary, should improve the psychological mindedness of our workforce and the experience of our service users.
6.0 Access to Family Therapy and Family Interventions within Adult Mental Health

6.1 Current Context
Family therapy and other structured family interventions are not readily available within adult mental health services, irrespective of clinical diagnosis. This is partly related to the organisation of existing service structures, which do not to facilitate interventions requiring co-ordination and co-working. Lack of access to family therapy in Adult Mental Health Services contrasts strongly with the rich family therapy resources in CAMHS within the Trust. Clearly there are opportunities to utilise the skills and expertise within CAMHS in a consultative and supervisory capacity. However the process of how this will be operationalised across the Trust will require longer term service development. Marcus Averbeck, as Head of Family Therapy will be taking the lead on this project, pending service level agreement.

6.2. Contemporary Practice in Family Therapy and Family Intervention - Terminology
To avoid confusion about terminology, in the context of the present document, Family Therapy refers to interventions which are predominantly systemic or integrative in modality. Family Therapy is conducted in a clinic setting and involves more than one, and sometimes several clinicians working together, some of whom may be behind a reflective screen, offering consultation to those in the room with a family. Family Therapy has demonstrated efficacy and effectiveness in the treatment of a range of disorders, including psychosis. The evidence base (Stratton, 2005) indicates that clinical outcomes are similar across different kinds of family therapy, suggesting that well trained practitioners draw on a range of approaches to meet the needs of each family.

By contrast, Psychosocial Family Intervention, sometimes referred to as family management or behavioural family therapy, describes an approach which was designed specifically for those with serious mental illness. The approach was originally developed to reduce high EE in families with a relative who had schizophrenia, and thereby reduce risk of relapse. This intervention is adopted predominantly by PSI clinicians and the work often takes place in the family home rather than a clinic setting (though not exclusively). The approach has a number of different aims. These include: improving the emotional climate in the family by reducing stress and burden on relatives; enhancing the capacity of relatives to problem solve; reducing the expression of anger and guilt by the family; encouraging the setting of limits and maintaining appropriate levels of separation; attaining desirable change in relatives behaviour and belief systems (Pharaoh et al., 2003).

7.0 Family Therapy and Psychosocial Family Intervention initiatives across the Trust
7.1 Bromley CMHT – Existing Service
A family consultation service was developed four years ago in Bromley. The service has multi-professional membership, with representatives from all three sub-teams. Referrals are accepted from any part of the service, including inpatient facilities, and the service is available to clients and families irrespective of clinical presentation. The team use a one-way mirror to facilitate consultation between team members, and the service is primarily systemic in orientation. Three of the team members have qualifications in systemic family therapy. There is high demand for the service and a waiting list is in operation. One session a week is committed to the service.

7.2 Bromley CMHT – New Initiatives
The service described above, is currently piloting a project to offer family intervention to clients in the early stages of psychosis and families. This was launched in July 2005 and is set to run for one year initially. Additional time was not available to set up a separate service, so in order to provide access to clients in the early stages of psychosis, 50% of the existing resource has been re-directed to this group. The therapeutic orientation is integrative and evidence based, and will be reflexive to the needs of individual families. Preliminary audit work was undertaken to identify the potential need, and thirty one families have been identified as meeting the target criteria. The project will be evaluated for clinical effectiveness using measures identified via a Cochrane review of family interventions for psychosis.

7.3 Orpington CMHT – Existing Service
In Orpington CMHT, a Family Therapy Service was initiated 18 months ago. From humble beginnings, this service is now multi-professional and has contributors from each clinical team. It is accessible to clients and families with a range of clinical presentations from across the CMHT. The theoretical model underpinning the service is broadly systemic and a one-way screen is used during sessions. This service has been successful and has a waiting list for families to be seen.

7.4 Orpington CMHT – New Initiatives
In line with improving access to psychological therapy for psychosis, a new family therapy initiative will be launched in Orpington in October 2005. One session a week will be dedicated to providing family therapy to clients and families with psychosis. As with the Bromley initiative, this service will be accessible to clients across the CMHT. This will ensure that clients with first episode psychosis can receive family intervention early on in the course of their illness. Theoretical underpinnings to the service are broadly systemic and draw on the acclaimed Stanford and Burbach (1998) model, which integrates systemic and family management models of practice.
The services in Bromley and Orpington demonstrate what can be achieved within a general CMHT setting. The respective services are multi-professional, and emerged from existing resources. Contributors range from those without experience in any psychotherapeutic modality, to those with systemic training. Stratton (2005) has commented upon the importance of the 'cascade effect', whereby trained family therapists can improve the skills of other team members through joint working, supervision, etc. The dissemination of skills is evident in these services, and this notion is equally valid when applied to skills development in other therapeutic modalities.
7.5 Bexley North LIT and Bexley AOT Joint initiative
Two Thorn trained nurses, one from each of the above teams, offer Psychosocial Family Intervention to clients with psychosis. The service has been running for five years and flexibly accommodates the needs of families, in terms of timing and location. The service is accessible to clients from both teams. The nurses involved do not have this work reflected in their caseload levels, and so can only see two families a fortnight. Regular supervision is provided by a qualified family therapist based within Bexley North CAT team. Over the last year eight families have received intervention from this service. In order to provide greater access, the clinicians delivering the therapy would need to have reduced generic caseloads. This is not sanctioned at present due to pressure within the teams for care co-ordinators. The service demonstrates that collaboration between PSI trained clinicians across team boundaries can result in improved access to well organised, and evidence based family intervention. Not having protected time to engage in focused therapeutic activity is the primary barrier to developing this service further in Bexley, and setting up similar services elsewhere.

7.6 Systemic Therapy in Bexley CAT Team
One clinical psychologist, who is an experienced and trained systemic family therapist, offers family and couple therapy to families within the CAT team. Due to lack of resources, most of his work is conducted without the support of other team members. Cases taken on are complex in nature, however none of the clients seen have a schizophrenia spectrum diagnosis. However, this clinician provides ongoing supervision to the Thorn practitioners, who offer the PSI based family intervention service described above.

7.7 Family work conducted by individual practitioners
There is evidence of individual Thorn trained staff engaging in PSI based family interventions across the Trust. However, these activities are not supported by a robust supervision structure and rarely meet the NICE guidelines recommendations. Clients and families benefiting from the work tend to be on the caseload of the individual practitioner, as lack of protected time prohibits the service being offered more widely. Furthermore, within the model, at least two practitioners should be working with a family at any one time. Greenwich has the most staff trained in PSI family intervention. However, many feel de-skilled having not used the approach for a number of years, and some would require ‘refresher’ courses, to feel competent in their skills. Furthermore, new initiatives would require management agreement over protected time for those keen to offer in NICE guidelines level family intervention. Some of the most skilled staff now occupy management roles, which impacts on their ability to diversify into family work.
The forthcoming PSI focus groups (Sept 05 onwards) will provide a forum to identify possible strategies to develop FI work in a more co-ordinated way. Suggestions to emerge will be forwarded to the head of family therapy and incorporated into the wider strategy for increasing access to family therapy.

8.0 Audit Processes to facilitate the NICE guide lines recommendations for delivery of CBT and FI for Schizophrenia

Baseline data was collected in spring 2005 regarding the delivery of CBT and FI for psychosis, over the preceding year in CMHT’s. Due to the small numbers of clinicians involved in the provision of these treatments, it was possible to collect the data retrospectively. However, it was not possible to include information pertaining to numbers of clients offered the interventions; reasons for non-engagement or withdrawal from treatment. Until now this data has not been routinely recorded, and relying on clinicians recall would have led to inaccuracies which could have been misleading.

In addition to having accurate information regarding who is offered, receives and completes treatment, it is vital that we have information about the numbers of clients who would meet the NICE guidelines criteria for access to CBT and FI. Broadly speaking, anyone with a schizophrenia spectrum diagnosis should be considered eligible for access to CBT, and FI if the client is in close contact with family members. Despite the requirement for ICD 10 diagnoses to be input onto PIMS, the majority of team leaders deemed this information to be inaccurate, and not all team leaders could give information about diagnosis based on team caseload.

It is recommended that the following information is routinely and consistently recorded, in order to identify the numbers of clients who should be offered CBT and FI currently and in the future. Furthermore, this will provide information about our capacity to deliver in relation to the NICE guidelines for schizophrenia (2002).

8.1 Information to be audited to facilitate access to CBT and FI for Psychosis
To follow is the criteria outlined in the NICE guidelines pertaining to eligibility and prioritisation for access to CBT and FI for Psychosis. It is recommended that we begin an audit process to collect this patient information within the CMHT’s. Furthermore, we need to collect information on the numbers of clients who are offered, as well as receive these interventions, and compare our capacity to deliver against the NICE guidelines recommended standard.

9.1 NICE guidelines recommendations for access to CBT and FI for Psychosis

- Numbers of clients with a schizophrenia spectrum diagnosis
- Numbers of clients meeting priority criteria listed in figure 8.2
- Numbers of clients offered CBT and FI for Psychosis
- Numbers of clients engaged in CBT and FI for Psychosis
- Number of sessions received
- Reason for termination of treatment
As a Trust we may choose to arrive at our own priority criteria for access to CBT and FI for clients with psychosis. For example, we may choose to give additional priority to clients early in the course of their illness. It is recommended that should we choose to deviate from the priority guidance outlined by NICE, a multi-professional expert committee meet to make this decision.

**Dr Marina Richards**

**Clinical Psychologist**

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**Criteria for access to CBT**

**Eligibility**
- Anyone with a schizophrenia spectrum disorder (schizophrenia, schizo-affective disorder, delusional disorder), to have access to CBT for Psychosis.

**Prioritisation**
- Persisting symptoms (negative or positive)
- Repeated relapse

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**Criteria for access to Family Intervention**

**Eligibility**
- Any family living with or in close contact with a family member who has a schizophrenia spectrum disorder.

**Prioritisation**
- Experienced a recent relapse
- Considered at risk of relapse (2 or > episodes in the last year)
- Persisting symptoms