

Evidence-based psychotherapeutic interventions in the community care of schizophrenia

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There is a need to research the admixture of two strands in the community care of patients with schizophrenia: the delivery of mental health services by community teams and the use of psychotherapeutic interventions. Community teams increasingly dominate the provision of care for individuals with schizophrenia in many economically developed countries. At the same time, recent research shows that newer and more structured psychotherapies can lead to improved outcomes under experimental conditions for people suffering from schizophrenia, yet we do not know whether community teams can deliver psychotherapy effectively.

In this editorial we first refer, albeit briefly, to the evidence for community mental health teams. We then review recent findings on types of psychotherapeutic treatment that might be delivered by such teams. We also make note of some other psychological treatments that might be effective, because it is likely that community teams will need to consider them in conjunction with psychotherapy. Finally, we discuss what forms of research and service development are necessary to fuse the two strands.

COMMUNITY TEAMS AS VEHICLES FOR THE DELIVERY OF EFFECTIVE TREATMENTS

The introduction of treatments for schizophrenia and other severe psychiatric disorders in community-oriented settings has been the dominant trend in mental health services in economically developed countries during the past 40 years (Levine, 1981). Increasingly, this trend is supported by the research evidence that interventions that take place mainly outside of hospital are, on balance, preferable on a range of outcome indicators (Burns *et al*, 1993). To summarise a complex debate, mental health teams are more successful at maintaining clinical contact, are more valued by

patients and offer greater opportunity for staff to deliver continuing and effective face-to-face treatments; they have produced improved patient outcomes in several domains, although notably not in symptom reduction (Lehman & Steinwachs, 1998; Mueser *et al*, 1998). In other words, community teams are necessary but not sufficient for modern mental health care, which blends an effective delivery vehicle, such as assertive community treatment, with an effective direct treatment method.

The 'evidence-based medicine' approach (Sackett *et al*, 1996) so far has been applied more often to pharmacological than to psychological treatments, but Cochrane collaboration systematic reviews have begun to appear (Mari & Streiner, 1996). Other relevant forms of review, not using the Cochrane methodology, also have been published. The Patient Outcomes Research Team (PORT) programme in Baltimore, for example, using a structured expert review method that includes randomised controlled trial (RCT) and non-RCT data, has examined the evidence for the range of active ingredients in community treatment of schizophrenia. Among their conclusions were that: psychoeducational methods and cognitive-behavioural treatments (less well established) are efficacious treatments for patients with schizophrenia under experimental conditions; and there is little evidence that dynamic psychotherapy has any beneficial effects (Lehman & Steinwachs, 1998). Since this report appeared, however, the evidence for an effect of psychotherapeutic interventions in schizophrenia has strengthened, as we summarise below.

PSYCHOTHERAPEUTIC INTERVENTIONS FOR SCHIZOPHRENIA

Until recently only a few studies had subjected forms of psychotherapy for schizophrenia other than dynamic psychotherapy

to scientific evaluation (Roth & Fonagy, 1996; Fenton, 2000). In the past decade, however, two particular modalities have emerged with a growing evidential base: cognitive-behavioural therapy (CBT) and personal therapy.

Of previously established efficacy for depression, CBT also has been applied over the past decade in Britain to the treatment of schizophrenia (Sensky *et al*, 2000). This approach includes structured and systematic reality testing and belief modification, it highlights the internal inconsistency for lack of evidence for a belief and suggests that patients test alternative explanations with the goal of forming new beliefs. Recent results are encouraging, with patients assigned to CBT showing fewer symptoms as well as less disruption to everyday life. This work now has been extended, with larger trials replicating the positive effects of CBT in a convincing way, showing, for example, benefits in terms of positive symptoms and a 25-50% reduction in recovery time (Drury *et al*, 1996). Building on these early findings, a multi-centre RCT demonstrated superiority compared with standard care in terms of symptom reduction, lower drop-out rates and patient satisfaction (Kuipers *et al*, 1997).

Unlike CBT, personal therapy was designed at the outset to be a long-term, disorder-relevant intervention, tailored for individuals with schizophrenia (Hogarty *et al*, 1997). The goals of personal therapy are to increase foresight through the accurate appraisal of emotional states, their appropriate expression and assessment of the reciprocal response of others. The strategies are supplemented by phase-specific psychoeducation and behavioural therapy techniques. An RCT of personal therapy led to improved social adjustment of patients for up to three years after discharge. Nevertheless, personal therapy also increased the rate of psychotic relapse for patients living independently of their families, and the proponents of this treatment suggest that it might be applied best when patients have achieved symptom and residential stability (Hogarty *et al*, 1997). This approach is now being developed into a more sophisticated form of psychosocial intervention called cognitive enhancement therapy (CET).

OTHER PSYCHOLOGICAL INTERVENTIONS RELEVANT TO COMMUNITY TEAMS

The use of psychotherapy for schizophrenia needs to be considered in the context of

other forms of psychological intervention that have been tested in community settings. We describe here three treatment approaches. These were selected to illustrate interventions that have shown varying degrees of efficacy in RCTs and in the future may be available to be deployed by staff community teams.

Family psychological interventions for schizophrenia

One of the most striking aspects of the treatment of schizophrenia is the disjunction between the strength of what is known of the efficacy of family psychosocial and psychoeducational methods of treatment, and the poor availability of these treatments in ordinary clinical settings (Penn & Mueser, 1996). These psychosocial family interventions tend to include seven components: an alliance with relatives who care for the person with schizophrenia; reduction of adverse family atmosphere; enhancement of the capacity of relatives to anticipate and solve problems; reduction of expressions of anger and guilt by the family; maintenance of reasonable expectations for patient performance; encouragement of relatives to set appropriate limits; and attainment of desirable change in relatives' behaviour and belief systems. A Cochrane collaboration systematic review has concluded that such treatment is generalisable, and that families receiving this intervention can expect less-frequent relapse and admission in their relatives with schizophrenia, without any additional burden of care (Mari & Streiner, 1996). There is some evidence that multiple family models may be even more effective than interventions for single families (McFarlane *et al*, 1995), in terms of reduced relapse rates and offering an expanded social network. Thus, in addition to the ethical arguments for including the family in the treatment programme, there is now a strong evidential basis for doing so.

Psychological methods to improve the use of other treatments

Psychological treatments for schizophrenia can yield indirect benefits by enhancing the use of other treatments. Adherence to medication regimens (or compliance) provides an example. Recent work has demonstrated that the predictors of adherence to medication include attitudes to treatment, substance misuse and insight (Haynes *et al*, 1996; Kampman & Lehtinen, 1999),

as well as specific psychological interventions (Eckman *et al*, 1992). More recently, Kemp *et al* (1996), in an RCT, have shown that a cognitive-behavioural package adapted from motivational interviewing produced improvements in attitudes to medication insight and medication when it included knowledge of drugs, recognition of side-effects and the use of standard measures, use of educational strategies for patients and carers and the use of motivational interviewing procedures in dealing with non-adherence.

Psychological support during critical transitions

Empirical data indicate that the risk of adverse outcome is not constant over time, but fluctuates dramatically and predictably in accord with landmarks in the course of illness, for instance, the risk of suicide peaks during the period shortly after hospital discharge. Accordingly, researchers have begun to test the concept of 'critically timed' interventions (CTIs) at transitional moments across the life course. An intervention of this kind, in which psychological support and social skills training were important elements, now has been tested in a randomised clinical trial among patients with schizophrenia during the critical period of transition from shelter to community housing. The trial demonstrated a threefold reduction in the recurrence of homelessness (Susser *et al*, 1997). Critically timed intervention now has been adapted and is being tested in further randomised trials for the time of transition from other institutions (hospitals, prisons) to community housing.

THE AGENDA FOR RESEARCH: INTEGRATION

To integrate the probable benefits from these psychotherapeutic and other psychological interventions into the routine practice of community mental health teams, we propose that three sequential elements are necessary (Medical Research Council, 2000). The first stage is a dialogue between researchers, patients/consumers, caregivers/family members and those responsible for mental health service policy, so that the research activities are initiated that directly address agreed areas of unmet service need. Based upon the results of these discussions, new forms of treatment and service delivery can be developed as

exploratory trials to investigate whether they produce favourable benefits for patients and their effect sizes (NHS Executive, 1996). The evidence of CTI, for example, is at this stage. Second, it needs to be demonstrated whether psychotherapeutic interventions that have proved to be efficacious in exploratory trials can also survive assessment in definitive RCTs, usually in multiple sites.

For the third stage, psychotherapeutic interventions of proven benefit need to be subjected to an assessment of their effectiveness and costs in non-experimental settings that are designed to endure, through assessment of their effects after widespread dissemination into routine practice. At this stage the therapies themselves may need to be adapted, so as to be compatible with the established practices and styles of community teams. The use of CBT for schizophrenia is now approaching this stage. This third stage in the production line of evidence-based clinical practice will involve an understanding of the training and continuing professional development and knowledge acquisition requirements of staff to implement a new psychological treatment modality, addressing professional barriers that may limit uptake, and a further investigation of the 'minimum effective dose' or the key active ingredients of the intervention (Lehman & Steinwachs, 1998; National Institute for Mental Health, 1998).

We propose that to produce real evidence-based change in service delivery, the balance of training and funding in research will need to shift towards the third stage. The experience of recent decades suggests that even fully proven interventions for schizophrenia will not be implemented widely unless accompanied by vigorous advocacy and institutional incentives for adoption. Efficacious medications tend to be taken up, because pharmaceutical companies see to it, but for other treatments such as psychotherapy it is left to professionals, patients and family members to play this role. Presently we are ill prepared to undertake it. In terms of the field of psychological intervention for schizophrenia, the data now provide substantial evidence for efficacy and weaker evidence for effectiveness and cost-effectiveness, but the barriers to routine implementation have barely begun to be addressed; we should urgently do so. In future, if these treatments are incorporated into clinical practice, different professions

may come to share some basic core understanding of the interrelated psychological interventions that they use, and then have differentiated types of training. Ultimately, by working together within a local community mental health service, these professions may be able to provide a range of psychological treatments, and thereby a more complete and effective service, for patients with schizophrenia.

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