SIGN

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Scottish Intercollegiate Guidelines Network

Psychosocial Interventions in the Management of Schizophrenia

A National Clinical Guideline

October 1998

KEY TO EVIDENCE STATEMENTS AND GRADES OF RECOMMENDATIONS

The definitions of the types of evidence and the grading of recommendations used in this guideline originate from the US Agency for Health Care Policy and Research[1] and are set out in the following tables.

STATEMENTS OF EVIDENCE

Ia	Evidence obtained from meta-analysis of randomised controlled trials.
Ib	Evidence obtained from at least one randomised controlled trial.
IIa	Evidence obtained from at least one well-designed controlled study without randomisation.
IIb	Evidence obtained from at least one other type of well-designed quasi-experimental study.
III	Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies and case studies.
IV	Evidence obtained from expert committee reports or opinions and/or clinical experiences of respected authorities.

GRADES OF RECOMMENDATIONS

A **Requires at least one randomised controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendation.**
(Evidence levels Ia, Ib)

B **Requires the availability of well conducted clinical studies but no randomised clinical trials on the topic of recommendation.**
(Evidence levels IIa, IIb, III)

C **Requires evidence obtained from expert committee reports or opinions and/or clinical experiences of respected authorities. Indicates an absence of directly applicable clinical studies of good quality.**
(Evidence level IV)

GOOD PRACTICE POINTS

☑ Recommended best practice based on the clinical experience of the guideline development group

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NOTES FOR USERS OF THE GUIDELINE

DEVELOPMENT OF LOCAL GUIDELINES

It is intended that this guideline will be adopted after local discussion involving clinical staff and management. The Area Clinical Audit Committee should be fully involved. Local arrangements may then be made for the derivation of specific local guidelines to implement the national guideline in individual hospitals, units and practices and for securing compliance with them. This may be done by a variety of means including patient-specific reminders, continuing education and training, and clinical audit.

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STATEMENT OF INTENT

This guideline is not intended to be construed or to serve as a standard of medical care. Standards of medical care are determined on the basis of all clinical data available for an individual case and are subject to change as scientific knowledge and technology advance and patterns of care evolve.

These parameters of practice should be considered guidelines only. Adherence to them will not ensure a successful outcome in every case, nor should they be construed as including all proper methods of care or excluding other acceptable methods of care aimed at the same results. The ultimate judgement regarding a particular clinical procedure or treatment plan must be made by the doctor in light of the clinical data presented by the patient and the diagnostic and treatment options available.

Significant departures from the national guideline as expressed in the local guideline should be fully documented and the reasons for the differences explained. Significant departures from the local guideline should be fully documented in the patient's case notes at the time the relevant decision is taken.

A background paper on the legal implications of guidelines is available from the SIGN secretariat.

REVIEW OF THE GUIDELINE

This guideline was issued in 1998 and will be reviewed in 2000 or sooner if new evidence becomes available. Any updates to the guideline in the interim period will be noted on the SIGN website. Comments are invited to assist the review process. All correspondence and requests for background information regarding the guideline should be sent to:

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Summary of recommendations

PSYCHOSOCIAL INTERVENTIONS IN THE MANAGEMENT OF SCHIZOPHRENIA

C **The treatment of individuals with schizophrenia requires a co-ordinated multidisciplinary approach.**

C **A Care Plan should be drawn up which specifies all aspects of the care to be provided.**

C **Care should be taken to avoid overly stressful interventions which may result in worsening of psychotic symptoms.**

ACUTE PHASE

B **Families and carers should be involved from the outset** (with the patient's consent).

B **Once a diagnosis has been established, information should be provided to families and carers on the illness, its aetiology, course, treatment and the services available, including information regarding local and national support groups.**

A **Information should be provided by an experienced health professional who is familiar with the concerns and circumstances of the carers/relatives.**

☑ Information may not be assimilated in one session and repetition may be required.

STABILISATION PHASE

Families and carers will continue to receive education and support in this phase, which may be integrated into a Family Intervention Programme.

A **An Education Programme for patients should be undertaken in this phase, giving information on the illness and on the benefits and side effects of medication, which should allow optimal prescribing and hence improved compliance.**

☑ Information should be skilfully delivered in a way that meets individual needs.

A **Family Intervention Programmes should be implemented in appropriate cases following assessment.**

A **The Family Intervention Programme should include:**

- **an education programme**
- **analysis of family relationships and functioning**
- **family sessions to address the problems identified in the analysis**
- **relatives' support group.**

☑ Family Intervention Programmes should be integrated with other aspects of care.

C **Family relationships should be assessed to identify the need for family sessions to address relationship difficulties.**

☑ A relationship of trust and an explanation of the aims of the programme are essential.

☑ The aims of family sessions should include:

- construction of an alliance with the family
- improvement of adverse family atmosphere
- enhancement of the capacity of the relatives to anticipate and solve problems
- reduction of feelings and expressions of anger and guilt by the family
- maintenance of reasonable expectations for patient performance
- attainment of desirable change in relatives' behaviour and belief system.

C **The Intervention Programme should continue for at least nine months with family sessions at least monthly.**

A **Intervention Programmes should be carried out by a trained health professional.**

STABLE PHASE

Family Intervention Programmes will continue into this phase.

A **Cognitive Behaviour Therapy should be considered for symptoms of psychosis which are distressing and resistant to conventional treatment.**

1 Introduction

Schizophrenia affects one person in a hundred at some stage in life. The onset is usually in the twenties or thirties and the subsequent course is variable. Unless the initial illness is brief, incomplete recovery and further relapses are the most likely outcome.

Both the positive symptoms (thought disorder, hallucinations, delusions) and the negative symptoms (social withdrawal, self neglect, lack of motivation) may contribute to a deterioration in interpersonal relationships.

Following an admission to hospital, patients with schizophrenia who are discharged to an environment where there are high levels of criticism, hostility and over-involvement are three or four times more likely to relapse than those moving to an environment where these features are not present.[2] **Family Interventions** have been formulated to reduce these features, to lessen the burden on carers and reduce the frequency of relapse. This approach, however, has not been made generally available.[3]

Cognitive Behaviour Therapy has been shown to benefit some patients with schizophrenia.[4-7] As with other psychosocial interventions, there are difficulties in subjecting this individually-tailored approach to systematic study. The most recently published study shows clear and lasting benefit for a substantial number of patients with treatment-resistant sysmptoms.[6-8] However, it is unclear how to target those most likely to benefit.

Note that, in most research studies, psychosocial interventions have been supervised by experienced clinical psychologists and some studies have found the techniques to be less widely accepted and effective in ordinary practice *(see section 5.2)*. Although it is anticipated that appropriate health or social work professionals will be able to carry out this work in everyday practice, training will be required *(see section 4.1)*.

For simplicity, the guideline refers throughout to 'patients' with schizophrenia. The guideline development group recognise that some readers may prefer to substitute alternative terminology such as 'client' or 'service user', according to individual preference.

2 What are psychosocial interventions?

This evidence-based guideline necessarily focuses on those interventions for which there exists evidence of effectiveness and does not aim to cover all of the wide range of psychosocial interventions which have been proposed as contributions to the management of schizophrenia.

The Clinical Resource and Audit Group (CRAG) good practice statement on services for people affected by schizophrenia outlines the aims of psychosocial therapies:[9]

- assessment
- support
- explanation and education
- building concentration
- reinforcement of reality
- help with relationships and communication
- treatment of non psychotic symptoms such as anxiety and mood disturbance
- dealing with challenging behaviours, e.g. aggression, self harm
- structuring the day
- attention to daily living skills
- working with families.

These psychosocial therapies are part of the standard management of schizophrenic illnesses, but have not been subjected to systematic evaluation and are therefore not included in this guideline. This does not imply that they are not essential components of good practice.

The remainder of this section describes the evidence for the effectiveness of Education Programmes, Family Interventions, and Cognitive Behaviour Therapy in the management of schizophrenia. Section 3 provides recommendations for the application of these interventions in clinical practice, according to the phase of the illness.

2.1 EDUCATION PROGRAMMES

Education Programmes are directed at either patients or carers/family members and have several aims. Improvement in knowledge of schizophrenia and its course and in compliance with treatment has been shown. There is also evidence of greater satisfaction with services provided. Some programmes go beyond the provision of information and take an educational approach to skills training or problem solving.[10, 11]

Evidence level Ib

Education Programmes for patients may be undertaken in individual or in group settings. Simple information-giving is less effective than interactive sessions.[12] The focus includes giving information about the course and management of the illness, including the importance of compliance with medication and the management of stress.

Providing carers and family members with information on the likely course of the illness, the treatments available, the importance of compliance and the services available is an essential element of good practice.[13] It may be undertaken as part of a Family Intervention Programme *(see below)*.

Specific techniques, e.g. use of homework or video, have not been shown to improve the assimilation of information, but a group setting has advantages.[12]

Evidence level IIa

2.2 FAMILY INTERVENTIONS

The aims of 'Family Intervention' include reduction of frequency of relapse into illness and reduction of hospital admissions, reduction in the burden of care on families and carers, and improvement in compliance with medication.

Some Family Intervention Programmes have targeted families where there are high levels of criticism, hostility and over-involvement.[10, 11, 14-17] 'High expressed emotion' is a measure of these features and programmes which reduce this or reduce the amount of 'face to face' contact between the patient and family members have been shown to reduce the frequency of relapse. However, the measurement of expressed emotion is a research technique which is not practical for everyday use. Family Intervention Programmes which are not derived from this theoretical background have been shown to be effective.[18-22]

Evidence level Ib

Most intervention strategies contain more than one technique. Separating and defining the effects of the components of an intervention strategy is not possible at present as few studies examine the effect of a single technique and only a general description of interventions used in research studies is usually given. However, a number of practice guides have been published which give detailed descriptions of the techniques employed in some studies.[23-25] Family Intervention has been shown to be effective with some variation in the components of the programme, but family sessions to address the problems identified in the analysis may not be effective if the patient is not included.[26, 27] Social skills training and vocational rehabilitation were included in some studies. These are not covered as separate interventions in the guideline.

2.3 COGNITIVE BEHAVIOUR THERAPY

Cognitive Behaviour Therapy for psychosis is a modification of standard cognitive behavioural therapy. The aim is to modify symptoms (e.g. delusions, hallucinations)[4] or the consequences of the symptoms which may be cognitive, emotional, physiological or behavioural.[5] The treatment programme is intensive (involving about 20 hours of individual treatment) and based on an individually tailored formulation which provides an explanation of the development, maintenance and exacerbation of symptoms and of pre-morbid mood, interpersonal and behavioural difficulties.

There is now good evidence that treatment resistant symptoms (delusions, hallucinations) can be substantially reduced in a significant proportion of those who complete therapy. It is not yet clear who is most likely to benefit from treatment and many patients may be unwilling to participate. The treatment is well tolerated. However, reduction of symptoms has not been shown to lead to significant social or lifestyle improvements.[6, 8]

Evidence level Ib

A combination of the following techniques has been shown to be most effective in lessening symptoms of psychosis resistant to other forms of treatment:[6]

- enhancement of cognitive behavioural coping strategies [5]
- developing a rationale to explain symptoms[28]
- realistic goal setting
- modification of delusional beliefs[29]
- modification of dysfunctional assumptions.

A number of these techniques are a refinement of normal good practice using a systematic approach.

'Early Intervention Studies' have aimed to identify prodromal symptoms or the 'signature' preceding relapse. The approach is not a form of cognitive therapy, but early intervention with medication or Cognitive Behaviour Therapy may be facilitated.[30]

2.4 OTHER INTERVENTIONS

'Case Management' and 'Assertive Outreach Programmes' may include psychosocial interventions, but these are beyond the scope of this guideline. 'Compliance Therapy' has been shown to be effective in groups of patients many of whom, but not all, had schizophrenic illnesses.[31]

3 Psychosocial interventions in clinical practice

3.1 INTRODUCTION

All published studies of Family Interventions have taken place while subjects are receiving appropriate medication. There have been no studies to demonstrate if psychosocial interventions are effective without concomitant use of medication. Some interventions are effective in part because they improve compliance with medication. Psychosocial intervention should not be seen as an alternative to drug treatment and the most effective treatment will make use of a combination of complementary approaches.

C **The treatment of individuals with schizophrenia requires a co-ordinated multidisciplinary approach.**

C **A Care Plan should be drawn up which specifies all aspects of the care to be provided.**

Throughout all phases of the illness, support and encouragement are a standard component of treatment. Individual or group psychotherapy are sometimes considered as a treatment component, but there is no good quality evidence on their effectiveness.

C **Care should be taken to avoid overly stressful interventions which may result in worsening of psychotic symptoms.**

Specific interventions are considered below in relation to the phase of the illness. For more detailed discussion of the evidence and references relating to the effectiveness of recommended interventions, see section 2.

The illness can be characterised by three phases that merge into one another without absolute clear boundaries between them:[13]

- **Acute phase**
  During this florid psychotic phase, patients exhibit severe psychotic symptoms such as delusions and/or hallucinations and severely disorganised thinking and are usually unable to care for themselves appropriately. Negative symptoms often become more severe as well.
- **Stabilisation phase**
  During this phase, acute psychotic symptoms decrease in severity. This phase may last for six or more months after the onset of an acute episode.
- **Stable phase**
  Symptoms are relatively stable and, if present at all, are almost always less severe than in the acute phase. Patients can be asymptomatic, others may manifest non-psychotic symptoms such as tension, anxiety, depression or insomnia.

3.2 ACUTE PHASE

In the acute phase management focuses on areas outlined in section 2, particularly assessment, support, explanation, reinforcement of reality, and dealing with challenging behaviours.[9]

3.2.1 SUPPORT AND EDUCATION FOR FAMILIES AND CARERS

A number of randomised studies have demonstrated benefit from involving families and carers in Family Intervention Programmes, including the provision of information and education for families and carers. As discussed in section 2, the form of intervention varies between studies, but in each case information was provided by experienced health professionals.

Evidence level Ib (see sections 2.1 and 2.2)

B **Families and carers should be involved from the outset** (with the patient's consent).

B **Once a diagnosis has been established, information should be provided to families and carers on the illness, its aetiology, course, treatment and the services available, including information regarding local and national support groups.**

A **Information should be provided by an experienced health professional who is familiar with the concerns and circumstances of the carers/relatives.**

☑ Information may not be assimilated in one session and repetition may be required.

3.2.2 PATIENT EDUCATION

An Education Programme for patients may be initiated at this stage but will need to be tailored to the individual's mental state. This may necessitate waiting until the 'stabilisation' phase.

3.2.3 COGNITIVE BEHAVIOUR THERAPY

The addition of Cognitive Behaviour Therapy to standard inpatient treatment has been shown to accelerate recovery and discharge from hospital in one study.[32, 33] This important finding requires further clarification before this can be recommended for routine clinical use *(see section 2.3)*.

3.3 STABILISATION PHASE

3.3.1 EDUCATION

As discussed in section 2.1, Education Programmes have been shown to improve patients' knowledge of schizophrenia, compliance with treatment, and satisfaction with services provided.

Evidence level Ib (see section 2.1)

A **An Education Programme for patients should be undertaken in this phase, giving information on the illness and on the benefits and side effects of medication, which should allow optimal prescribing and hence improve compliance.**

☑ Information should be skilfully delivered in a way that meets individual needs.

Education and support for family and carers, if appropriate, would be continued in this phase as part of a Family Intervention Programme.

3.3.2 FAMILY INTERVENTION

Family Intervention has been shown to be effective in reducing relapse and admission to hospital when implemented after first episodes of illness or subsequent relapses.[34]

Evidence level Ia (see section 2.2)

A **Family Intervention Programmes should be implemented in appropriate cases following assessment.**

A **The programme should include:**

- **an education programme**
- **analysis of family relationships and functioning**
- **family sessions to address the problems identified in the analysis**
- **relatives' support group.**

☑ Family Intervention Programmes should be integrated with other aspects of care.

It is important that professional staff involved in Family Intervention Programmes adopt a non-judgmental approach when dealing with issues related to 'high expressed emotion.' The aim is to help the family to cope with the illness, not to allocate blame for relationship difficulties. The Family Intervention approach is likely to be applicable in settings where there are other carers.[35]

C **Family relationships should be assessed to identify the need for family sessions to address relationship difficulties.**

☑ A relationship of trust and an explanation of the aims of the programme are essential.

Families may merit priority where the patient relapses frequently or has been violent, where there is a single parent or where a substantial number of hours of face to face contact occur each week.

☑ The aims of family sessions should include:

- construction of an alliance with the family
- improvement of adverse family atmosphere (i.e. lowering the emotional climate in the family by reducing stress and burden on relatives)
- enhancement of the capacity of the relatives to anticipate and solve problems
- reduction of feelings and expressions of anger and guilt by the family
- maintenance of reasonable expectations for patient performance
- attainment of desirable change in relatives' behaviour and belief system.

Family Intervention Programmes of different length and intensity have been shown to be effective. Brief interventions may not be effective and it has been suggested that programmes should be indefinite in length, but there is no clear evidence on this or on the benefits of repeating a programme.

C **The Intervention Programme should continue for at least nine months with family sessions at least monthly.**

3.4 STABLE PHASE

3.4.1 FAMILY INTERVENTION

Family Intervention Programmes will continue into this phase. Depending on the extent of recovery, the focus of rehabilitation will be on self care, occupation and leisure activities.

3.4.2 COGNITIVE BEHAVIOUR THERAPY

Cognitive Behaviour Therapy techniques have been demonstrated to produce benefits for some patients at this stage, although their advocates suggest that the potential benefit is greatest when they are used before delusions and behaviour patterns have become established. These techniques are still undergoing modification.

Evidence level Ib (see section 2.3)

A **Cognitive Behaviour Therapy should be considered for symptoms of psychosis which are distressing and resistant to conventional treatment.**

Cognitive Behaviour Therapy requires further study and treatment should be undertaken where possible as part of a clinical trial designed to define the role of Cognitive Behaviour Therapy more clearly.

3.4.3 EARLY INTERVENTION

The identification of prodromal symptoms which would facilitate an early intervention strategy has been an area of recent interest. The early intervention used in studies completed to date has usually been an adjustment of medication, but the use of early cognitive intervention is under investigation. Reliable identification of prodromal symptoms which predictably lead to relapse has not been demonstrated. Monitoring patients for prodromal and early symptoms is good practice. Families and carers can provide the earliest indication of this.

4 Implementation of the guideline

4.1 MANAGEMENT AND TRAINING

Psychosocial interventions may be delivered by suitably trained health or social work professionals from a variety of backgrounds. The common elements of the interventions represent good practice and should be familiar to all mental health nurses and should therefore be a component of preregistration nurse education.

In most research studies, family sessions have been supervised by experienced clinical psychologists. It is anticipated that appropriate health or social work professionals will be trained to carry out this work in everyday practice. There is evidence that community psychiatric nurses can be trained successfully[36, 37] but this requires further clarification. Inexperienced professionals attempting to carry out this work may do more harm than good.

Evidence level Ib

A **Intervention programmes should be carried out by a trained health professional.**

An approach to management involving psychosocial interventions is an essential component of the work of community psychiatric nurses (CPN) working with patients with schizophrenia. Training in psychosocial intervention for qualified mental health nurses could be achieved as follows:

- incorporated into courses leading to the Specialist Practitioner Qualification (SPQ) as a CPN
- incorporated into other SPQ courses for mental health nurses, e.g. Rehabilitation and Resettlement in Mental Health Nursing, or Forensic Mental Health Nursing
- offered to currently qualified CPNs and other relevant mental health nurses on a continuing education basis.

Clinical psychologists have received the intensive training required for the provision of Cognitive Behaviour Therapy. Other healthcare professionals may be trained to employ a cognitive approach with appropriate supervision, e.g. managing symptoms.

4.2 CONTINUING EDUCATION

All healthcare staff involved in the care of patients with schizophrenia should be familiar with the appropriate aspects of treatment including psychosocial interventions. Continuing education is required to ensure that new advances are assimilated and incorporated into local management guidelines.

4.3 ORGANISATION OF SERVICES

At present, the interventions outlined in this guideline are not used consistently in clinical practice. Available evidence suggests that successful implementation of psychosocial interventions requires a team approach where the interventions are part of an integrated care plan. If they are the sole responsibility of one team member, they are less likely to be successful.[37, 38]

Provision of comprehensive services encompassing the approaches outlined may have resource implications which will require to be addressed by Health Boards and Primary Care Trusts.

5 Recommendations for audit and research

5.1 KEY POINTS FOR AUDIT

Firm outcome measures related to psychosocial intervention techniques are difficult to identify in ordinary clinical practice where standardised assessments are not often used. Some outcome measures are already recorded, such as:

1. *Number of admissions/length of admission*
2. *Number of contacts with psychiatric services.*

Other assessments are carried out as part of routine clinical care, but not in a formal way which would permit audit:

3. *Assessment of mental health, including minor exacerbations of symptoms*
   This assessment could be formalised using a scale such as the Royal College of Psychiatrists Health of the Nation Outcome Scales (HoNOS).[39] There are a number of other assessment scales which tend only to be used in research and clinical trials.
4. *Assessment of compliance with medication (possibly including plasma drug levels)*
5. *Recording of episodes of depression and suicide attempts*
6. *Social assessment*
   Several of the studies on Family Intervention have used the Social Functioning Scale developed by Birchwood.[40] HoNOS includes some measures of social functioning.[39]
7. *Assessment of relatives' distress / family burden*
   This has been assessed in research studies using the Goldberg's General Health Questionnaire, which is administered to family members.[41]
8. *Assessment of patients' and carers' satisfaction with services provided*
9. *Assessment of patients' and carers' knowledge of schizophrenia*
   This might be assessed using the Knowledge About Schizophrenia Inventory (KASI).[25]

A separate area is the provision of services and an audit of the implementation of the guideline would require recording of items such as:

1. *Number of interventions undertaken*
2. *Number of health professionals trained and available to provide interventions*
3. *Size of 'At Risk' population*.

5.2 RECOMMENDATIONS FOR RESEARCH

Several clinical trials are underway which should further clarify the efficacy and applicability of Cognitive Behaviour Therapy in the management of schizophrenia. The value of Cognitive Behaviour Therapy in the acute phase of illness requires further investigation.

The effectiveness of Family Intervention has been established, but further clarification of the contribution of individual components of the approach is needed. Further research is also required on outcomes (including patient and carer satisfaction measures) and on the continuation of the approach following an initial treatment programme.

Some studies have found these techniques less widely accepted and effective in ordinary clinical practice than expected from research studies.[38, 42, 43] Further evaluation in this area is desirable.

Annex

SYSTEMATIC REVIEW UNDERTAKEN FOR THE GUIDELINE

The evidence base for this guideline was synthesised in accordance with SIGN methodology. A systematic review of the literature was carried out using an explicit search strategy based on the Cochrane search strategy for meta-analyses and randomised controlled trials.

The search covered the Cochrane Library, plus the Embase, Healthstar, Medline and PsycINFO databases, using key words including cognitive therapy, behaviour therapy, cognitive behavioural therapy, psychosis, clinical trials, schizophrenia, hallucinations, delusions, and relapse. The initial search was supplemented by following up references from papers identified through the search, and by material identified separately by members of the development group.

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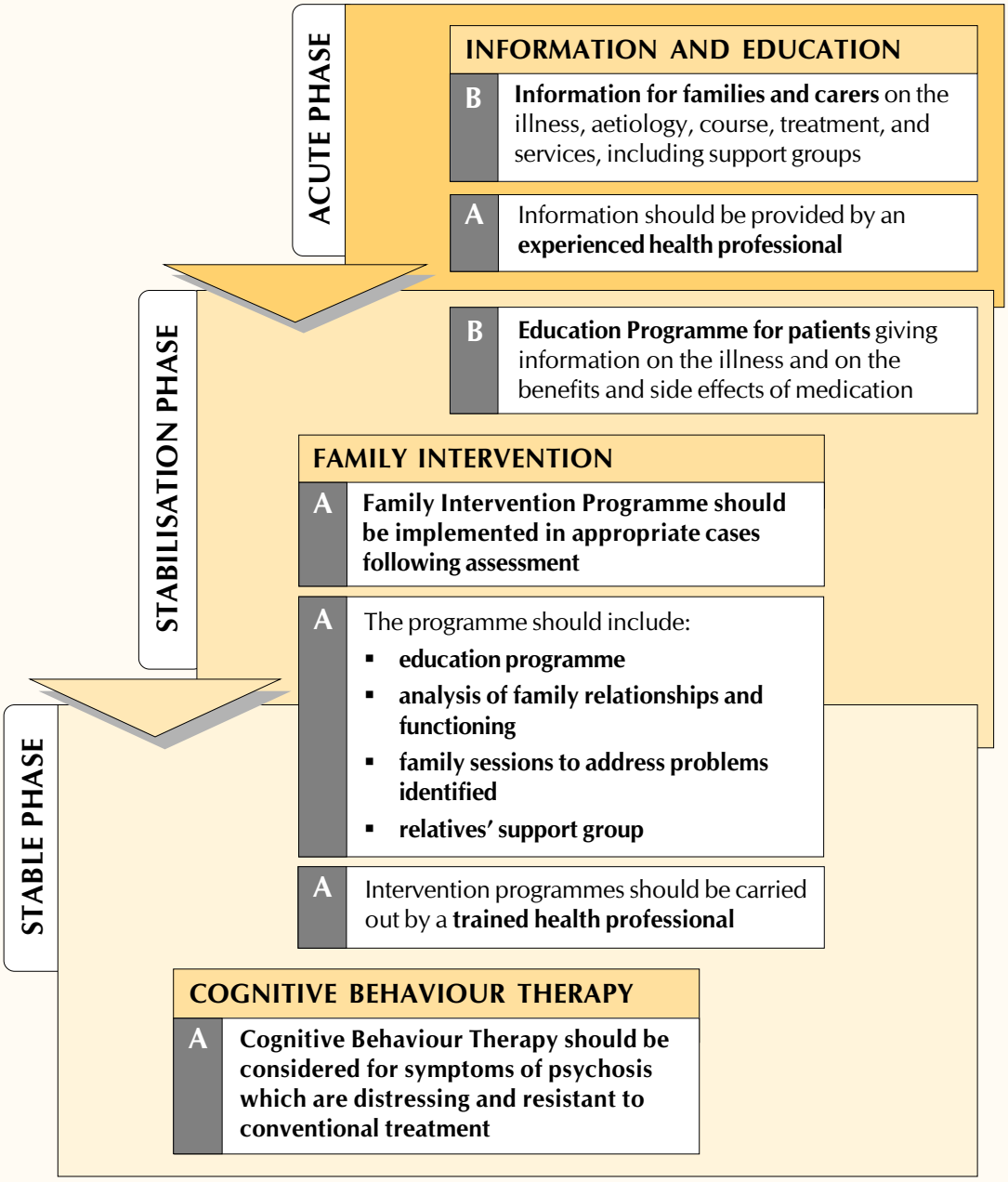
Psychosocial Interventions in the Management of Schizophrenia

Quick Reference Guide



GENERAL RECOMMENDATIONS

C	Treatment of individuals with schizophrenia requires a **co-ordinated multidisciplinary approach**
C	A **Care Plan** should specify all aspects of care to be provided
C	Care should be taken to **avoid overly stressful interventions** which may result in worsening of psychotic symptoms
B	**Families and carers** should be involved from the outset (with the patient's consent)

KEY: A B C **indicates grade of recommendation**

Derived from the national clinical guideline recommended for use in Scotland by the Scottish Intercollegiate Guidelines Network, 9 Queen Street, Edinburgh EH2 1JQ

This guideline was issued in October 1998, and will be reviewed in 2000

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