South London and Maudsley NHS
NHS Foundation Trust

KING'S College LONDON
University of London

What is the effectiveness of psychological therapies for people with severe and persistent mental illness?

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Consensus Development Conference on Improving Mental Health Transitions
4-6 November 2014 – Edmonton, Alberta

Conflict of interest declaration

I have no conflicts of interest to disclose

My context: King's College London and South London and Maudsley NHS Foundation Trust:

- Academic Health Sciences Centre (KCL & SL&M)
- Core population – 4 South London Boroughs 1.3 million; inner city, very high indices of social deprivation and ethnic diversity
- Care organised into care pathways by Clinical Academic Groups – including for Psychosis /SPMI.
- These CAGs bring together clinical services with education and research
- A clinical psychologist and the clinical director and joint leader of the Psychosis CAG

I spent … 10 years of my life in a cycle of gradually getting ill, getting arrested…, being sectioned, and feeling suicidal because of the side effects of the drugs I was prescribed. Even though I was at risk of suicide, I would be deemed 'well' and released from hospital because the schizophrenia was in remission. I would then stop my treatment because of the side effects and gradually get ill all over again over the following 6 months or so.

Personal Account A, NICE Schizophrenia Guideline 2009

Why are psychological interventions needed for people with SPMI?

- People with SPMI frequently experience persisting psychotic symptoms and mood disturbances
- These affect everyday life, causing personal distress, impeding social and vocational functioning and leading to relapse and re-hospitalisation.
- Although the first line of treatment for SPMI is typically medication, many experience a sub-optimal response.
- Psychological therapies (PTs) have been developed to address these needs.
- When I started to work with people with SPMI in 1979, it was thought ineffective and even risky to work psychologically: ‘do not talk with people about their delusions’

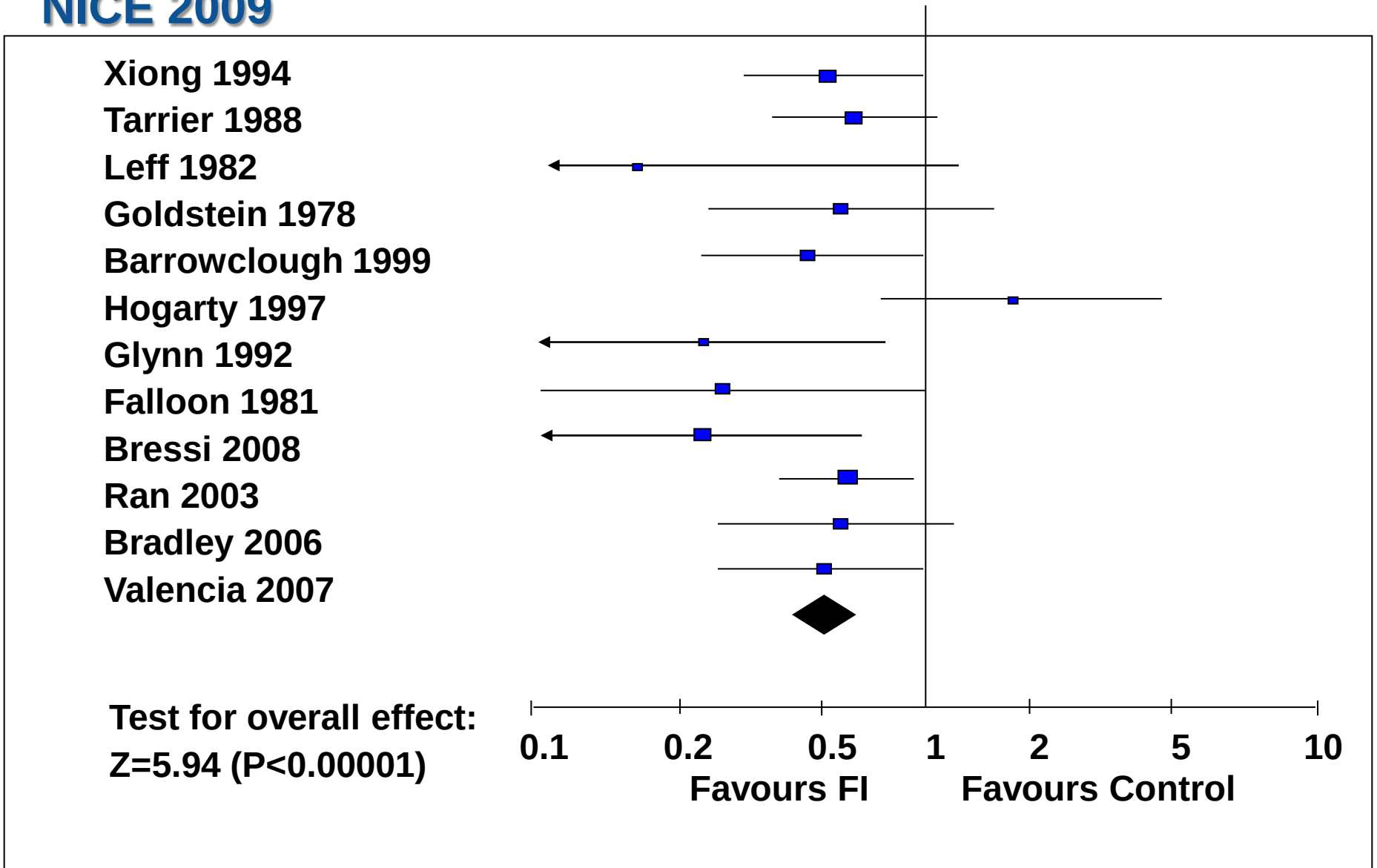
Psychological interventions which promote better outcome and recovery for people with SPMI: Outline

1. What is the evidence?
   - Method – based on published meta-analyses and reviews; national treatment guidelines
   - Focus on Cognitive Behaviour Therapy for Psychosis (CBTp) and Family Interventions (FI)
2. Limitations of evidence – often organised by treatment and diagnosis, mostly ‘schizophrenia’ or ‘psychosis’ but not specific to SPMI. Some rare exceptions.
3. Service user / patient groups demanding fair access to therapies
4. Challenges of effective psychological intervention delivery in routine mental health services
5. Recommendations

Meta-analyses

- A method of bringing together results from different studies
- Usually only randomised controlled trials
- Quality check on studies
- Choice of outcomes – symptoms (both general and psychosis specific), relapse, hospitalisation, depression, quality of life, social functioning, patient experience and family ‘burden’
- Only the outcome shared by studies can be entered into the analysis
- An overall calculation determines if the treatment or control is favoured and the size of the effect

A meta-analyses example: Family intervention compared with Standard Care – Relapse (1-12 months into treatment) NICE 2009



Meta-analyses of Family Intervention

FI is a therapy involving the person with psychosis and the family in ‘psychoeducational’ and coping interventions, and aiming to enhance family communication

First author	Date	Country	Main outcome	Main finding
Pitschel-walz	2001	Germany	Relapse	+
Pilling	2002	UK	Relapse	+
Pfammatter	2006	Switzerland	Relapse	+
Lincoln	2007	Germany	Relapse	+
Pharoah	2010	UK	Relapse	+

Studies included up to 3,000 people with a diagnosis of schizophrenia.
Conclusion: FI reduces relapse and rehospitalisation & is cost effective

CBT for Psychosis; Aims and methods

- To work on ***personal recovery goals*** agreed with client – these are likely to include:
- Reduce distress associated with psychotic symptoms
- Develop an understanding of psychosis to enable improved self-management and to reduce the risk of relapse
- Reduce depression and anxiety
- Improve self-esteem and well being
- Build up social life and vocational functioning

- Weekly or fortnightly sessions, but vary with need; Sessions lasting 50 minutes, but flexible in length

- Nine months' duration (average of 20 sessions)

What is the evidence? CBTp meta-analyses

First author	Date	Country	Outcomes considered	Main finding
Gould	2001	USA	Symptoms	+
Zimmerman	2005	USA	Symptoms	+
Pfammater	2006	Switzerland	Symptoms	+
Wykes	2008	UK	Multiple	+
Lynch	2010	UK	Symptoms	-
Sarin	2011	Scandinavia	Symptoms at follow up	+
Jauhar	2014	UK	Symptoms	+/-
NICE	2009/2014	England/Wales	Multiple	+
Turner	2014	Netherlands	CBT vs. other therapies	+
Burns	2014	Canada/NL	Medication-unresponsive	+
Van der Gaag	2014	NL/UK	Hallucinations and delusions	+

Outcomes of CBT for Psychosis Effect sizes
(Wykes et al, 2008)

	Mean Weighted Effect Size	Number of Studies	Sample Size
Target Symptom	0.400	33	1964
Positive Symptoms	0.372	32	1918
Negative Symptoms	0.437	23	1268
Functioning	0.378	15	867
Mood	0.363	15	953
Hopelessness	-0.190	4	431
Social Anxiety	0.353	3	61

Evidence suggests that CBTp, added to medication, can improve symptoms, mood and everyday functioning, over and above the effects of medication alone

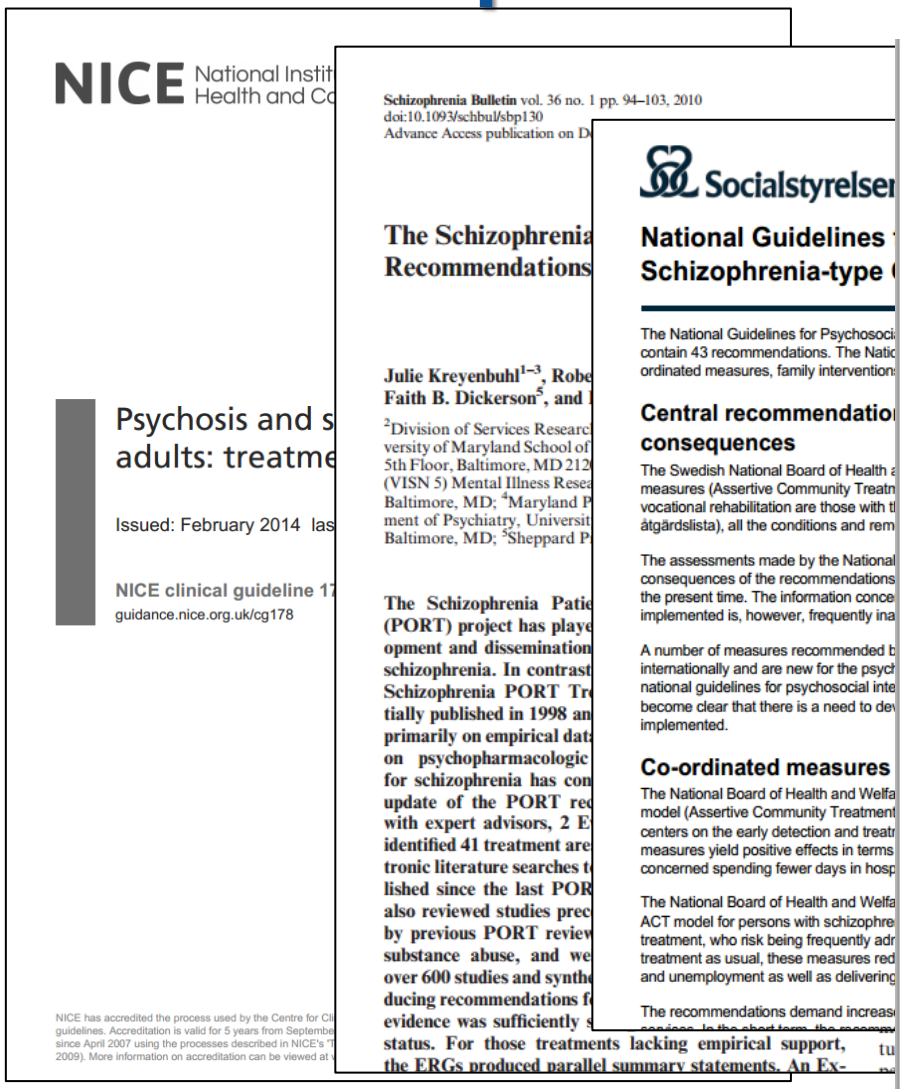
Arts therapies

- One meta-analysis (NICE) 2009
- For people with a diagnosis of Schizophrenia/ SPMI

Author	Date	Country	Main outcome	Main finding
NICE	2009	UK	Negative symptoms	+

Arts therapies included music, body-orientated or art therapy, and seemed especially helpful with people who are less verbal and helped with engagement and reducing negative symptoms/increasing activity. This may be especially relevant to people with SPMI

Treatment guidelines from N America and Europe


NICE National Instit
Health and Co

Psychosis and s
adults: treatme

Issued: February 2014 las

NICE clinical guideline 17
guidance.nice.org.uk/cg178

NICE has accredited the process used by the Centre for Cli
guidelines. Accreditation is valid for 5 years from Septembe
since April 2007 using the processes described in NICE's "
2009). More information on accreditation can be viewed at

Schizophrenia Bulletin vol. 36 no. 1 pp. 94–103, 2010
doi:10.1093/schbul/sbp130
Advance Access publication on D

The Schizophrenia
Recommendations

Julie Kreyenbuhl[1–3], Robe
Faith B. Dickerson[5], and

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(VISN 5) Mental Illness Rese
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ment of Psychiatry, Universit
Baltimore, MD; [5]Sheppard P

The Schizophrenia Patie
(PORT) project has playe
opment and dissemination
schizophrenia. In contrast
Schizophrenia PORT Tr
tially published in 1998 an
primarily on empirical dat
on psychopharmacologic
for schizophrenia has con
update of the PORT rec
with expert advisors, 2 E
identified 41 treatment are
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lished since the last POR
also reviewed studies prec
by previous PORT review
substance abuse, and we
over 600 studies and synth
ducing recommendations f
evidence was sufficiently s
status. For those treatments lacking empirical support,
the ERGs produced parallel summary statements. An Ex-

Socialstyrelsen

National Guidelines
Schizophrenia-type

The National Guidelines for Psychosoci
contain 43 recommendations. The Natic
ordinated measures, family intervention

Central recommendatio
consequences

The Swedish National Board of Health a
measures (Assertive Community Treatn
vocational rehabilitation are those with t
åtgärdslista), all the conditions and rem

The assessments made by the National
consequences of the recommendations
the present time. The information conce
implemented is, however, frequently ina

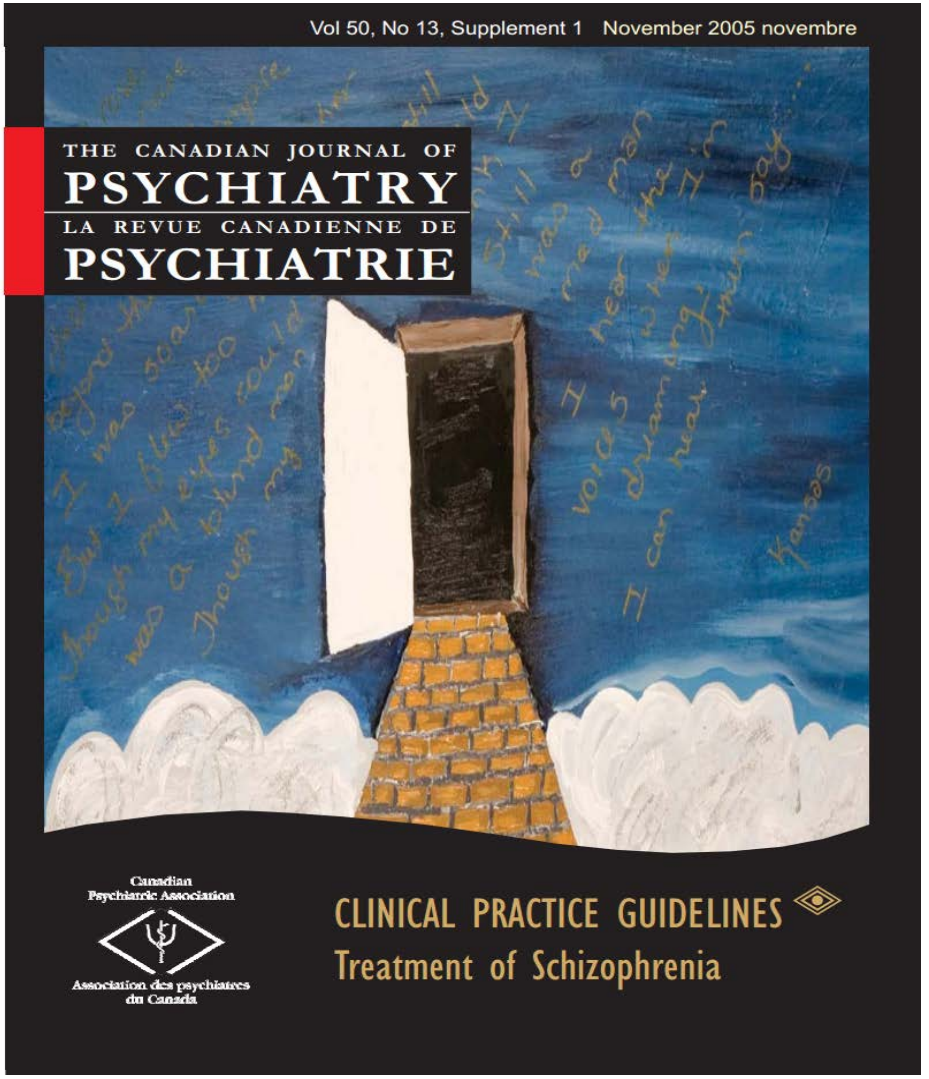
A number of measures recommended b
internationally and are new for the psych
national guidelines for psychosocial inte
become clear that there is a need to dev
implemented.

Co-ordinated measures

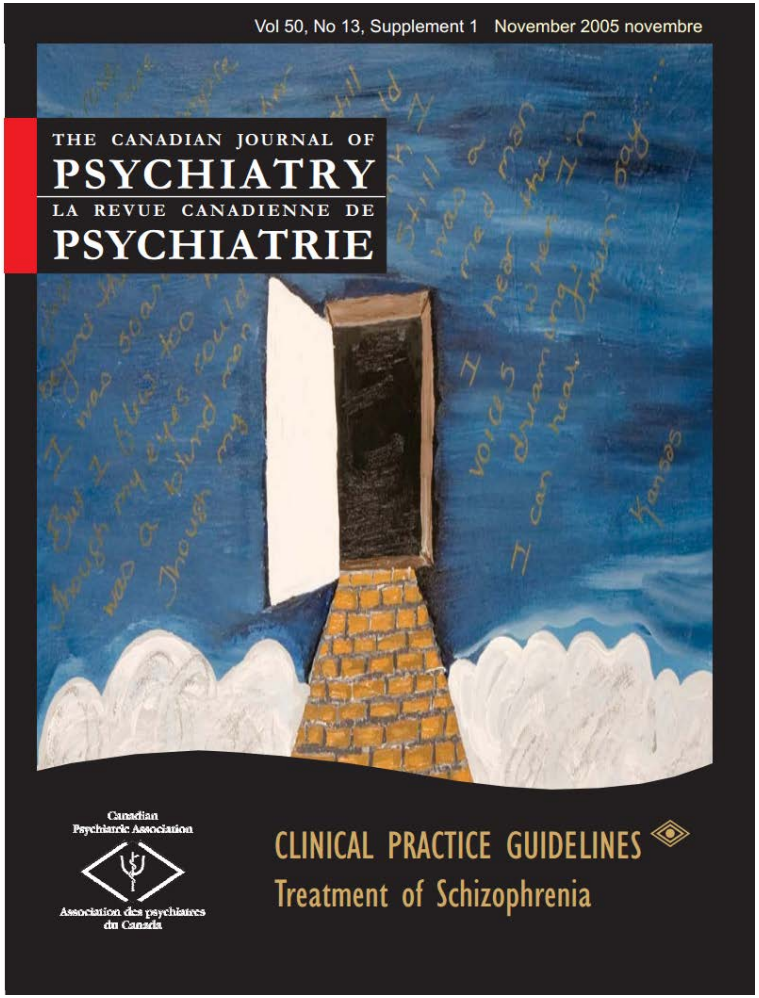
The National Board of Health and Welfa
model (Assertive Community Treatment
centers on the early detection and treatr
measures yield positive effects in terms
concerned spending fewer days in hosp

The National Board of Health and Welfa
ACT model for persons with schizophre
treatment, who risk being frequently adr
treatment as usual, these measures red
and unemployment as well as delivering

The recommendations demand increas

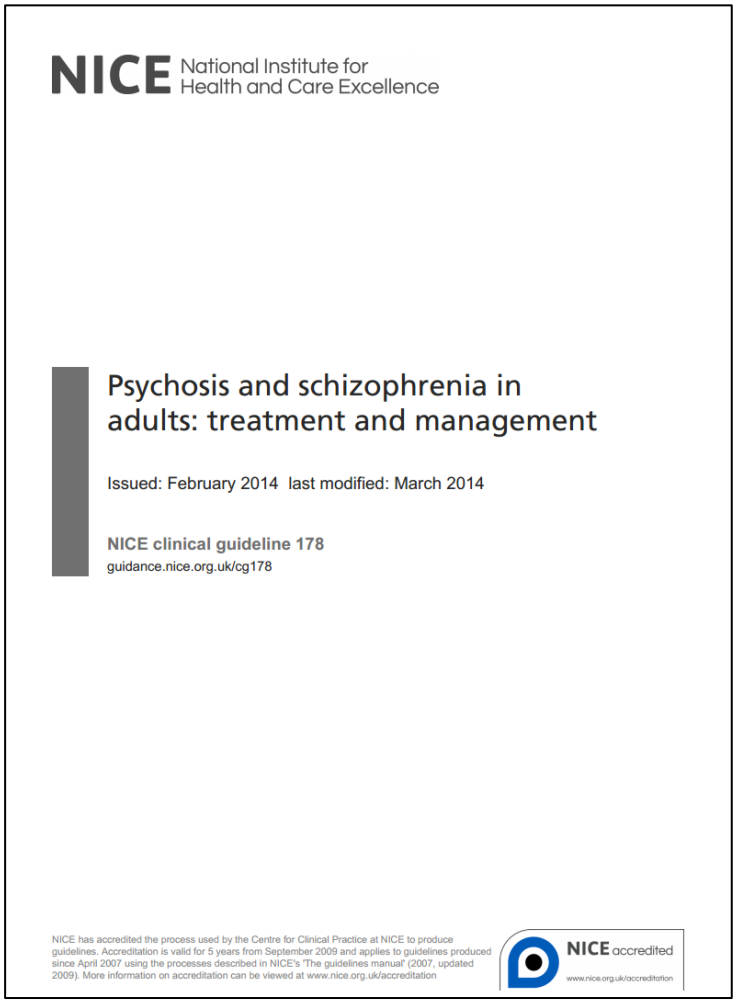


Canadian Journal of Psychiatry - Clinical Practice Guideline, 2005: Recommendations



- **Cognitive-behavioural interventions**
  - Cognitive therapy should be offered to treatment-resistant patients.
  - Cognitive-behavioural interventions should be considered in the treatment of stress, anxiety, and depression in patients with schizophrenia; some adaptation of the techniques used in other populations may be necessary.
- **FI**
  - Family interventions should be part of the routine care for patients with schizophrenia.

NICE (2014) Psychosis and Schizophrenia Recommendations: Psychological therapies



For people with an acute exacerbation or recurrence of psychosis or schizophrenia, offer: oral antipsychotic medication in conjunction with psychological interventions (family intervention and individual CBT)

Pharmacotherapy alone is not regarded as optimal treatment.

NICE (2014) Psychosis and Schizophrenia Recommendations: Psychological therapies

1. **Offer CBT** to all people with psychosis or schizophrenia. Offer to assist in promoting recovery in people with persisting positive and negative symptoms and for people in remission.

2. **Offer family intervention** to all families of people with psychosis or schizophrenia who live with or are in close contact with the service user. Family intervention may be particularly useful for families of people with psychosis or schizophrenia who have: recently relapsed or are at risk of relapse or have persisting symptoms

3. **Consider offering arts therapies** to all people with psychosis or schizophrenia, particularly for the alleviation of negative symptoms.

Also – newly published: NICE (Sept 2014) Bipolar disorder Recommendations: Psychological therapies

Offer adults ***with bipolar disorder in the longer term***:

1. A family intervention to people with bipolar disorder who are living, or in close contact, with their family in line with the NICE clinical guideline on psychosis and schizophrenia in adults.
2. A structured psychological intervention (individual, group or family; CBT, interpersonal therapy or family couples therapy), which has been designed for bipolar disorder and has a published evidence based manual describing how it should be delivered, to prevent relapse or for people who have some persisting symptoms between episodes of mania or bipolar depression.

Is there any evidence specific to people with SPMI? – Not very much

ONLINE FIRST

Randomized Trial to
of Cognitive Therapy
With Schizophrenia

Paul M. Grant, PhD; Gloria A. Huh, MSEd; Di

Context: Low-functioning patients with chro
phrenia have high direct treatment costs and in
incurred due to lost employment and produ
have a low quality of life; antipsychotic medic
psychosocial interventions have shown limit
to promote improved functional outcomes.

Objective: To determine the efficacy of an
recovery-oriented cognitive therapy progr
prove psychosocial functioning and negative
(avolition-apathy, anhedonia-asociality
functioning patients with schizophrenia.

Design, Setting, and Participants: A sin
18-month, randomized, single-blind, parallel
enrolled 60 low-functioning, neurocogni
paired patients with schizophrenia (mean age,
33.3% female; 65.0% African American).

Interventions: Cognitive therapy plus stan
ment vs standard treatment alone.

Main Outcome Measures: The primary out
sure was the Global Assessment Scale score at
after randomization. The secondary outcomes
on the Scale for the Assessment of Negative
and the Scale for the Assessment of Positive
at 18 months after randomization.

Results: Patients treated with cognitive therapy showed

Arch Gen Psychiatry.
Published online October 3, 2011.
doi:10.1001/archgenpsychiatry.2011.129

Article

A Randomized, Controlled Trial of Cognitive Behavioral Social Skills Training for Middle-Aged and Older Outpatients With Chronic Schizophrenia

Eric Granholm, Ph.D.

John R. McQuaid, Ph.D.

Fauzia Simjee McClure, Ph.D.

Lisa A. Auslander, Ph.D.

Dimitri Perivoliotis, M.S.

Paola Pedrelli, M.A.

Thomas Patterson, Ph.D.

Dilip V. Jeste, M.D.

Objective: The number of older patients with chronic schizophrenia is increasing. There is a need for empirically validated psychotherapy interventions for these patients. Cognitive behavioral social skills training teaches cognitive and behavioral coping techniques, social functioning skills, problem solving, and compensatory aids for neurocognitive impairments. The authors compared treatment as usual with the combination of treatment as usual plus cognitive behavioral social skills training.

Method: The randomized, controlled trial included 76 middle-aged and older outpatients with chronic schizophrenia, who were assigned to either treatment as usual or combined treatment. Cognitive behavioral social skills training was administered over 24 weekly group sessions. Blind raters assessed social functioning, psychotic and depressive symptoms, cognitive insight, and skill mastery.

Results: After treatment, the patients receiving combined treatment performed social functioning activities significantly more frequently than the patients in treatment as usual, although general skill at social functioning activities did not differ significantly. Patients receiving cognitive behavioral social skills training achieved significantly greater cognitive insight, indicating more objectivity in reappraising psychotic symptoms, and demonstrated greater skill mastery. The overall group effect was not significant for symptoms, but the greater increase in cognitive insight with combined treatment was significantly correlated with greater reduction in positive symptoms.

Conclusions: With cognitive behavioral social skills training, middle-aged and older outpatients with chronic schizophrenia learned coping skills, evaluated anomalous experiences with more objectivity (achieved greater cognitive insight), and improved social functioning. Additional research is needed to determine whether cognitive insight mediates psychotic symptom change in cognitive behavior therapy for psychosis.

(Am J Psychiatry 2005; 162:520–529)

Grant et al, 2012 and Granholm et al, 2005

- RCTs of CBT for people with schizophrenia and low functioning, and cognitive difficulties; one older people; mostly living in supported housing
- Grant: 18 months recovery programme
- Granholm: 6 months, group-based

- 1. CBTp led to improved functioning, motivation and reductions in positive symptoms
- 2. Improvements in coping, insights and social functioning

A sub group of people with SPMI refuse medication

Cognitive therapy for people with schizophrenia spectrum disorders not taking antipsychotic drugs: a single-blind randomised controlled trial

Anthony P Morrison, Douglas Turkington, Melissa Pyle, Helen Spencer, Alison Brabban, Graham Dunn, Tom Christodoulides, Rob Dudley, Nicola Chapman, Pauline Callcott, Tim Grace, Victoria Lumley, Laura Drage, Sarah Tully, Kerry Irving, Anna Cummings, Rory Byrne, Linda M Davies, Paul Hutton

Summary

Background Antipsychotic drugs are usually the first line of treatment for schizophrenia; however, many patients refuse or discontinue their pharmacological treatment. We aimed to establish whether cognitive therapy was effective in reducing psychiatric symptoms in people with schizophrenia spectrum disorders who had chosen not to take antipsychotic drugs.

Methods We did a single-blind randomised controlled trial at two UK centres between Feb 15, 2010, and May 30, 2013. Participants aged 16–65 years with schizophrenia spectrum disorders, who had chosen not to take antipsychotic drugs for psychosis, were randomly assigned (1:1), by a computerised system with permuted block sizes of four or six, to receive cognitive therapy plus treatment as usual, or treatment as usual alone. Randomisation was stratified by study site. Outcome assessors were masked to group allocation. Our primary outcome was total score on the positive and negative syndrome scale (PANSS), which we assessed at baseline, and at months 3, 6, 9, 12, 15, and 18. Analysis was by intention to treat, with an ANCOVA model adjusted for site, age, sex, and baseline symptoms. This study is registered as an International Standard Randomised Controlled Trial, number 29607432.

Findings 74 individuals were randomly assigned to receive either cognitive therapy plus treatment as usual (n=37), or treatment as usual alone (n=37). Mean PANSS total scores were consistently lower in the cognitive therapy group than in the treatment as usual group, with an estimated between-group effect size of −6·52 (95% CI −10·79 to −2·25; p=0·003). We recorded eight serious adverse events: two in patients in the cognitive therapy group (one attempted overdose and one patient presenting risk to others, both after therapy), and six in those in the treatment as usual group (two deaths, both of which were deemed unrelated to trial participation or mental health; three compulsory admissions to hospital for treatment under the mental health act; and one attempted overdose).

Interpretation Cognitive therapy significantly reduced psychiatric symptoms and seems to be a safe and acceptable alternative for people with schizophrenia spectrum disorders who have chosen not to take antipsychotic drugs. Evidence-based treatments should be available to these individuals. A larger, definitive trial is needed.

Funding National Institute for Health Research.

Lancet 2014; 383: 1395–403

Published Online February 6, 2014 http://dx.doi.org/10.1016/S0140-6736(13)62246-1

See Comment page 1364

School of Psychological Sciences (Prof A P Morrison D Clin Psy, M Pyle BSc, N Chapman D Clin Psy, S Tully MSc, P Hutton D Clin Psy) and Centre for Biostatistics (Prof G Dunn PhD) and Centre for Health Economics, Institute of Population Health (Prof L M Davies MSc), University of Manchester, Manchester, UK; Greater Manchester West Mental Health NHS Foundation Trust, Manchester, UK (Prof A P Morrison, M Pyle, N Chapman, L Drage MPhil, S Tully, K Irving BSc, R Byrne BSc, P Hutton); Newcastle University, Newcastle-upon-Tyne, UK (Prof D Turkington MD, H Spencer BA, R Dudley PhD, A Cummings BSc); Northumberland, Tyne and Wear NHS Mental Health Foundation Trust, Newcastle-

The Lancet
Volume 383, Issue 9926, Pages 1395-1403
(April 2014)
DOI: 10.1016/S0140-6736(13)62246-1

Evidence Based Mental Health Commentary on Morrison et al 2014

- *Evid Based Mental Health* doi:10.1136/eb-2014-101892 3 Sep 2014
- **Psychosis patients refusing antipsychotic medicine could benefit from CBT in terms of both symptom reduction and social functioning**
- **Tania Lecomte**
- Département de Psychologie, University of Montreal, Montreal, Quebec, Canada; tania.lecomte@umontreal.ca
- **What is already known on this topic?**
- Individuals with psychotic disorders might choose to forgo antipsychotic medication because of side effects. Over 40 randomised controlled trials (RCT) have demonstrated that cognitive behavioural therapy for psychosis (CBTp) is generally efficacious in improving symptoms.
- **Most participants in the CBTp condition improved in terms of overall and positive symptoms.**

The evidence for CBTp and FIp is clear, but in most services only one treatment is routinely offered to all

- Medication
- Services and teams differ in provision of other evidence-based interventions
- Less variability in the UK in the Early Intervention services

NICE 2014 Recommendation

‘not only should Early Intervention Services provide the full range of evidence based treatments (both psychosocial and pharmacological) recommended in this guideline, ***but all teams and services*** should do so, irrespective of the orientation or type of team or service considered.’

Psychosis and schizophrenia in adults: NICE guideline February 2014

NICE National Institute for Health and Care Excellence

What do service users and other experts say?

Dolly Sen, Service User Consultant

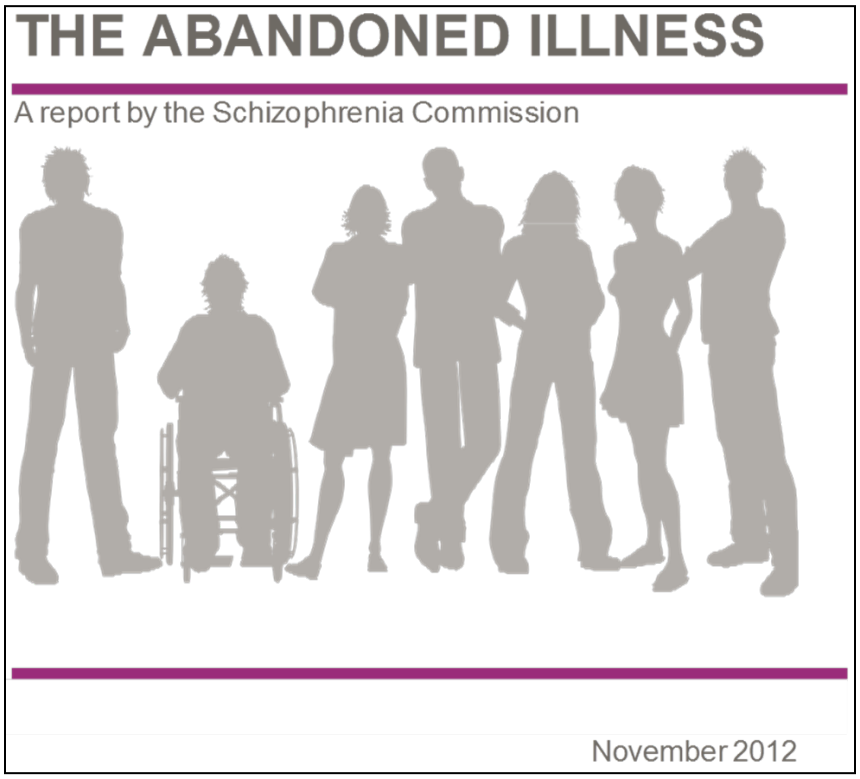
"I always asked for some kind of psychological therapy or talking therapy but was told, no, it was too dangerous. I had to wait 20 years for something that was the most beneficial thing. [Therapy] has changed my life basically."

Talking to Norman Lamb, MP, Minister of State, on 19 December 2012 at SLaM

Delays in accessing psychological therapy in SLaM (Peters et al, 2009) (N=74)

Before being offered psychological therapy:

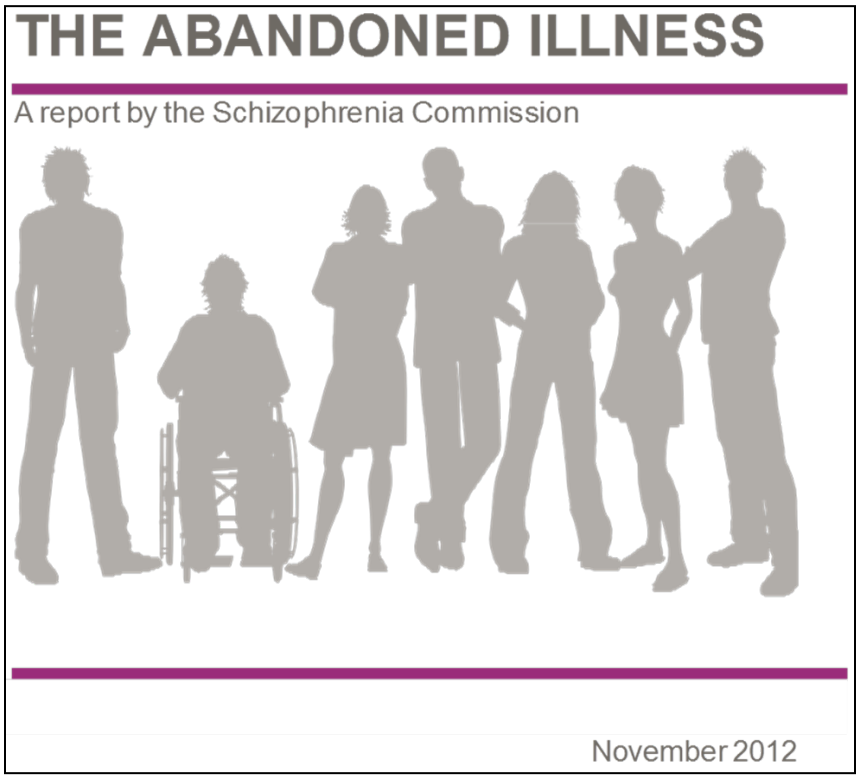
- Mean length of illness was 8 years (range 0-32)
- Mean of 2.8 in-patient admissions (range 0-20)
- In contrast 96% were on antipsychotic medication, with very little delay once seen in mental health services



"Research has led to a range of evidence-based psychological treatments. We know much more about 'what works' than we used to. . . The committed individuals who went into the mental health profession to improve lives should be helped to do exactly that."

Schizophrenia Commission

Prof Sir Robin Murray



But research suggests that, in the UK, only 1 in 10 access CBT and even fewer Family Intervention, despite guidance

Schizophrenia Commission, 2012

Barriers to implementation of mental health guidelines
(Tansella and Thornicroft, 2009)

- Individual (e.g. practitioner knowledge or skill; attitudes)
- Local (e.g. information systems; local commissioning; training availability)
- National (e.g. policy; funding; national training standards)

69% of Trusts have funding challenges for providing access to psychological therapies for people with a diagnosis of schizophrenia

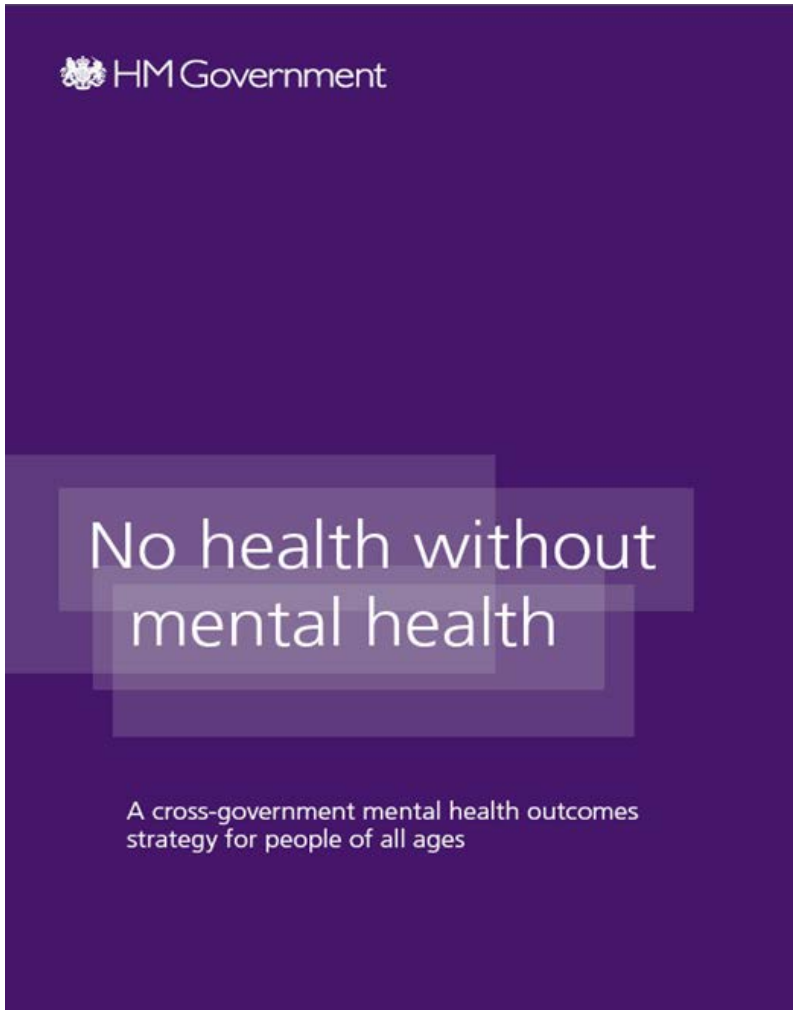
94% have encountered obstacles in making psychological therapies available, including insufficient skilled staff

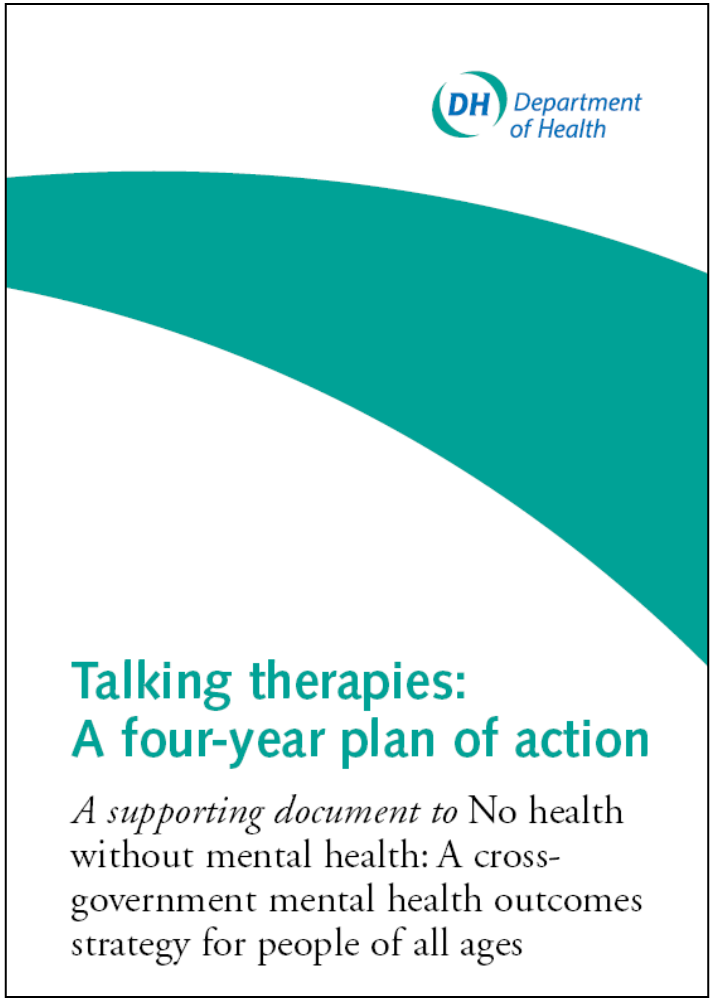
Service users in the UK started to demand equal access to psychological therapies for people with severe mental illness in 2010

Rethink survey (2010)

UK Government policy

IAPT for SMI Improving Access to Psychological Therapies: Severe Mental Illness, 2011





2014


Rethink Mental Illness.
1 in 3 people being treated for schizophrenia have not been offered any form of talking therapy
Over 1,000 of our supporters have joined our call for better access to talking therapies
Take action NOW.
#weneedtotalk
www.rethink.org/weneedtotalk
#weneedtotalk
www.rethink.org/weneedtotalk

Rethink Mental Illness: Schizophrenia Summit – April 2014

Staff attitudes (Prytys et al, 2010)

Clinical Psychology and Psychotherapy
Clin. Psychol. Psychother. (2010)
Published online in Wiley InterScience (www.interscience.wiley.com). **DOI**: 10.1002/cpp.691

Implementing the NICE Guideline for Schizophrenia Recommendations for Psychological Therapies: A Qualitative Analysis of the Attitudes of CMHT Staff

M. Prytys, P. A. Garety, S. Jolley, J. Onwumere and T. Craig*
Institute of Psychiatry, Kings College, London, UK

Objectives. Despite national guidelines recommending cognitive–behavioural therapy (CBT) and family intervention (FI) in the treatment of schizophrenia, levels of implementation in routine care remain low. The present study investigates attitudinal factors amongst community mental health team (CMHT) staff affecting guideline implementation.
Design. CMHTs were audited to measure the capacity and delivery of CBT and FI, and semi-structured interviews were conducted with staff from the teams.
Methods. Four CMHTs were audited, and five care coordinators from each team were interviewed. A purposive approach to sampling was used to represent the range of professional training of care coordinat-

Obstacles: Staff attitudes
(Prytys et al, 2010)

- Community mental health workers working with people with SMI interviewed (N=20)
- Some staff very pessimistic about recovery
- Some staff doubtful as to relevance of psychological therapy
- Others saw PT and medication together as best treatment
- Most thought specialist therapists needed

Changing attitudes

‘*After ten years of working in a general community mental health clinic, I had a career crisis. I was working in a field based intensive case management program for high utilizers of the mental health system. My most difficult clients were not improving and I was burned out. I thought about leaving the profession. Merely by chance, I attended a training on CBT with difficult clients. I was excited to learn that cognitive behavioral therapists were developing treatment programs for the complex and multi-problem clients that I saw in my social work practice. My CBT training has transformed my practice and provided wonderful opportunities for the development of clinical skills. Some of my practice interests include working with [people with SPMI and] substance related and addictive disorders, borderline personality disorder, and trauma’*

Chris Counts, LCSW in USA

KING'S HEALTH PARTNERS

An Academic Health Sciences Centre for London

Pioneering better health for all

South London and Maudsley
IAPT- SMI Demonstration Site for Psychosis
2012-2015

Prof Philippa Garety
Dr Louise Johns
IAPT-SMI Clinical director and Project Lead

Psychosis Clinical Academic Group

King's College London | Guy's and St Thomas' NHS Foundation Trust | King's College Hospital NHS Foundation Trust | South London and Maudsley NHS Foundation Trust

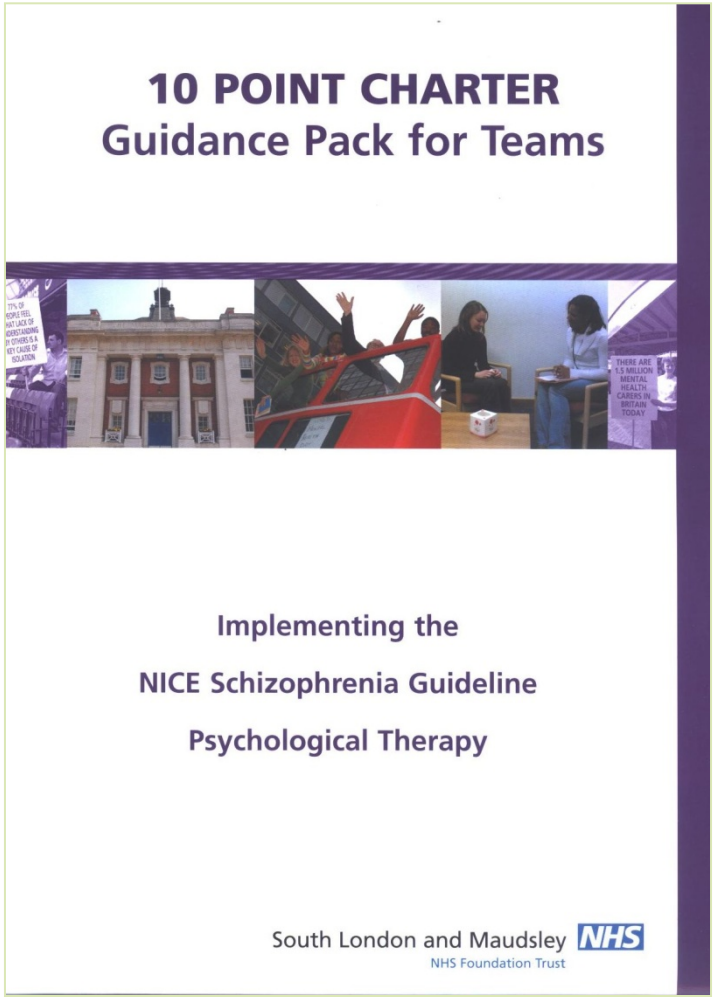
iapt
Improving Access to Psychological Therapies

NHS

IAPT SMI – Implementation of increased access to psychological therapies in SLaM

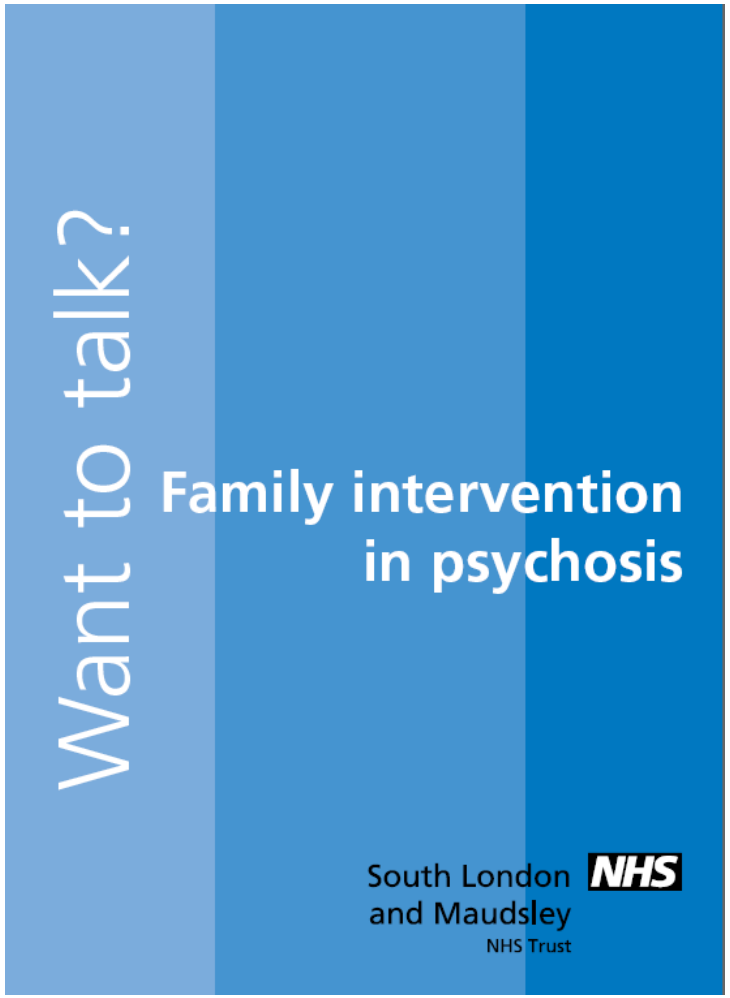
Focus on overcoming known obstacles:

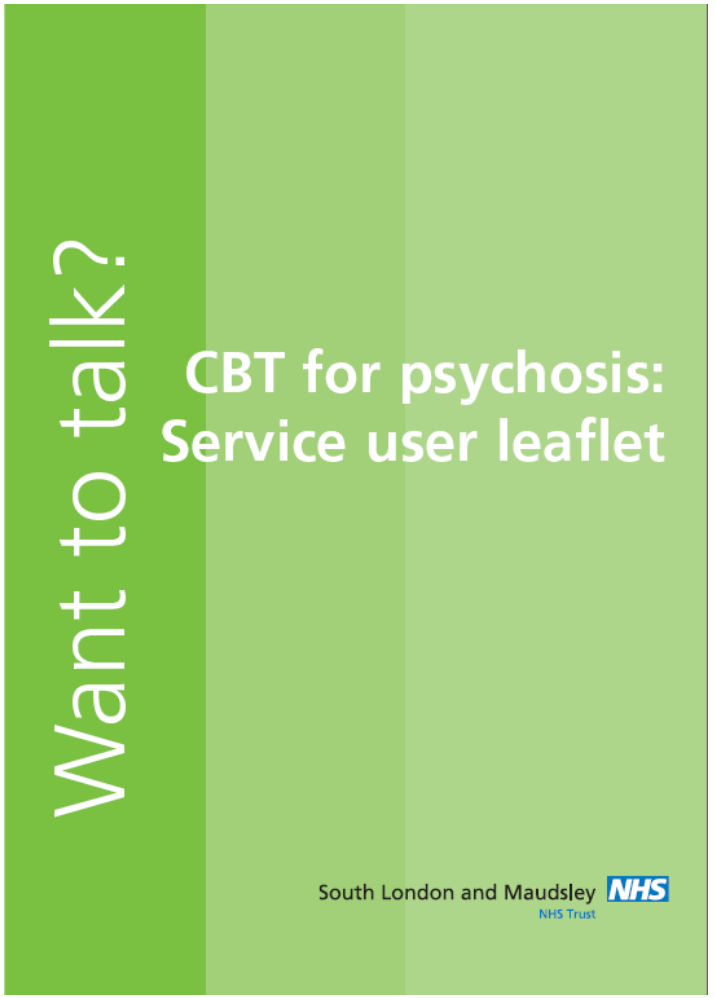
1. Ensuring psychological treatments are formally integrated into care pathways, with clinical and management leadership
2. Service user and carer involvement to support access
3. Staff training, at all levels
4. Therapy competence and quality criteria –national standards
5. Skilled staff funded, employed and supervised
6. Data gathering, data systems and outcomes put in place



iapt
Improving Access to Psychological Therapies
NHS

Information co-produced with service users and carers





Training at all levels in Psychological Therapies for Psychosis in SLaM

Level	Staff Targeted	Course content
Basic Awareness	All, including non-clinical	Introduction to psychological understandings of psychosis and care giving; treatments available (1/2 day)
Enhancing practice	Clinical staff	CPD workshops and Summer Schools in psychological interventions for psychosis
Manualised interventions	Clinical staff	Behavioural Activation, Graded Exposure, ACT, Carer Support, BFT, Group work – graduate level qualifications or in-service (3 day courses; or 1 day/week over yr full cert)
Formal Psychological Therapies	Therapists	Postgraduate Diplomas in CBT for Psychosis; and Family Interventions in Psychosis; in-service training and supervision (1-2 yrs, p-t)
Supervision	Experiences therapists,	Evidence-based approaches to CBT and FI supervision, service development, implementation and training others

IAPT SMI Demonstration site
Initial progress after 12 months

- There is a very strong demand for CBTp from across services
- Waiting time cut by 40% to 1.5 months
- Progress slower with FIp; few people are in close contact with family and more decline offer
- Outcomes are very positive (symptoms, recovery goals, mood) with effect sizes similar to trial results
- Reduction in inpatient bed days and improvement in quality of life suggests PTs are cost-effective

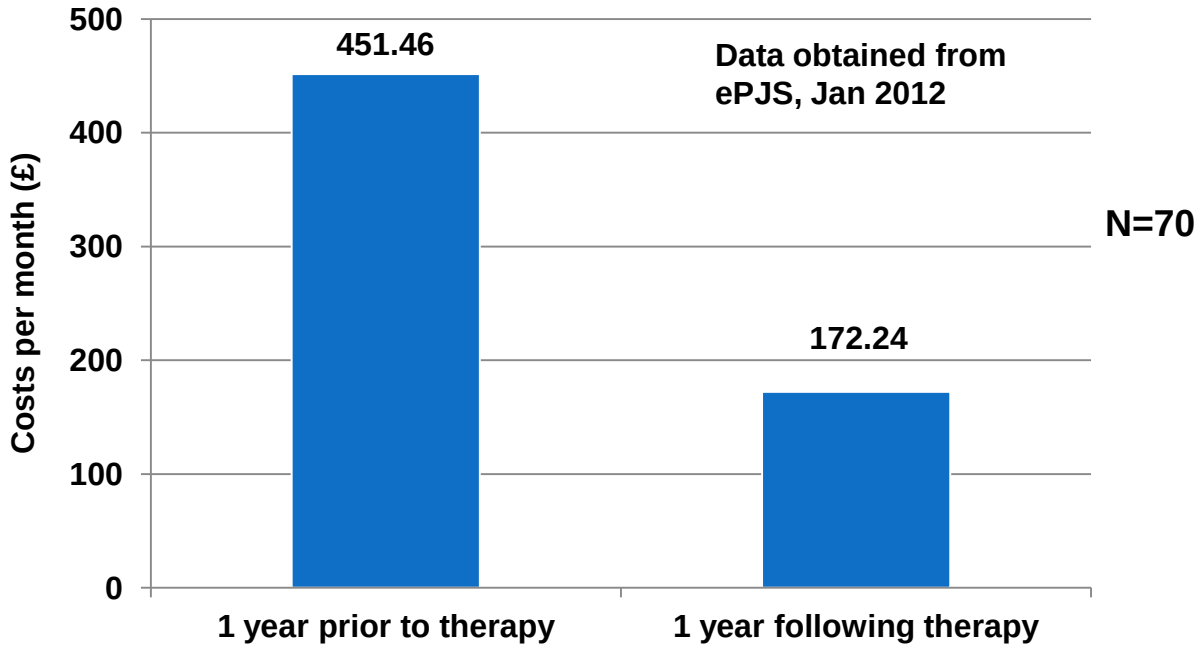
Economic analyses: Schizophrenia Commission, Rethink (Knapp et al, 2012; 2014) and NICE (2014)

Economic analyses suggest that:
FIp is cost effective by reducing relapse and bed usage with high confidence;

CBTp meets acceptable thresholds of cost effectiveness
(cost for improvement in quality of life) and may reduce costs by reducing inpatient use for certain groups

Arts therapies – the economic evidence is lacking

Reduction in service-use costs (admissions & home treatment team days) in the year following therapy, compared to the year prior to therapy (p <.05*)



iapt
Improving Access to Psychological Therapies

NHS

Conclusions and recommendations

1. Evidence

- Medication alone is not the optimal treatment for people with SPMI. Pharmacotherapy should therefore be combined with evidence-based PT for optimal treatment effectiveness.
- The evidence base is strong for FI and good for CBT. More people access CBT. They are considered likely to be cost-effective. Arts therapies also may be helpful.
- Where people refuse pharmacotherapy, emerging evidence suggests that it is acceptable and safe to provide CBT alone.

Conclusions and recommendations

2. Context and delivery

- Choice of PT should be offered in partnership with the service user and family to promote service user's recovery and self-management goals, in a wider context of recovery-focussed services.
- To improve access to PTs, national, regional and local organisational programmes and training developments are required. The involvement of service user and consumer groups is an important component of advocacy, policy development and implementation.
- Although further research is required on the application of PTs with sub-groups of people with SPMI, including people with bipolar disorder, the evidence suggests that all services for people with SPMI should offer PTs

“The CBT enabled me to get in control of what was in my head. Everything is less chaotic and my mind is now freed up to do other things.”

Dolly Sen
Service user and film-maker

Thank you for listening

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