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## **Implementing Psychosocial Intervention (PSI): a key feature of progressive Community Mental Health Services**

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### **Introduction**

PSI may best be considered an umbrella term that refers to the use of a structured, collaborative, cognitive-behaviourally orientated approach to working with service-users and families, which incorporates a number of important therapeutic components (Bowers 1997, Gillam 2002, Brooker & Brabban 2004, Mullen 2009): engagement and outcome-orientated assessment; psycho-education; psychological approaches to managing symptoms, such as stress management, coping strategy enhancement, communication skills training, structured problem-solving, and cognitive-behavioural intervention; medication adherence strategies; and, structured relapse prevention planning (Butler 2011).

Psychosocial approaches have much to offer in the management and treatment of serious mental illness, complementing psycho-pharmacological treatment (NICE 2009). In particular, within the United Kingdom, it is recommended that family intervention and cognitive behavioural intervention (CBT) should be routinely available for service-users and their families / carers (Brooker & Brabban 2004, NICE 2009). Indeed, the expectation that services and practitioners will make evidence-based interventions more available to service-users and families is increasingly emphasised within the national guidance (*for example*: NICE 2009), though this often presents particular challenges for services (Butler 2011).

Within this short chapter, a brief introduction is provided to the practice of PSI, focusing in particular upon the most commonly available forms of PSI, key stages of the care process and principles for practice.

### **Considering Different Forms of PSI**

Effective forms of PSI are based upon a clear underlying model or framework, and a structure and plan for the intervention being offered. Intervention focuses upon current problems of relevance to the person, and is implemented through a collaborative relationship between the practitioner and client (Whitfield & Williams 2003, Whitfield & Davidson 2007).

Four of the most commonly available forms of PSI are:

***Cognitive-behavioural intervention:*** an active, directive, time-limited, structured, formulation-driven, psychological approach that focuses upon the inter-relationship between thinking (cognitive), feeling and behaviour (behavioural) as targets for change, which is now used to treat a variety of psychiatric disorders (see: Beck et al 1979: 3, Rachman & Wilson 1980: 195).

As a distinctive psychological approach, intervention involves the use of specific cognitive and behavioural methods to assist the person to reflect upon, evaluate and respond to unhelpful thoughts and to test out thoughts and beliefs through behaviour, with the aim of helping them to view situations in realistic and less threatening ways, thereby promoting recovery from emotional distress and behavioural disturbance, achieving positive behavioural change and improving functioning.

Primarily focusing upon here and now experiences, intervention is directly related to a shared understanding (*or formulation*) of the individual's problems and difficulties, and the person is actively involved in the change process: monitoring their own thoughts, feelings and behaviours; putting into practice what is learned within structured therapeutic sessions through homework / practice tasks; and, monitoring the impact of change strategies (Whitfield & Davidson 2007).

This approach is most usually delivered in an individual or group format over a time-limited series of sessions.

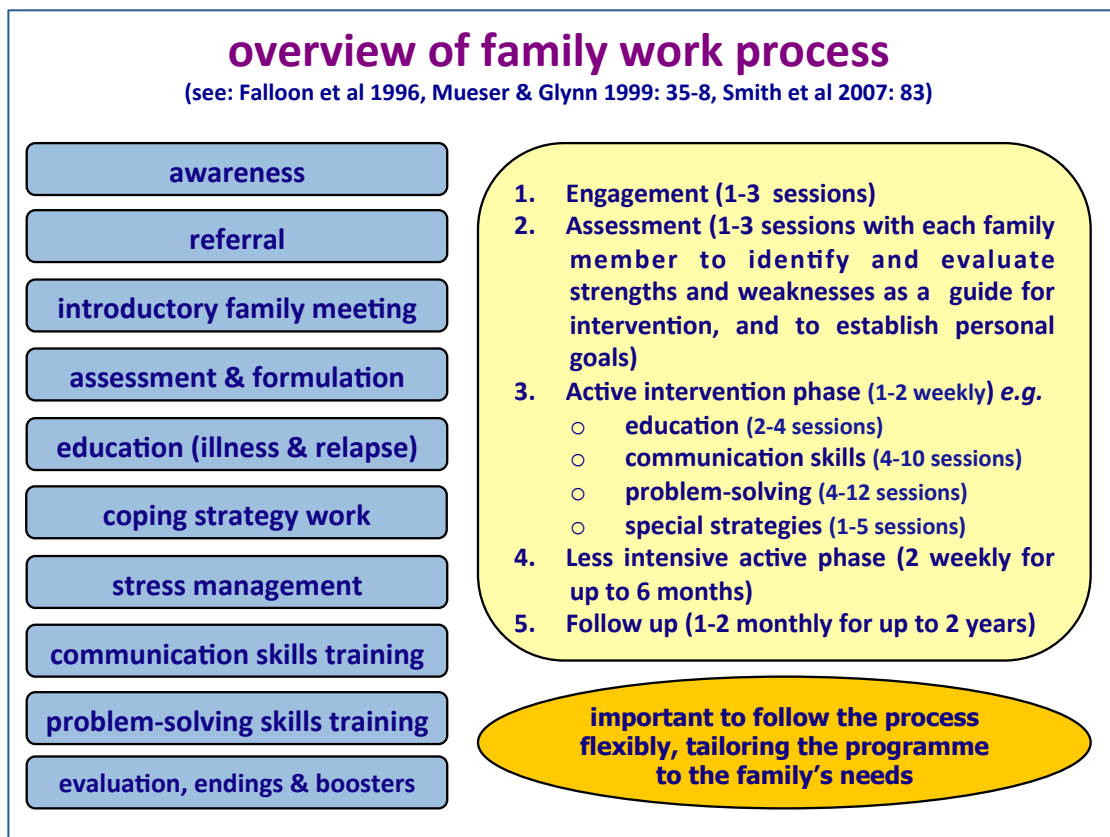
***Behavioural family intervention:*** an integrated and structured psychosocial approach '*to help a family within which one or more members are experiencing symptoms of psychosis, to understand as much as possible about the illness and examine their intuitive coping responses and strategies. Through acknowledging that the symptoms of psychosis itself and the stress of coping with it can hinder communication, families are encouraged to consider the value of using a structured approach to problem-solving that has been useful by many others in a similar situation*' (Falloon et al 1984, cited in Smith et al 1997: 29).

As a problem-solving orientated approach, this involves all family-members, including the *index patient*, to openly share information, generate helpful ideas, and develop and practice new skills, with the aim of enhancing understanding, family communication and problem-solving.

Importantly, this approach involves reducing negative affect: *interrupting hostility or criticism; reinforcing client participation; acknowledging concerns; redirecting family-members to session goals; and, prompting constructive communication.*

The family practitioner(s) adopts the role of a guide or teacher, in helping family members to acquire and use new skills. This approach involves a tailored programme of sessions, as summarised in Fig. 1.

Fig. 1: Overview of Family Intervention (in PSI)



**Medication Management (or Adherence Therapy):** referred to as medication management, compliance or adherence therapy (Kemp et al 1997, Gray et al 2002, Harris 2002, Harris, Neurolink 2006, Baker & Gray 2009), this approach involves the collaborative use of a series of practical motivational, psycho-educational and cognitive-behavioural strategies with the person, which typically include (Gray et al 2002, Kemp et al 1998):-

- *motivational: reviewing illness history with the service-user; exploring his/her ambivalence about taking medication; planning for the future;*
- *psycho-educational: giving information; providing education about the illness and treatment;*
- *cognitive-behavioural: systematic assessment and monitoring of symptoms and treatment effects / side-effects; self-monitoring methods; exploring / testing beliefs about medication; structured problem solving.*

Through a two-way collaborative process between doctor or health-care professional and the service-user, this approach seeks to gain the service-user's active participation within their own treatment and care, promoting their role within their own recovery. The characteristics of this collaborative alliance or partnership are as follows: ensuring the person has enough information about their illness and treatment options to participate as a partner in any decisions about treatment; making joint decisions about treatment; supporting the person in medicine taking after a decision has been made.

**Structured Relapse Prevention Planning:** a collaborative therapeutic activity which involves working with the service-user to develop an individual relapse picture that helps to identify their ‘at risk’ mental states, develop a relapse plan (also referred to as a relapse drill), and promote the service user’s understanding and their control over re-occurring problems/symptoms. Often a key feature of cognitive-behavioural intervention, this involves a number of key steps, as summarised in Fig. 2.

**Fig. 2: Stages of Relapse Prevention Planning**

<b>the structured relapse prevention planning process</b>	
<b>Step 1 *</b>	<b>Engagement &amp; Education</b>
<b>Step 2 *</b>	<b>Identifying Early Warning Signs</b>
<b>Step 3</b>	<b>Timelining: <i>what happens when</i></b>
<b>Step 4 *</b>	<b>Developing the Relapse Plan</b>
<b>Step 5 *</b>	<b>Rehearsal &amp; Monitoring</b>
<b>Step 6 *</b>	<b>Clarifying the Relapse Picture &amp; Refining the Relapse Plan</b>

\* Birchwood M, Spencer E & McGovern D (2000)

### Considering Suitability for PSI

Of course, determining the person’s suitability for one of more of these psychosocial interventions is one of the aims of conducting a structured PSI assessment. Whitfield & Davidson (2007: 64), Westbrook et al (2007: 58) and Moorey (1996) provide guidance on considering suitability, which may be summarised as follows:

- the person’s problems can be understood using the model / framework – *for example*, a case of problems with behaviour / emotion / thoughts, and (*for cognitive-behavioural intervention*), thoughts and beliefs affect the problem;
- the initial formulation of the problem makes sense to the person;
- the person is able to engage in a collaborative relationship;
- the person is able to focus on problems;
- the initial formulation of the problem leads to the identification of clear goals for intervention;
- the person is willing to engage in activities that test out the validity of their thoughts / behaviour;
- the person is willing to practice new ways, or enhance existing ways, of coping with their problems;
- the person can access thoughts and tolerate affect (*for cognitive-behavioural intervention*);
- the person is optimistic / hopeful about the intervention and likely change;
- the person is motivated / committed to change.

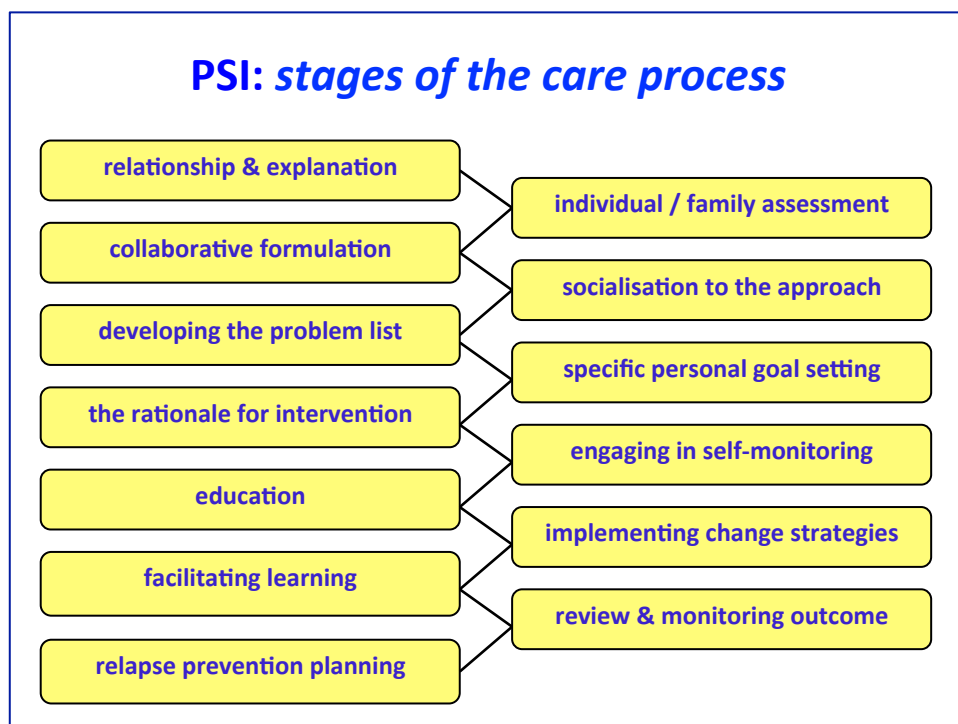
In specifically considering behavioural family intervention, Kuipers et al (2002), Gamble & Brennan (2006) and Smith et al (2007: 73) provide helpful guidance for consideration, which may be summarised as follows:

- one or more family-members experience schizophrenia or other long-standing mental health problem (e.g. affective / anxiety disorders);
- the need for family work has been identified through the care-planning framework;
- the service-user is experiencing a recent psychotic relapse or early warning signs, or has experienced multiple relapses even though taking regular medication;
- a carer(s) is experiencing a problem associated with the illness;
- within the home environment, there are repeated arguments or violence or vulnerability to abuse, or there is intolerance / stress among those with whom the service-user lives;
- the service-user finds it difficult to engage within care and this is placing a burden on the carers, potentially placing them at risk;
- the service-user has only recently been diagnosed as having psychosis;
- the family has specifically requested family work.

### Providing PSI: a practice pathway

Once it has been decided to refer a service-user for a PSI, it will be helpful to move through the key stages of the PSI care process, as shown in Fig. 3.

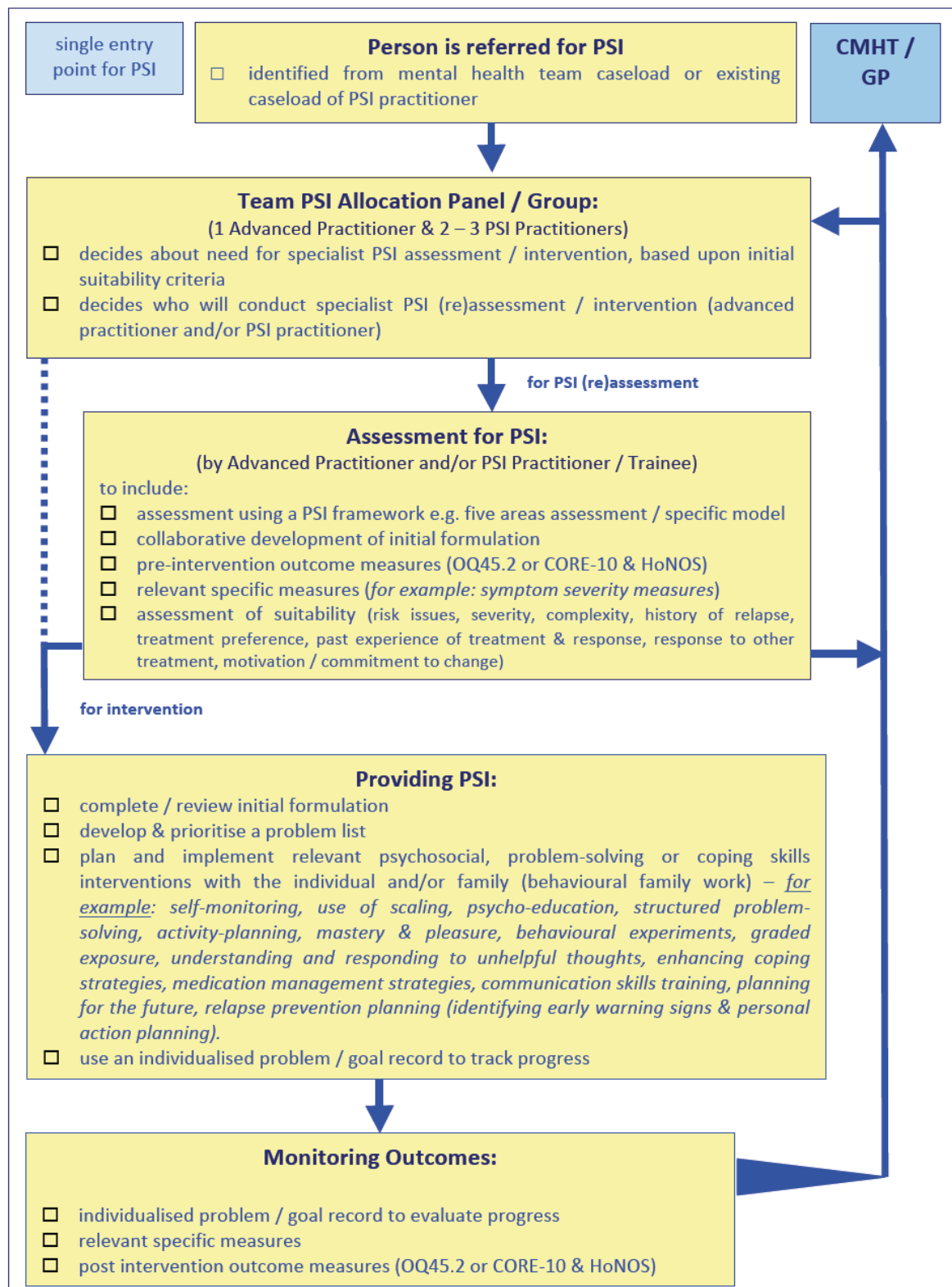
**Fig. 3: PSI: Stages of the Care Process**



Within the community mental health team (CMHT), practitioners who have completed a recognised and accredited educational programme in PSI will be able to conduct a structured PSI assessment and provide time-limited intervention that is

based upon a collaborative formulation of the service-user's experiences, problems and needs, under the supervision of an advanced practitioner, such as the team clinical psychologist. The PSI practitioner should ideally follow a practice pathway, a summary example of which is shown in Fig. 4 (Butler 2011: 81), which should ideally involve participating within team-based PSI practice group meetings to discuss those service-users being referred for and offered PSI.

**Fig. 4: PSI Practice Pathway (Butler 2011: 81)**



## From Assessment & Formulation to Treatment: using a generic framework

Conducting a structured PSI assessment and developing a shared individualised understanding of the person's experiences, problems and needs (*formulation*) will most usually require two sessions (Westbrook et al 2007: 54), though this may need to be extended for those with particularly complex needs.

The aims of this phase are to identify the presenting problems, to determine past and present level of functioning, and to elicit information that will facilitate the development of a meaningful formulation, thereby leading to the clarification of problems and negotiation of goals for treatment and care (Kirk 1989: 13-15, Wells 1997: 21-22). Introducing baseline self-monitoring to further clarify key aspects of the problem, and providing initial information about the treatment approach, are integral to the assessment and formulation phase.

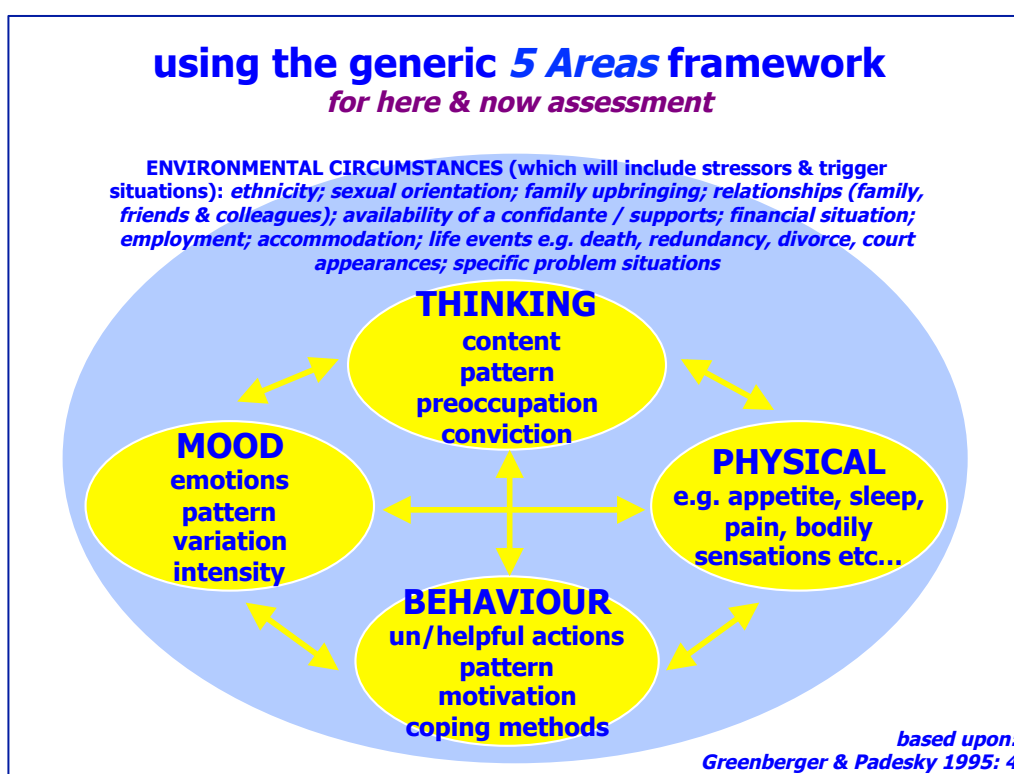
Kirk (1989: 22), Wells (1997: 35-39) and Westbrook et al (2007: 44) further describe a series of stages to the assessment and formulation phase, which may be summarised as follows:

1. explaining the structure and purpose of assessment;
2. gaining a detailed description of the presenting problem(s);
3. conducting a cognitive-behavioural analysis, which will involve use of the cognitive ABC model (activating event, beliefs / thoughts, consequences), a consideration of contextual, influencing and maintaining factors, an exploration of the consequences of the problem, and the development of a specific model-driven analysis as the assessment evolves;
4. establishing how the problem developed (*longitudinal assessment*), which will involve a consideration of the onset and course of the problem, predisposing factors, past stressors, past coping strategies, early experiences, relationship issues, and evident underlying beliefs / assumptions;
5. exploring coping resources and assets / strengths;
6. considering previous psychiatric history;
7. determining the person's attitude to identified problems and to treatment and engagement;
8. introducing baseline homework, practice and monitoring tasks;
9. developing a preliminary formulation, which may initially take the form of a basic maintenance cycle;
10. negotiating specific and detailed goals, written in positive terms.

One of the most common and accepted methods of beginning to develop a mutual 'here and now' understanding of the problem for the novice practitioner is to use a generic framework, such as the Five Areas Framework (Greenberger & Padesky 1995), which emphasises the assessment of different inter-related aspects of the person's experience: *the environment (circumstances); impact on thinking; impact on mood; impact on physiological experience; impact on behaviour.*

An outline summary of this generic framework is provided in Fig. 5, together with some examples of key issues for exploration.

Fig. 5: Using a Generic Framework



In highlighting the inter-related nature of these aspects, a subsequent treatment focus upon one of these five areas is likely to subtly affect and influence change in one or more other areas.

Of course, a developmental aspect may be added to this generic framework, by including details of the person's significant early experiences and (*hypothesised*) core beliefs, which directly influence their individual behavioural strategies and 'here and now' experiences.

Upon mutually developing a shared understanding of the person's problems, the approach will move towards agreeing a problem list and negotiating personal goals as the focus for treatment and care. This will then lead to a discussion of meaningful practical methods / strategies that are likely to address the selected problem / issue and lead to goal attainment.

To illustrate this, consider the common experiences of those with depression, anxiety or those who hear distressing voices – intervention will involve the use of selected cognitive and behavioural strategies, which will need to be tailored to the individual – *for example*:

- activity scheduling to address issues of withdrawal and inactivity (*for further information, see: Martell et al 2010, Chap 5*);
- graded exposure to address avoidance and escape behaviours;
- enhancing positive coping methods to address the experience of distressing voices and thoughts (*for further information, see: Mills 2006: 190-193*);
- structured problem-solving to address practical problems;



- the use of cognitive re-structuring and thought records in developing skills at balancing and responding to unhelpful thoughts (*for further information, see: Greenberger & Padesky 1995*);
- behavioural experiments for testing out unhelpful thoughts and for supporting and reinforcing more realistic, alternative viewpoints (*for further information, see: Bennett-Levy et al 2004*).

It is critical to thoroughly discuss and explain the rationale for proposed intervention strategies and to facilitate frequent opportunities for review and learning, in seeking and maintaining the individual's active engagement.

### **Monitoring Outcomes: further developing the case for PSI**

An integral aspect of PSI involves engaging the service-user in actively monitoring their own progress and the impact of the selected intervention strategies, in enabling them to recognise the value of intervention and their continued efforts in using such.

As a related service example of this, a concurrent service audit was designed and introduced as an expected component of practice by PSI-trained practitioners within a Trust in the South of England (Butler 2011). In providing an overview of the outcomes being achieved by mental health nurse or social work practitioners, outcome monitoring with 61 service-users receiving time-limited structured PSI sessions demonstrated a reduction in psychological distress as measured using the OQ45.2 (Outcome Questionnaire) self-reported outcome measure (Lambert & Burlingame 1996), and a reduction in practitioner-rated HoNOS (Health of the Nation Outcome Scales) total scores (Wing, Curtis & Beevor 1996). Importantly, practitioners were encouraged to actively involve and discuss individual outcome findings with the service-user as part of their routine PSI practice.

Upon further considering OQ45.2 findings:

- *66% of service-users showed a statistically significant and reliable improvement at post-intervention;*
- *71% of service-users achieved a reliable improvement in symptom distress at post intervention;*
- *a smaller number of service-users achieved a reliable improvement in interpersonal relations (23%) and social role (33%);*
- *the risk levels of 35 (57%) service-users reduced, and no risks were reported for a further 9 (15%) service-users.*

These outcomes of providing short-term PSI within a UK Community Mental Health Trust are viewed as very encouraging, highlighting the value of promoting the implementation of evidence-based interventions and integrating outcome monitoring as a routine component of service provision (Butler 2011).

Though the provision of PSI is most likely to form only part of a wider care package designed to address the specific needs of the service-user, this should be considered

as an important therapeutic component of the integrated care-plan for those with moderate – severe mental illness.

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