EDITED BY
ALAN MEADEN
AND ANDREW FOX

Innovations in PSYCHOSOCIAL INTERVENTIONS for PSYCHOSIS

Working with the hard to reach

Innovations in Psychosocial Interventions for Psychosis

Despite the steady acceptance of psychological interventions for people with psychosis in routine practice, many patients continue to experience problems in their recovery. The need to develop new approaches, particularly for those who are more difficult to engage and have significant co-morbidities is therefore important. *Innovations in Psychosocial Interventions for Psychosis* positions psychological formulation as a key organising principle for the delivery of care within multidisciplinary teams. The interventions described all have the common theme of supporting recovery and achieving goals that are of primary importance to the service user which targets interventions on broader obstacles to recovery.

Along with their experienced contributors, Alan Meaden and Andrew Fox introduce new developments in psychological interventions for people affected by psychosis who are hard to reach, working in a variety of settings with people at various stages of recovery. The book is divided into three parts. In Part I brief interventions and approaches aimed at promoting engagement are described as interventions in their own right. Part II is focussed on longer term interventions with individuals. Some of these highlight new developments in the evidence base whilst others draw on work applied less frequently to psychosis drawing from the broader psychological therapy practice-based evidence field. In Part III attention is given to innovations in group settings and those aimed at promoting greater multidisciplinary working in settings where a whole team approach is needed.

Each chapter describes the theory underpinning a different approach, its development, key strategies, principles and stages, and contains case examples that illustrate the use of the approach in a clinical setting. *Innovations in Psychosocial Interventions for Psychosis* will be an invaluable resource for professionals working with this client group, including clinical and counselling psychologists, psychiatrists and other allied health professionals.

Alan Meaden is a consultant clinical psychologist at the Birmingham and Solihull Mental Health NHS Foundation Trust and is the lead for the trust's Assertive Outreach and Non-Acute Inpatient Services.

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I would like to dedicate this book to my wife Ann whose support is always there and to Mark Swain for reminding me that there are no problems, only solutions waiting to be found.

Alan Meaden

I would like to dedicate this to Amy, for her patience, and to Glynn Farmer for showing me that the owls are never what they seem.

Andrew Fox

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List of abbreviations

AOT	Assertive Outreach Team
CARM	Cognitive Approach to Risk Management
CBT	Cognitive Behavioural Therapy
CTO	Compulsory Treatment Order
EWS-P	Early Warning Signs of Psychosis
EWS-R	Early Warning Signs of Risk
HDU	High Dependency Unit
MDT	Multidisciplinary Team
PLF	Personal Level Shared Formulation
PICU	Psychiatric Intensive Care Unit
REBT	Rational Emotive Behaviour Therapy
SAFE	Shared Assessment, Formulation and Education

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Chapter 1

The need for innovation when providing services for the difficult to engage

Alan Meaden and Andrew Fox

In contemporary mental health, recovery and social inclusion are key concepts that underpin the delivery of services (e.g. No Health Without Mental Health, Department of Health, 2011). However, complex mental health needs and engagement difficulties can act as a barrier to recovery and social inclusion (Meaden & Hacker, 2010). In this text we have drawn together descriptions of various psychosocial approaches that are currently being used with people who have complex mental health needs (such as those associated with diagnoses such as schizophrenia and other psychoses), but who can be difficult to engage in services. We describe psychosocial interventions as referring to a broad range of psychological treatments which aim to address the way in which psychological and social factors interact in the emergence and course of psychotic symptoms and experiences. We would also include the way in which individuals respond to biological factors in this description.

Early texts such as that by Birchwood and Tarrier (1992) led to a significant increase in the range of psychosocial interventions offered to people with psychosis. Indeed, relapse prevention, behavioural family therapy and, not least, Cognitive Behavioural Therapy (CBT), have all now been adopted as part of routine practice. However, not all individuals report benefit (Yung, 2012). Indeed there remains a group of people who are persistently hard to reach and resistant to these treatments. In this book we attempt to further the range of interventions offered by drawing on the work of a broad range of authors working in diverse settings. In many cases we have been fortunate to have worked alongside them and shared the emergence of their ideas and therapeutic endeavours.

It has also on a personal level been part of our on-going efforts to enable and support a group of service users all too often neglected in the rush to endorse NICE-compliant treatments (sometimes to the exclusion of other approaches) in their recovery. The approaches detailed in this book offer various ways through which people – who may, at best, be ambivalent about their involvement in services – can be supported to progress in their recovery. We believe these approaches can be labelled as ‘innovative’ in that they represent novel modifications, adaptations and syntheses of existing psychosocial approaches tailored to meet the needs of a disengaged population of people with complex

mental health difficulties. These innovations have been developed through clinical work in a variety of inpatient and community settings, including acute inpatient wards, assertive outreach teams and inpatient rehabilitation services. In this way, we believe that this text represents 'practice-based evidence' (Green, 2008), acting both as a guide for intervention and as a catalyst for the development of research that evaluates the effectiveness of these approaches in practice. There is clear evidence across all chapters of a shared commitment to using innovative clinical practice to enhance recovery and social inclusion for those who are experiencing complex mental health difficulties. We would echo the sentiments that 'you need hope to cope' (Perkins, 2006: 112) and believe that this collection offers some direction and optimism to clinicians who wish to use psychosocial interventions to support those with the most complex mental health and behavioural needs.

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Part I

Innovations in engagement and brief therapies

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Chapter 2

The Adapted Open Dialogue approach

Gert van Rensburg

Introduction

Open Dialogue (OD) is an approach to working with people experiencing complex mental health difficulties that in many ways departs from 'traditional' Western psychiatric approaches. It involves a re-conceptualisation of the way mental health teams work with people with psychosis (and their families) and the roles of these people in treatment. Following a workshop facilitated by the originators of the approach, Jaakko Seikkula and Tom Andersen, this was considered for implementation within an inpatient rehabilitation setting. It was proposed that critical elements of the OD approach could enhance therapeutic work with people who are difficult to engage. The current chapter aims to provide a brief overview of the background to the development of the original ideas and theoretical constructs of OD, followed by a detailed description of how these have been applied in a low-secure environment within an inpatient rehabilitation service for people with complex mental health needs in the UK.

Theoretical background and development: Need Adapted Treatment

It is not possible to understand OD without reviewing the Need Adapted Treatment (NAT) orientation from which it developed. NAT originated from what Alanen (1997) describes as the "Turku Schizophrenia Project" initiated in 1968 in Turku, Finland. Through both research and therapeutic interventions, the project set out to construct the best possible treatment for psychosis associated with schizophrenia. The project ran uninterrupted but with much development along the way through into the 1990s, by which stage the approach was known as Need Adapted Treatment.

Alanen describes the original developmental goal as follows: 'To develop the treatment of Schizophrenia-group patients with an integrated but psychotherapeutically oriented approach' (Alanen, 1997: 141). The focus was on developing and fostering a basic psychotherapeutic attitude in the approach employed by staff as well as developing the hospital wards to become psychotherapeutic communities. This included the use of family therapy and activities, a focus on the development of individual therapeutic relationships and pharmacotherapy as

treatment supportive of the psychological therapy. An emphasis on team work was supported by supervision and training to equip all staff members to become involved in the therapeutic work. There was a commitment to the systematic evaluation of the approach to monitor the treatment needs of the patients and to ascertain how the development of the approach affected treatment outcomes.

Concept and principles

Alanen (1997) acknowledges that the term NAT has not gone unchallenged. A specific query relates to the concept of 'need'. Alanen argues that needs are not to be defined in terms of philosophical or social psychological constructs but rather as a clinical concept that describes what is required for a specific individual at a given point of treatment. The term NAT therefore reflects the heterogeneity and uniqueness of the therapeutic needs of each person requiring treatment.

NAT involves a hermeneutic approach with the aim being to arrive at a psychological understanding of the difficulties as they present in the context of the individual and their environment. This includes not only difficulties caused by symptoms but also the significance the symptoms have for the individual. This psychological understanding then becomes the bedrock guiding all therapeutic interventions. Aaltonen and Räkköläinen (1994) propose the concept of 'shared mental representation' to be employed to steer the treatment process. This is similar to the concept of 'shared formulation' (Meaden & Hacker, 2010), with the same intended aim of integrated treatment guided by an evidence-based psychological understanding of the difficulties.

NAT emphasises the importance of sharing the psychological understanding amongst the treatment team, the service user and members of their immediate social network. Further emphasis is placed on treatment as a process rather than an episode or event where needs are real and changing (hence 'need adapted'). Alanen (1997) also argues that not only do service users often not receive the treatment they need, but many also receive treatment they do not need, such as unduly long hospital admissions and excessive neuroleptic treatment. Thus NAT aims to provide the required treatment as determined by the psychological understanding and to prevent unnecessary interventions (Alanen, 1997).

Alanen summarised NAT in terms of four general principles (Alanen *et al.*, 1991; Alanen, 1997):

- All therapeutic activities are planned and carried out flexibly and individually as each case demands.
- Assessment and treatment are underpinned and guided by a 'psychotherapeutic attitude'. This requires clinicians to develop an understanding of past and present events for the service user as well as the people in their social network and how these can be utilised in the overall approach. It further requires observation of the clinician's own emotional responses when in dialogue with the service users.