



The British
Psychological Society

Psychosis and Schizophrenia in Adults

British Psychological Society response to
the NICE consultation

October 2013

About the Society

The British Psychological Society, incorporated by Royal Charter, is the learned and professional body for psychologists in the United Kingdom. We are a registered charity with a total membership of just over 50,000.

Under its Royal Charter, the objective of the British Psychological Society is "to promote the advancement and diffusion of the knowledge of psychology pure and applied and especially to promote the efficiency and usefulness of members by setting up a high standard of professional education and knowledge". We are committed to providing and disseminating evidence-based expertise and advice, engaging with policy and decision makers, and promoting the highest standards in learning and teaching, professional practice and research.

The British Psychological Society is an examining body granting certificates and diplomas in specialist areas of professional applied psychology.

Publication and Queries

We are content for our response, as well as our name and address, to be made public. We are also content for NICE to contact us in the future in relation to this consultation response. Please direct all queries to:-

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About this Response

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We hope you find our comments useful.



David J Murphy CPsychol
Chair, Professional Practice Board

National Institute for Health and Care Excellence

Psychosis and schizophrenia in adults

Stakeholder Comments

Please enter the name of your registered stakeholder organisation below.

NICE is unable to accept comments from non-registered organisation or individuals. If you wish your comments to be considered please register via the [NICE website](#) or contact the [registered stakeholder organisation](#) that most closely represents your interests and pass your comments to them.

Stakeholder Organisation:	The British Psychological Society
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Name of commentator:	
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Order number <i>(For internal use only)</i>	Document	Page Number	Line Number	Comments
	Indicate if you are referring to the Full version or the Appendices	Number only (do not write the word 'page/pg') . Alternatively write 'general' if your comment relates to the whole document.	Number only (do not write the word 'line') . See example in cell below	Please insert each new comment in a new row. Please do not paste other tables into this table, as your comments could get lost – type directly into this table.

Example	Full	16	45	Our comments are as follows
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Proformas that are not correctly submitted as detailed in the line above may be returned to you

1	Full & NICE Guideline	General		The Society welcomes the addition of 'psychosis'. However the concept still seems rather reified. – at some points there is an implication that an illness 'does things' to people rather than there being a need to understand why people have certain experiences and feelings, and what can help. An example would be on page 3 – 'a major psychiatric disorder that alters a person's perception, thoughts, mood and behaviour'.
2	NICE Guideline	20	1.3.1.1	The Society welcomes the inclusion of a recommendation that early intervention in psychosis be made available to all people with a first episode or presentation of psychosis.
3	NICE Guideline	20		The Society believes that assessment may take some time and it is worth engaging somebody in order to access good quality information. We would suggest that it is worth advising on how trauma and PTSD should be assessed. We would also recommend the inclusion of any caregivers, and information sharing preferences and also whether the person is a parent and support for children is required.
4	NICE	8	13	

	Guideline			Where the affective psychoses are distinguished from schizophrenia spectrum psychosis, it would be helpful to be clearer in noting the potential for diagnostic uncertainty. In these cases, we would recommend the need to use clinical judgement in determining the most appropriate interventions.
5	NICE Guideline	11		We are concerned that it appears to be assumed that all service users will find medication helpful in first episode, whereas this is not the case.
6	NICE Guideline	15	1.1.3	The Society welcomes the attention to physical health and monitoring of physical health.
7	NICE Guideline	19	1.2.3.2	The Society welcomes the recommendation not to offer medication preventatively as timely.
8	NICE Guideline	22	1.3.4.2	We welcome the advice to offer psychological intervention to those not wishing to take medication. However, the wording 'advise that psychological interventions are more effective when delivered in conjunction with antipsychotic medication' is overly restrictive. Although RCTs show this to be the case <i>on average</i> , it should be acknowledged that this may not be the case for all service users depending on their specific circumstances and needs. We would recommend inserting the phrase 'under certain conditions'. This point also applies to communication with service users about other issues.
9	NICE Guideline	24		The Society strongly endorses the recommendation that 'Treatment with antipsychotic medication should be considered an explicit individual therapeutic trial'. We welcome this as. Indeed we believe that were medication used in this way, the quality of mental health services would be significantly improved.
10	NICE Guideline	38	2.1-2.5	The Society welcomes the research recommendations.
11	NICE Guideline	27	6	We would welcome a clearer distinction in relation to the difference between the formulation arising from routine psychiatric assessment and a psychological formulation. This distinction is not widely understood in services.
12	Full	199	21	The Society welcomes recognition of the benefits of peer support. However, it is perhaps unnecessarily harsh on professional staff who work in the teams which in recent times have specialised in reaching those hard to engage i.e. assertive outreach teams. There is no research cited to support the statement that "assertive attempts to re-engage patients are perceived as harassing".
13	Full	226-325	All	We believe that the guideline is missing any review of

				<p>other up-and-coming approaches and especially ACT and mindfulness. There are now enough studies to at least warrant a review. Four RCTs of ACT for psychosis are quoted in the new book “ACT and Mindfulness for Psychosis” – pg 7: Bach & Hayes (2002), Gaudiano & Herbert (2006), Shawyer et al (2012), White (2011). Evaluations of mindfulness other than Chadwick et al (2005, 2009).</p> <p>The Society believes that, based on the evidence now available, ACT offers a viable alternative to the traditional CBT model of therapy for psychosis: ACT's therapy goals of promoting acceptance, psychological flexibility and valued living are appropriate to the often long term nature of psychosis, fit well with a recovery framework, and represent a helpful shift from a more traditional approach in which symptom elimination would be viewed as the key criteria for measuring treatment effectiveness.</p> <p>Reference: Bach, P., & Hayes, S.C. (2002). The use of acceptance and commitment therapy to prevent the rehospitalisation of psychotic patients: A randomized controlled trial. <i>Journal of Consulting and Clinical Psychology</i>, 70, 1129-1139.</p> <p>Chadwick, P. (2005). Mindfulness groups for people with psychosis. <i>Behavioral and Cognitive Psychotherapy</i>, 33, 351-359.</p> <p>Chadwick, P., Hughes, S., Russell, D., Russell, I., & Dagnan, D. (2009). Mindfulness groups for distressing voices and paranoia: A replication and randomized feasibility trial. <i>Behavioural and Cognitive Psychotherapy</i>, 37, 403-412.</p> <p>Gaudiano, B.A., & Herbert, J.D. (2006). Acute treatment of inpatients with psychotic symptoms using acceptance and commitment therapy: Pilot results. <i>Behaviour Research and Therapy</i>, 44, 415-437.</p> <p>Shawyer, F., Farhall, J., Mackinnon, A., Trauer, T., Sims, E., Ratcliffe, K., Lerner, C., Thomas, N., Castle, D., Mullen, P., & Copolov, D. (2012) A randomised controlled trial of acceptance-based cognitive behavioural therapy for command hallucinations in psychotic disorders. <i>Behaviour Research and Therapy</i>, 50, 110-121</p> <p>White, R.G., Gumley, A.I., McTaggart, J., Rattrie, L., McConville, D., Cleare, S, et al. (2011). A feasibility study of Acceptance and Commitment Therapy for emotional dysfunction following psychosis. <i>Behaviour Research and Therapy</i>, 49, 901–907.</p>
14	Full	260	2	<p>The Society believes that some reference to the likely need for some adaptation for particular groups is needed, such as people with a learning disability. For example, an additional recommendation such as:</p> <p>“9.4.10.6 CBT treatment is likely to need adaptation for</p>

				some groups with coexisting conditions, such as people with a learning disability or autistic spectrum condition.”
15	Full	260	2	The Society would welcome further clarification on whether ‘planned’ sessions mean those 16 sessions are attended or offered. Some reference to what would be considered an adequate “dose” is also needed.
16	Full	260	4	The Society would welcome the inclusion of ‘formulation-driven’ or ‘individually formulated’ somewhere as well as the recommendation to follow a manual. Reference should be made to CBTp not simply being CBT for psychosis but for any other difficulties, which may be secondary to psychosis or may be co-morbid (for example, anxiety, depression, OCD, PTSD). This should be made explicit or otherwise state that trials have not been held of ‘CBT for anxiety in people with psychosis’ and that this is needed.
17	Full	260	21	We believe that there is a need for research into the efficacy of CBT for co-morbid difficulties in the context of psychosis; for example, OCD, PTSD, depression, anxiety, substance misuse, personality traits, anger. Clients with psychosis are usually excluded from research trials on ‘CBT for Any of the above’.
18		318	11	The Society would suggest adding two more recent reference Read & Bentall (2012) and Steel (2011). Read, John and Bentall, Richard P. (2012). Negative childhood experiences and mental health: theoretical, clinical and primary prevention implications. <i>British Journal of Psychiatry</i> , 200:89-91, DOI: 10.1192/bjp.bp.111.096727 Steel, C. (2011). The relationship between trauma and psychosis: a CBT perspective. Available online: http://www.ukpts.co.uk/site/assets/Steel-UKPTS-Oxford-2011.pdf
19	Full	319	1-20	It is worth noting that the research on PTSD is secondary to psychotic episodes and/or hospital admissions. See Morrison et al’s (2003) review for discussion and references. Reference: Morrison, A. P., Frame, L., & Larkin, W. (2003). <i>Relationships between trauma and psychosis: A review and integration</i> . The British Journal of Clinical Psychology, 42 , 331–351. doi:10.1348/014466503322528892.
20	Full	320	18-34	It would be helpful to distinguish between working with people with trauma histories (where the history is often incorporated into a psychological formulation of their psychosis and other distressing experiences) and people with psychosis who also meet the criteria for PTSD such as having flashbacks. Standard CBTp

				involves work with trauma histories, but it is not clear what the evidence is for trauma-focused CBT where they meet PTSD criteria. The Society is concerned that the review therefore fails to acknowledge a lot of trials of relevance to lines 39-41 (table 86), because a lot of CBTp does address the 'psychological management of trauma'.
21	Full	321	5	<p>We would suggest the inclusion feasibility RCT (De Bont et al. 2013). The results of this feasibility trial suggest that PTSD patients with co-morbid psychotic disorders benefit from trauma-focused treatment approaches such as PE and EMDR.</p> <p>It would also be valuable to include the pilot study (van den Berg & van der Gaag, 2012). This is a current multi-site RCT in the Netherlands looking at the effect of treatment of posttraumatic stress disorder in people with a lifetime psychotic disorder. The treatment of PTSD has a positive effect on auditory verbal hallucinations, delusions, anxiety symptoms, depression symptoms, and self-esteem. EMDR can be applied to this group of patients without adapting the treatment protocol or delaying treatment by preceding it with stabilising interventions.</p> <p>References: de Bont, Paul A.J.M., van Minnen, Agnes . & de Jongh, Ad (in press, 2013). Treating PTSD in Patients With Psychosis: A Within-Group Controlled Feasibility Study Examining the Efficacy and Safety of Evidence-Based PE and EMDR Protocols. <i>Behavior Therapy</i>. Available online: www.sciencedirect.com</p> <p>van den Berg, D. P., & van der Gaag, M. (2012). Treating trauma in psychosis with EMDR: A pilot study. <i>Journal of Behavior Therapy and Experimental Psychiatry</i>, 43(1), 664–671. doi:10.1016/j.jbtep.2011.09.011</p>
22	Full	324	17	The Society recommends that this is revised to be more specific and state that someone with training in PTSD in Psychosis is needed and make reference of the potential need to adapt work for people with psychosis.
23	Full	507	28	It is worth noting that the current level of service provision in many areas means that it is not possible for all people with an established diagnosis of schizophrenia to have a joint care plan between primary and secondary care. It The guideline implies that all people with psychosis should be referred to secondary care, however, the recent Joint Commissioning Panel for Mental Health guidelines for community health services provide guidance about whether a person with psychosis could be seen in primary care alone, since secondary care is a limited resource and should be reserved for people with complex social needs and/or high risk.
24	Full	507	33	

				The Society recommends that carers should not only be offered an assessment of their needs but also the relevant support to meet these needs and offered follow up to ensure these needs have been met.
25	Full	508	15-44	<p>The Society welcomes the implication that a referral to secondary care may not always be necessary, although this is stated implicitly and tentatively. Factors that may be used to indicate that referral to secondary care is appropriate are:</p> <ul style="list-style-type: none"> a) Complexity, and by this we mean someone being very unwell and having a range of social needs that primary care cannot meet. b) Risk - Many of the points mentioned in this section about medication and side effects could be managed by the GP, with support/consultation from secondary care. <p>There needs to be more of this and reference to primary care needing training to better support people with psychosis.</p>
26	Full	510-513	All	We would recommend that a reference to the recovery model and its influence in recent years is included. Greater emphasis should also be made on personalised care and service-user driven outcomes.
27	Full	513	34	The Society believes that clients should not have to be referred to secondary care just to access psychological treatments. These should be made available in primary care; for example, SMI-IAPT initiatives.
28	Full	534	13	<p>The Society is concerned that this ignores two critical differences between Assertive Outreach (Assertive Community Treatment or Assertive Outreach and Intensive Case Management.)</p> <ul style="list-style-type: none"> 1 AO emphasises a team approach, ICM does not. 2 ICM is a poorly defined model, whereas ACT is very well defined. <p>The terms ACT and ICM are used interchangeably in the document, although the text does not cite any evidence that ACT and ICM are equivalent. The Cochrane review (Dieterich et al, 2010) may assert an equivalency between these two models, but there is a lack of evidence to support this. When AO and ICM are compared as different models, the evidence for ICM is weaker (e.g. Cochrane review, 1998). Conflating the two models then simply weakens the evidence for AO. It would be more helpful to look at evidence for clearly defined models, rather than conflating different models.</p> <p>Reference: Dieterich M, Irving CB, Park B, Marshall M. (2010). Intensive case management for severe mental illness. <i>Cochrane Database of Systematic Reviews</i> (10):CD007906.</p>
29	Full	534	26	

				<p>We believe that these definitions are unhelpful when attempting to make this comparison. The only difference given between ICM and non-ICM is caseload size. But since one is defined as up to and including 20, whereas the other is defined as over 20 people, the difference between services compared could just be a single additional case. This lack of clear difference perhaps accounts for the weak results reported on p 542.</p>
30	Full	547	8	<p>We suggest that it would be appropriate to add a caveat to the failure to find a large effect on duration of hospitalisation in the UK. This has already been explained by context (For example, Stefan Priebe et al, 2009). The already low bed numbers in the UK make it difficult for any services to reduce them significantly. An international comparison shows admissions in countries with comparatively high bed numbers, or when beds are cut as teams are established. In the UK there are probably more appropriate means to investigate effectiveness; for example, recovery outcomes.</p> <p>Reference: Priebe, S., Katsakou, C., Amos, T., Leese, M., Morriss, R., Rose, D., Wykes, T., and Yeeles, K. (2009) - <i>Patients' views and readmissions 1 year after involuntary hospitalisation</i> – The British Journal of Psychiatry, 194, 49-54.</p>
31	Full	551	18-22	<p>The Society believes that the smaller caseloads are a significant factor in the success of EIS. EIS care coordinators see their clients regularly (often 1-2 times/week), which contributes significantly to recovery and also allows better monitoring of signs of relapse, to prevent it earlier. EIS staff are usually more psychologically minded and/or trained in low-intensity psychological interventions (but not high intensity 'CBT or FI') This improves the overall care.</p>
32	Full	552	23	<p>On the previous page, the critical outcomes for ICM do not include symptom reduction. This seems appropriate, so it is not clear why the discussion about trade-off refers so much to symptoms. The Society would therefore welcome greater emphasis on the assessment of effectiveness in terms of recovery; for example, quality of life and functioning.</p>
33	Full	554	15	<p>There is a lack of distinction between ICM and AO which is unhelpful, given that in the UK in recent times assertive outreach teams have been focused on those with poor engagement and high desirability.</p>
34	Full	554	30	<p>We believe that there are significant service implications with this. We would recommend that clarification is made regarding whether EI is considered to be the most appropriate service or whether it is about extending the EI care package in an appropriate setting.</p>

35	Full	555	16	<p>There are often difficulties at the interface between mental health services and learning disability services (e.g. Royal College of Psychiatry, 2012, p.8), which can negatively affect the quality of care provided to people with a learning disability. We would therefore recommend the inclusion an additional explicit reference to the commissioning of clear arrangements between mental health and learning disability services (as recommended by the Joint Commissioning Panel for Mental Health, 2013, p.14) to ensure that people with a learning disability can access appropriate services for psychosis and schizophrenia. For example:</p> <p>“12.3.7.9 Commissioners should ensure there is clarity over how services are to be provided to people a learning disability, so that there is a clear pathway for them to follow. Disputes over eligibility criteria between mental health and learning disability services should not delay access to treatment.”</p> <p>References: Joint Commissioning Panel for Mental Health (2013) - <i>Guidance for commissioners of mental health services for people with learning disabilities</i> http://www.jcpmh.info/wp-content/uploads/jcpmh-learningdisabilities-guide.pdf</p> Royal College of Psychiatrists’ Faculty of Psychiatry of Intellectual Disability (2012) <i>People with learning disability and mental health, behavioural or forensic problems: the role of in-patient services</i> http://www.rcpsych.ac.uk/pdf/FR%20ID%2003%20for%20website.pdf
36	Full	580	1	<p>The Society would recommends that specific reference to the need for clear commissioning arrangements as to how crisis resolution and home treatment teams can be accessed by people with a learning disability be made. For example:</p> <p>“12.4.6.1 Consider crisis resolution and home treatment teams as a first-line treatment to support people with psychosis or schizophrenia during an acute episode in the community if the severity of the episode, or the level of risk to self or others, exceeds the capacity of the early intervention in psychosis services or other community teams to effectively manage it. Commissioners should ensure there is clarity over how these services are to be provided to people a learning disability, so that there is a clear pathway for them to follow. Disputes over eligibility criteria between mental health and learning disability services should not delay access to treatment.”</p>

Please add extra rows as needed

Please email this form to: schizophreniaupdate@nice.org.uk

Closing date: 5pm on 1 October 2013

PLEASE NOTE: The Institute reserves the right to summarise and edit comments received during consultations, or not to publish them at all, where in the reasonable opinion of the Institute, the comments are voluminous, publication would be unlawful or publication would be otherwise inappropriate.