National Clinical Programme for Early Intervention in Psychosis

Cognitive Behavioural Therapy

Standard Operating Procedure

Version 1.0 – January 2019

National Clinical
& Integrated Care Programmes
Person-centred, co-ordinated care

HSE Mental Health Services

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GLOSSARY OF ACRONYMS

ARMS:	at risk mental state
CAMHS:	child and adolescent mental health services
CBT:	cognitive behavioural therapy
CBTp:	cognitive behavioural therapy for psychosis
CMHT:	community mental health team
EIP:	early intervention in psychosis
FEP:	first episode of psychosis
MDT:	multidisciplinary team
NCAGL:	national clinical advisor and group lead
SOP:	standard operating procedure

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1. INTRODUCTION

Cognitive Behavioural Therapy for psychosis (CBTp) is an evidence based treatment for service users presenting with psychosis and is one of the main psychosocial interventions recommended by the NICE Guidelines (NICE, 2014). It is an intervention which the HSE supports all mental health services to provide as part of the National Clinical Programme for Early Intervention in Psychosis (NCP EIP). This intervention has been developed to meet the needs of service users and aims to ensure that they have access to an intervention that fits with their phase of recovery and need according to current evidence based practice. Like all psychological therapies the collaborative therapeutic relationship is the foundation on which these interventions rely. CBTp departs from the traditional wisdom of a "hands-off" approach to exploring the content of delusions and hallucinations. Instead there is an emphasis on "normalising" and de-stigmatising the experience of delusions and hallucinations that can readily be triggered by bereavement, stress, sleep deprivation, and other life experiences. The stress-vulnerability model (Myin-Germeys & van Os, 2007; Gispen-de Wied & Jansen, 2002) is part of an explanatory framework that formulates how psychotic symptoms may be generated and maintained without dismissing or challenging the reality of these experiences for the individual.

CBTp is an empirical approach and the use of measures and scales both complement the therapy process and track progress and meaningful change over the course of treatment. Undoubtedly, this has also contributed to the continued strength of evidence for CBT for psychosis. Many elements of the CBTp model have also been manualised to ensure therapists' effectiveness and fidelity to the model (Smith et al. 2003). CBT manuals also facilitate good quality clinician training.

Despite its evidence base and advocacy for psychological treatments in psychosis even when CBTp is made available in many settings there is a low and often hesitant uptake of this intervention. To facilitate engagement with CBTp and prepare service users to get optimal benefits from CBTp best practice would include an EIP Key Worker / CMHT member undertaking preparatory work using the CBT informed Coping Skills Manual that has been produced by the HSE for this purpose. At the very least all services users should receive written information indicating the rationale for CBTp and practical information about how it will made available to the service user. Where there are literacy issues, adaptation of written material or other mediums such

as videos may need to be considered to help the service user make informed choices about how and when they might wish to proceed.

1.1 Context for Delivery of CBTp

1.1.1 Preparatory Work:

There is emerging evidence / expert consensus to support “low intensity” and “brief session” CBT informed interventions in psychosis (Turkington et al. 2014). Brief sessions are used because many service users with psychosis have:

1) problems with concentration and attention that are aggravated by hallucinations / delusions;
2) thought disorder;
3) negative symptoms;
4) limited motivation to engage with cognitively taxing tasks.

“Brief session” CBTp informed approaches require more limited training for clinicians yet still provide significant therapeutic benefits. With training and supervisory supports in place, a range of disciplines in CMHTs can be supported to effectively deliver these “high yield” interventions. This set of interventions is particularly likely to help engage service users during their critical phase of first presentations with psychosis (Riggs & Creed, 2016). This approach is manualised to ensure clinicians’ effectiveness and to facilitate good quality training for clinicians.

This preparatory work is a collaborative process of engagement that includes education about psychosis, coping skills, mini-CBT formulations and relapse prevention. The manual is based on three aspects of the five-phase model developed by Turkington for the provision of CBT informed time-limited interventions by mental health nurses working in the community (Turkington 2002, 2006, 2014). These include:

a) Engagement and assessment
b) Formulation and
c) Symptom management.

This can be delivered by clinicians working on each CMHT including the EIP Key Workers. This preparatory work is optional but recommended and accordingly included in the Standard Operating Procedure (SOP).

1.1.2 CBTp:

CBTp will be delivered by professional Psychologists or CBT therapists. These clinicians must have core competencies in CBT and will additionally have undertaken specific training to facilitate working with people with psychosis. All early intervention psychosis service users should be able to access CBTp in their local CMHT / EIP service.

1.1.3 Dealing with Complexity:

A number of studies in CBTp show that there is a small cohort of service users who do not improve or benefit from CBTp (Lynch et al. 2010; Durham et al. 2003). These service users may present with more complex symptoms i.e. delusional jealousy, grandiosity, psychotic depression and / or where the psychosis co-exists with other difficulties such as trauma, serious risk to self or others, personality disorder and attachment difficulties. This cohort may require onward referral and input from the CBTp Lead (see **Appendix 1 – Competencies for CBTp Roles**) to optimise treatment outcomes or consider other intervention models that address service users' needs. This should be done in collaboration with the treating team including the Consultant Psychiatrist, professional psychologist and other multidisciplinary team members as further assessment may be necessary to consider if CBTp or other psychological interventions are most appropriate here.

1.2 Scope of SOP

The target population for this SOP are service users presenting to Mental Health Services with a diagnosis of First Episode of Psychosis (FEP) and aged between fourteen and sixty-four years of age, as per the remit of the National Model of Care for Early Intervention in Psychosis in Ireland.

The SOP specifically refers to CBTp and does not include other psychological interventions that may be of benefit to service users with FEP.

In relation to CBTp for service users with an At Risk Mental State (ARMS) the evidence base is not as robust and still evolving. Accordingly we recommend its use here be considered when this SOP is reviewed after 2 years.

Other CBTp interventions such as group CBTp, online CBTp and other CBTp informed practice interventions, all of which have been found to be of use in certain target groups at individual level are outside the scope of this SOP.

1.3 Framework for Delivery of CBTp

1.3.1 Timing of Intervention

Service users with First Episode of Psychosis should have CBTp available as appropriate throughout their 3 year engagement with the National Clinical Programme for Early Intervention in Psychosis (NCP EIP). Key for the NCP EIP is that there should be no internal waiting list for CBTp within Mental Health Services.

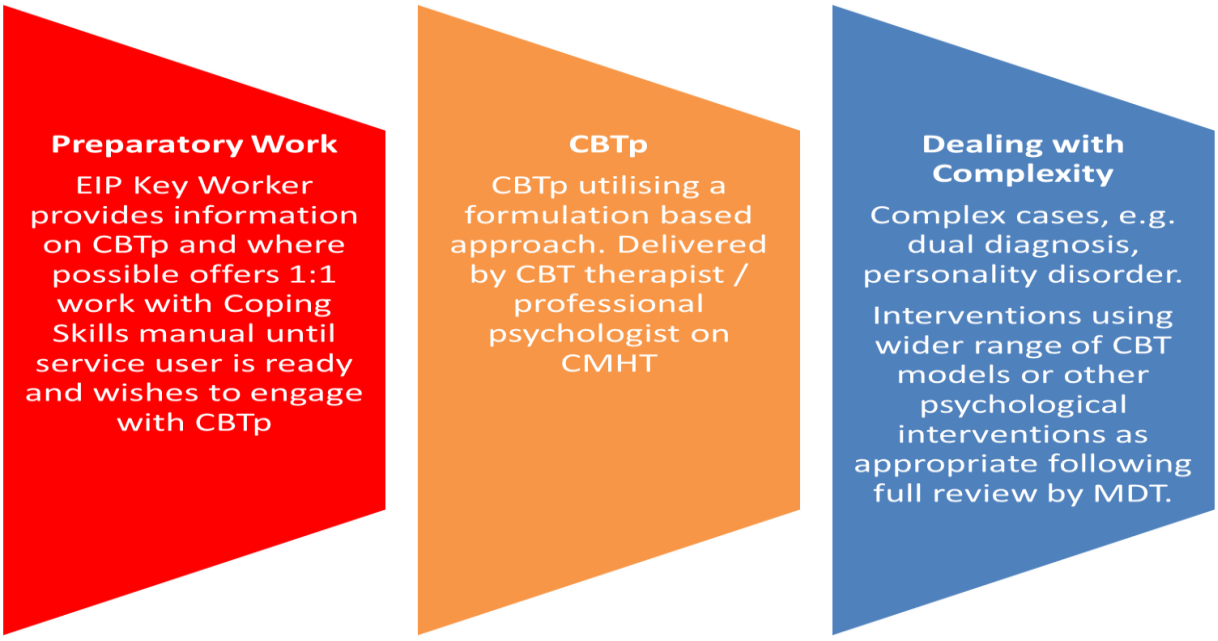

Figure 1: Flow of CBTp Intervention

1.3.2 Preparatory Work:

The provision of CBTp needs to be incorporated into the service user's care plan and considered how this might most effectively occur. As service users start their recovery from psychosis they may suffer from persistent symptoms such as suspiciousness, poor concentration and lack of motivation which make the offer of CBTp quite a daunting prospect for the service user.

Preparatory work for CBTp can be delivered by trained clinicians working on each CMHT as well as the EIP Key Worker. The "Coping Skills" manual also provides a helpful framework for EIP Key Workers and other CMHT team members to

collaboratively structure their engagement, psycho-education and problem solving strategies with the service user.

1.3.3 CBTp:

Clinicians' work will involve both engaging and working with people using formulation based CBTp contracting for a specific number (approximately 16) of treatment sessions. These contracts support protocol based interventions which are delivered under appropriate clinical supervision for specific symptom based issues, for example, use of cognitive behavioural skills, CBT formulation, reality testing and behavioural experiments. This will be delivered by the CBTp therapists / professional psychologists in a CMHT / EIP team setting, usually in a community setting where a service user is comfortable. In some instances, initial engagement may require the delivery of CBTp to occur in different locations depending on the service users' needs or preferences at that time, including in-patient units.

There is a clear understanding that service users with psychosis may also benefit from the use of other disorder specific models of CBT, e.g. social anxiety, depression, low self-esteem, and trauma focused CBT. This can normally be integrated into the anticipated 12 – 20 sessions of CBT but in some instances may justify more sessions or for the therapy process to be delivered in two distinct time phases if it is deemed appropriate to consolidate gains in one area before tackling another (e.g. addictions, trauma).

1.3.4 Dealing with Complexity:

CBTp Leads will work with the most complex presentations such as those with complex or complicated trauma, dual diagnosis or with complex risks. These more experienced CBTp therapists may also be also be required to see service users who, due to complexities arising in treatment, require reassessment, reformulation and review. This will be delivered by trained CBTp Clinicians with clinical expertise at this level. The number of sessions provided needs to be reviewed regularly and tailored to meet the needs of the service user but should be for a finite period of time.

It is important for the service user that alternative psychological interventions to CBTp are considered in consultation with the responsible consultant psychiatrist, professional psychologist and CMHT and that they are provided as appropriate.

2. CLINICAL IMPLEMENTATION PATHWAY

2.1 Introducing CBTp Intervention to Service Users

Following a comprehensive multidisciplinary assessment of the service user's needs and wishes the EIP Key Worker should introduce the option of CBTp to the service user. Ideally the service user and their family / carers should be given written information about CBTp by their EIP Key Worker. The care plan developed by the CMHT should consider each service user's suitability and readiness for CBT and whether preparatory work would improve engagement with CBTp. If so the potential value of working through the Coping Skills Manual should be explained to the service user and provided with their agreement. The service user may gain significant benefit from the already established engagement with the EIP Key Worker or other team members which will increase the likelihood of a more positive attitude towards engagement with CBTp at a later point.

2.2 CBTp

CBTp should be available to all service users with FEP as and when appropriate during their 3 year engagement with the NCP EIP. Baseline and session by session outcome measures will be conducted by the clinician with all service users who attend for CBTp. CBTp should be first offered within 3 – 6 months of the service user presenting with FEP, but in some instances where service users are unwell for prolonged periods of time the first offer of CBTp may need to be deferred. However this deferral should not extend beyond the first 12 months. Occasionally CBTp may be started as an inpatient. If CBTp is not initially availed of it will be re-offered during their engagement in treatment with the NCP EIP based on the assessed needs and wishes of the service users and the care planning process.

A significant number of service users who will take up the offer of CBTp will stop attending prior to the end of the number of sessions anticipated or agreed with them. This is often a pragmatic choice that the service user judges they have got as much as they wish from the therapy process but may also suggest resistance or misattunement which should be explored. It is reasonable for therapists to make some efforts to re-engage the service user in the therapy process but if the service user declines it should be recorded that the service user has not fully completed CBTp. Whether there

is a role for re-offering further CBTp sessions needs to be assessed on a case-by-case basis and should respect the service users' wishes.

2.3 CBTp for Complex Cases

Some service users may either have no significant response after engagement with CBTp or difficulties with engagement which may warrant referral to the CBTp Lead. Such decisions are best made through discussion with the CBTp Lead, the EIP Key Worker, the responsible Consultant Psychiatrist, professional Psychologist and other team members and in consultation with the service user and family / carers. A consensus decision that respects the service users' wishes should determine if more specialised CBTp or other psychological interventions are most appropriate for the individual at that time. The service user's readiness for more complex work is also considered and if appropriate this complex case CBTp can be put on hold and offered and re-offered at a later point. The same protocol of clinical scales and outcome measures should be undertaken with these cases.

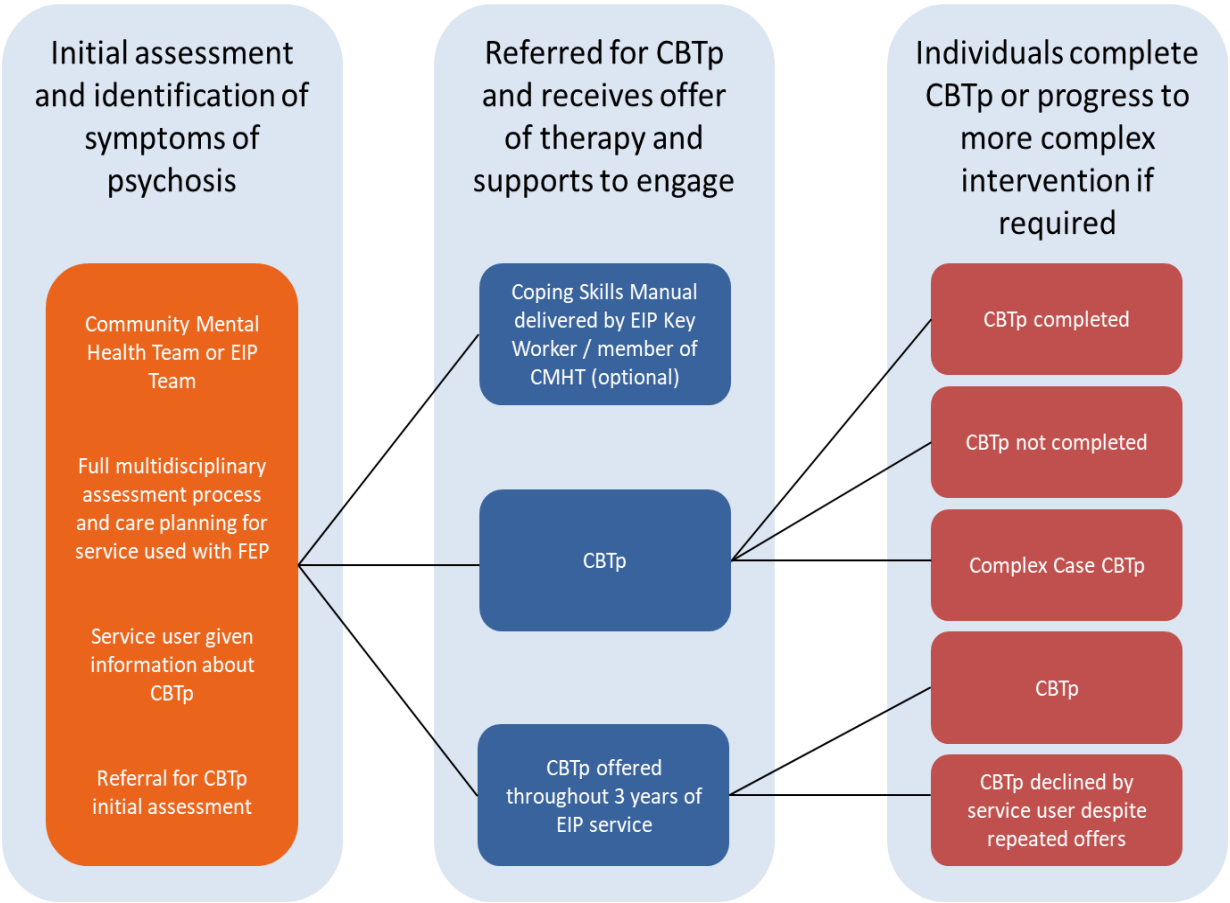

Figure 3: Clinical pathway for service users with FEP

2.4 Evaluation and Metrics

2.4.1 Clinical Assessments and Outcome Measures:

In order to ensure that CBTp is delivered as part of the National Clinical Programme for Early Intervention in Psychosis it is necessary to measure the impact of CBTp intervention on service user outcomes and experience.

The following assessments are recommended for use, there may be others (such as CHOICE) which may also be helpful also:

- **PSYRATS – The Psychotic Symptom Rating Scale** (Haddock, 1999) focusses on 2 main dimensions of psychotic symptomatology – hallucinations and delusions. The management of these experiences / symptoms is explicitly targeted within CBT for psychosis. The scale helps therapist and service users to jointly understand, with some precision, the nature, frequency severity and distress generated by their psychotic experiences. It has been validated to demonstrate change in a wide range of CBTp studies, including First Episode Psychosis (Drake, 2006). The PSYRATS should be collected at baseline, at 3 months, post therapy and again at 12 months from baseline;
- **QPR** (Neil, 2015) is a 15-item measure of Qualitative Process of Recovery from Psychosis developed with service users, which should be collected at baseline, at 3 months, post therapy and again at 12 months from baseline;
- **CORE 10** (Barkham, 2013) was developed from the CORE OM (Clinical Outcomes in Routine Evaluation – Outcome Measure). It is a 10-item scale to measure psychological distress over the course of psychologies therapies. In service users with psychosis it helps measure common symptoms of low mood, anxiety, panic, sleep disturbance and rates an individual's capacity to cope and seek help. It should be collected at baseline, at 3 months, post therapy and again at 12 months from baseline. The option of using after every session should be considered on an individual basis, however this is optional.
- **GAF – MIRECC version** is a clinician-rated measure of occupational functioning, social functioning and symptom severity. It should be collected at baseline, at 3 months, post therapy and again at 12 months from baseline. The timing of collection of clinical scales and outcome measures is reflected in the table below.

Baseline	Each CBTp session (optional)	3 Months	CBTp post therapy	12 Months
CORE 10	CORE 10	CORE 10	CORE 10	CORE 10
QPR		QPR	QPR	QPR
PSYRATS		PSYRATS	PSYRATS	PSYRATS
GAF (MIRECC version)		GAF	GAF	GAF

Table 1: Assessments & Outcome Measures for each stage of treatment

2.4.2 Metrics

Outcome measures and data collection are an essential element in monitoring the implementation of CBTp and ensuring that the interventions can be demonstrated to be accessible and beneficial to service users. It will help inform training and supervision needs within the National Clinical Programme for EIP and will contribute to continuous quality improvement. Systematic outcome data collection will be essential from the outset of the NCP EIP in line with best practice in CBTp. All CBTp practitioners will be requested to use the scales and to record that this has been completed. It is understood that at certain points service users may be too distressed to complete scales but this should be exceptional rather than the norm.

In year one each EIP service will be expected to report on a number of quantitative metrics using a standard excel template. This information will be collated by the National Office, and will inform all future planning and training and the identification of Key Performance Indicators.

Research and audit proposals will be developed in the context of the whole National Clinical Programme for Early Intervention in Psychosis.

3. GOVERNANCE

The governance of this intervention lies with the CHO Area Management Team. The Mental Health National Clinical Programme Office maintains oversight of the operational implementation in clinical practice.

3.1 Governance / Management Structure

This section outlines the roles and responsibilities for operational governance.

3.1.1 Office of the National Clinical Advisor & Group Lead for Mental Health

- Support the implementation of CBTp as one of the named interventions in the National Clinical Programme for Early Intervention in Psychosis;
- Design job description and identify competencies for selection of clinicians;
- Develop a training and supervision plan for CBTp;
- Maintain a data base of clinicians trained in CBTp;
- Manage, review and report on CBTp practice data nationally.

3.1.2 CHO Mental Health Area Management Team

- Ensure all line managers are aware of the requirements of CBTp as one of the named interventions in the NCP EIP;
- Support trained clinicians to deliver the intervention in a timely manner;
- Ensure that there is the expectation that clinicians trained in CBTp provide this intervention as part of their clinical practise for the EIP service;
- Identify future demand for training in this intervention and report to the Mental Health National Clinical Programme Office;
- Facilitate clinicians in the area to deliver and receive supervision and training as required;
- Provide the resources to cover local supervision and training sessions including venue catering and administration support;

- Monitor data on the provision of CBTp and report nationally as required per HSE operational plan;
- Report to the Mental Health National Clinical Programme Office on any particular obstacles or difficulties in implementing this plan.

3.1.3 NCP EIP Hub Team for the Catchment Area Population

- Provide clinical leadership and governance for the National Clinical Programme for EIP and CBTp for the catchment area population;
- To provide the leadership and expertise for CBTp delivery;
- Collate data on CBTp as provided by each trained clinician member;
- Report to CHO Mental Health Area Management Team on CBTp;
- CBTp Lead is a member of the Hub Team.

3.2 Service Delivery Roles and Responsibilities

To ensure the effective implementation of interventions for psychosis in each Adult CMHT and CAMHS, roles and responsibilities have been assigned and are listed below. An estimated time for each clinical component is included where appropriate. This is a guide and may vary locally.

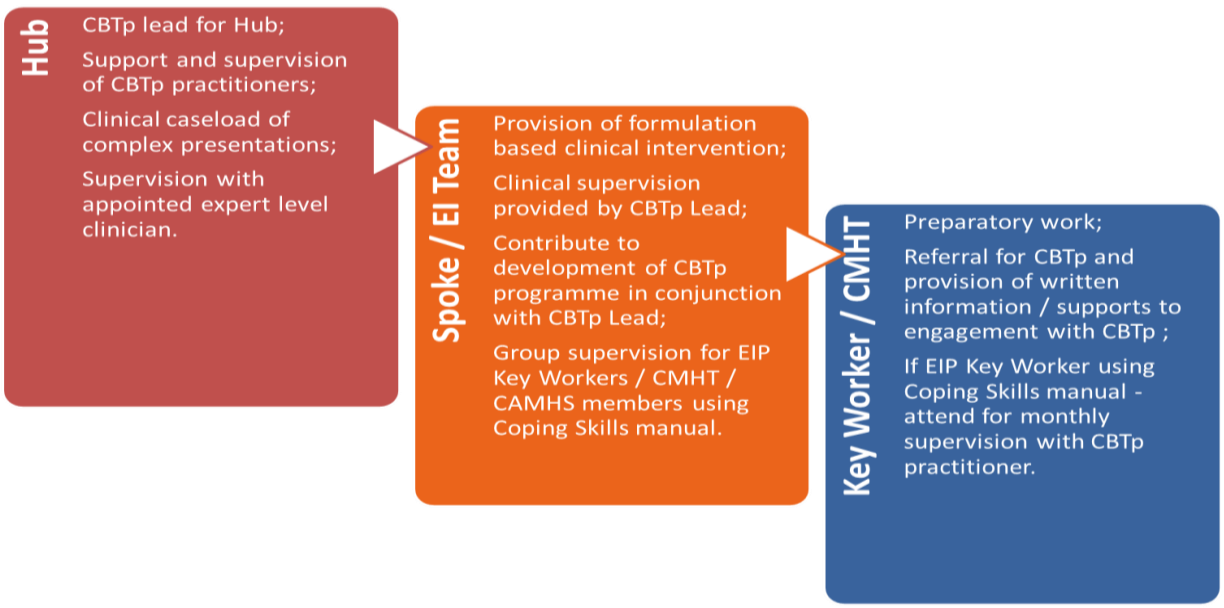

Figure 4: Roles & Responsibilities for psychosis interventions in each Adult CMHT & CAMHS

Ideally CBTp in CAMHS will be provided by a professional psychologist or a CBT therapist who works in CAMHS. Such clinicians should be trained in CBTp and each CAMHS team should have one clinician trained in CBTp delivery. Where CBTp cannot be provided within CAMHS the CAMHS Consultant responsible for the care and treatment of the young person should liaise with the CBTp Lead to arrange for CBTp to be provided within the CAMHS setting by an appropriate clinician who must be CAMHS competent.

3.2.1 CBTp Lead – CBTp Practitioner Dealing with Complex Cases

Roles and responsibilities of the CBTp Lead include the following:

- Attend Hub meetings;
- Ensure issues of clinical governance are brought to the EIP Clinical Lead and Hub Team;
- Maintain database of clinicians trained in area;
- Monitor access to and engagement with CBTp for psychosis across all teams;
- Monitor data and report to EIP Clinical Lead as per Hub policy;
- Support CBTp Clinicians locally and provide local training with other CBTp Clinicians;
- Maintain own EIP clinical CBTp caseload (minimum 2-3 cases) at a given time;
- Provide clinical input for complex EIP presentations to meet the needs of the Hub / Mental Health catchment area;
- Attend their own supervision with regard to CBTp case work and the process of supervising other clinicians;
- Document intervention in the chart as per local policies and procedures;
- Collect monthly data and complete datasheets;
- Provide CBTp supervision to clinicians, trainers and supervisors.

Estimated Time: Protected time of 0.5 – 1.0 WTE per CHO depending on population, geography and deprivation.

3.2.2 CBTp Clinicians:

Roles and responsibilities of CBTp Clinicians include the following:

- In collaboration with CMHT's and line managers, ensure CBTp is offered and provide documented opportunities to service users to engage with CBTp within 3 months of entry into the National Clinical Programme for Early Intervention in Psychosis. The intervention should be reoffered as appropriate over the 3 year course of the NCP EIP;
- Have a caseload of at least 4-5 service users at any given time;
- Document intervention in the chart as per local policies and procedures;
- Attendance for regular supervision with CBTp Lead;
- Attend national training as required;
- Collect monthly data and complete datasheets;
- Ensure all clinicians using Coping Skills are offered group supervision for 1 – 2 hours monthly and have necessary competence to carry out the preparatory work with the Coping Skills Manual;
- Bring any issues regarding training, supervision, levels of competence, etc, to the CBTp Lead.

Estimated Time: Protected time for CBTp Clinician per Adult CMHT (50,000) role can be split between 2 clinicians.

3.3 Documentation:

All CBTp intervention contacts should be recorded in the service users file in accordance with local policy and procedures, including the number of sessions, the nature of work conducted, assessments and outcomes.

4. SUPERVISION AND TRAINING

NICE Guidelines recommend that health care professionals providing psychological interventions should have an appropriate level of competence in delivering the intervention and be regularly supervised by a competent therapist and supervisor. With regard to CBTp this means that supervisors will also need to build up training, experience and competence in the therapeutic models for working with people with psychosis. A training plan will be developed to support implementation of the CBTp SOP which will be informed by current available CBT and CBTp expertise in Mental Health Services.

All clinicians providing CBTp must attend supervision on a regular basis. Supervision for the CBTp Leads will be provided externally at the outset until capacity is built up within Ireland.

4.1 Supervision Requirements for Clinicians

4.1.1 Supervision for CBTp Leads:

- Individual
- Facilitated by external provider
- 2 hours monthly, minimum 15 hours / year.

4.1.2 Supervision of CBTp Clinician:

- Local venue within Hub;
- 2 hours monthly, must attend 15 – 20 hours / year;
- Facilitated by CBTp Lead;
- Individual based supervision.

4.1.3 EIP Key Workers / Members of MDTs using the Coping Skills Manual

- Local venue;
- 1 – 2 hours per month;
- Facilitated by a local CBTp Clinician.

APPENDIX 1 – COMPETENCIES FOR CBTp ROLES

A1.1 CBTp Lead (Clinician Protected Time)

Qualifications:

- Substantive generic CBT training (e.g. professional accredited training in Clinical or Counselling Psychology; evidenced by transcript, CV and reference) AND at least 4 years post-qualification clinical experience and competency in delivering generic CBT.

OR

- A qualified Mental Health Professional;
- A recognised qualification in CBT:
    - Completion of a Post Graduate Qualification (at Diploma Level) in CBT (evidenced by transcript and supervisor reference)
    - It is not necessary for this qualification to have incorporated any training in working with psychosis
    - Accreditation by a body recognised to accredit CBT nationally or internationally, e.g. Cognitive Behavioural Psychotherapy Ireland (CBPI), British Association for Behavioural and Cognitive Psychotherapies (BABCP), etc.

AND

- Must have completed specific training in CBTp.

Experience:

- Have a least 4 years post graduate clinical experience and be currently working within CMHT with individuals with psychosis;
- Have experience of quality improvement projects in clinical practice with a range of disciplines;
- Have experience of attending CBT supervision and being a CBT supervisor;
- Have experience of providing CBT training and education;
- Have experience of leading a clinical project within services;

- Have experience of audit and research.

Competencies:

- An understanding of cognitive behavioural models of psychosis and the related evidence base;
- Ability in engaging, assessing and developing collaborative formulations with individuals with psychosis;
- Demonstrate an ability to deliver high quality, individualised, evidence-based interventions in accordance with NICE guidance and the competence framework for work with people with psychosis and bipolar disorder (Roth & Pilling 2013);
- Established experience of and commitment to developing CBT skills for on-going use in clinical practice with individuals with psychosis and bipolar;
- Leadership skills to enable a range of healthcare disciplines to successfully implement a CBTp clinical care pathway;
- High motivation, flexibility and the ability to offer a clinical outcome oriented approach with high levels of drive, commitment and enthusiasm;
- Exceptional communication and interpersonal skills combined with sound judgement are required to facilitate work with a wide range of individuals and groups. The role involves a high degree of interaction and collaboration with management and key stakeholders.

A1.2 CBTp Clinician

Qualifications:

- Substantive generic CBT training (e.g. on professional accredited training in Clinical or Counselling Psychology, evidenced by transcript, CV and reference)
- At least 3 years post-qualification clinical experience AND competency in delivering generic CBT.

OR

- A qualified Mental Health Professional;
- A recognised qualification in CBT

- Completion of a Post Graduate Qualification (at either Certificate or Diploma Level) in CBT (evidenced by transcript and supervisor reference).
- It is not necessary for this qualification to have incorporated any training in working with psychosis.

- Accreditation by a body recognised to accredit CBT nationally or internationally, e.g. Cognitive Behavioural Psychotherapy Ireland (CBPI), British Association for Behavioural and Cognitive Psychotherapies (BABCP), etc.

AND

- All CBT Clinicians must also undertake specific training in CBTp as required.

Experience:

- Have a least 2 years post graduate clinical experience and be currently working within CMHT with individuals with psychosis;
- Have experience of attending CBT supervision;
- Have experience of providing training and education;
- Have experience of audit or research.

Competencies:

- An understanding of cognitive behavioural models of psychosis and the related evidence base;
- Ability in engaging, assessing and developing collaborative CBT formulations with individuals;
- Demonstrate an ability to deliver high quality, individualised, evidence-based interventions in accordance with NICE guidance and the competence framework for work with people with psychosis and bipolar disorder (Roth & Pilling 2013);
- Established experience of and commitment to developing CBT skills for on-going use in clinical practice with individuals with psychosis;
- Demonstrate education and supervision skills with a variety of disciplines.

APPENDIX 2 – SUBGROUP FOR CBTp SOP DEVELOPMENT

Dr. Katherine Brown	National Clinical Lead and Chair
Ms. Rhona Jennings	Programme Manager, Mental Health Clinical Programmes
Ms. Caoimhe Black	Senior Social Worker
Dr. Ciaran Corcoran	Consultant Psychiatrist
Dr. Dermot Cohen	Consultant Psychiatrist (CAMHS)
Dr. Brian Fitzmaurice	Postgraduate Course Director, Cognitive Behavioural Psychotherapy, Consultant Psychiatrist
Dr. Edgar Lonergan	Principal Clinical Psychologist
Dr. James O'Mahoney	Interim Director of Nursing (CAMHS)
Ms. Aisling Quah	Senior Occupational Therapist

Consultation was completed across a wide range of disciplines and organisations.

APPENDIX 3 – REFERENCES

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