Consensus Development Conference on Improving Mental Health Transitions, Alberta Government & Institute of Health Economics, Edmonton, Alberta, November 4-6, 2014

Psychosocial interventions in severe mental disorders

How effective are psychosocial interventions?

Thomas Becker, Uta Gühne*, Steffi Riedel-Heller*

Department of Psychiatry II, Ulm University, Bezirkskrankenhaus Günzburg, Günzburg/ Ulm, Germany
* Institute for Social Medicine, Occupational Health and Public Health, Leipzig University, Leipzig, Germany

CONFLICT OF INTEREST

- Thomas Becker is one of the **authors** of the *DGPPN S3 guideline „Psychosocial interventions in severe mental disorders“* which was funded and edited by *Deutsche Gesellschaft für Psychiatrie, Psychosomatik, Psychotherapie und Nervenheilkunde* (DGPPN), the research department (Dep. of Psychiatry II, Ulm University) has received grant support for this.
- Furthermore, he reports **grant support** from *Federal Ministry of Health* (BMG, Germany) for a “Psychiatric Summer School” (2011-2013) and from *Federal Assoc. of the AOK* (AOK Bundesverband, Germany) for a QI implementation study.
- He has served as an **expert** for and received honoraria from the *Academic Research Evaluation Exercise* for the *Italian Ministry of University and Research* (coordinated by CINECA Inter-University Consortium) for reviewing tasks.
- The department has received funds to a minor extent for **symposia and in-house training** (from pharmaceutical industry such as: Lilly; Lundbeck; Janssen-Cilag).
- He (resp. the department) has received honoraria to a minor extent from institutions/ clinics for **lectures**.

In German psychiatry, there is a large number of practice guidelines and a substantial number of high-quality systematic evidence-based (S3) practice guidelines

Why do we need this one?

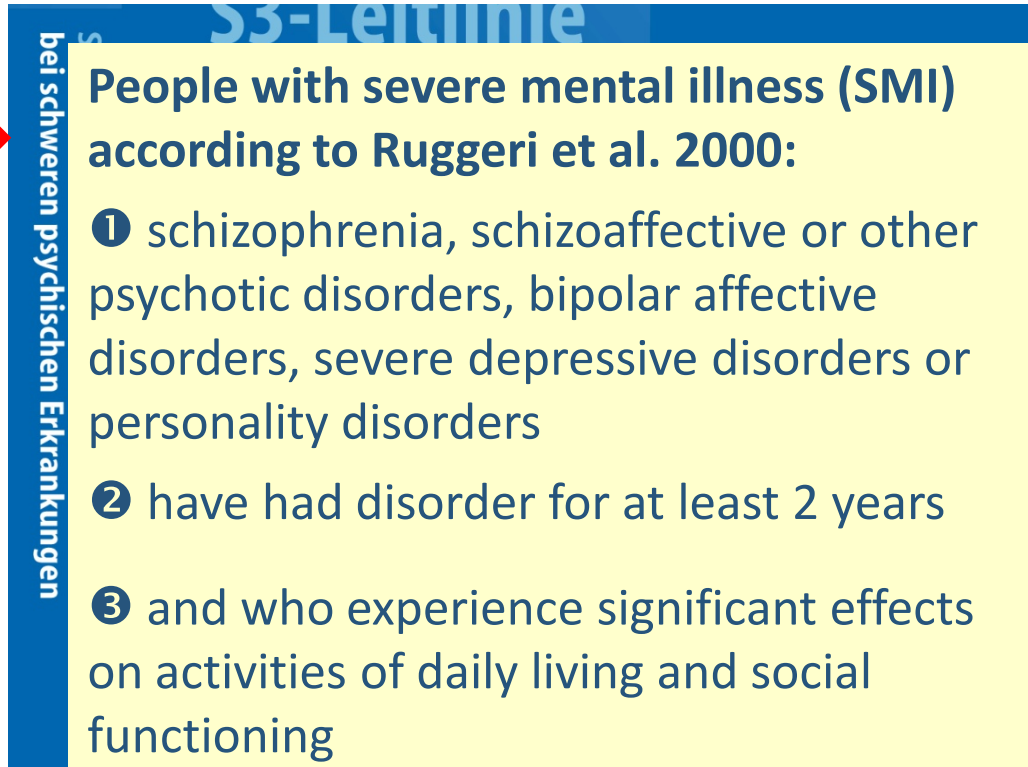
There are a few good reasons for a practice guideline on psychosocial therapies for severe mental disorders

❶ SMI = extremely relevant patient group

❷ Psychosocial interventions are a core component of treatment

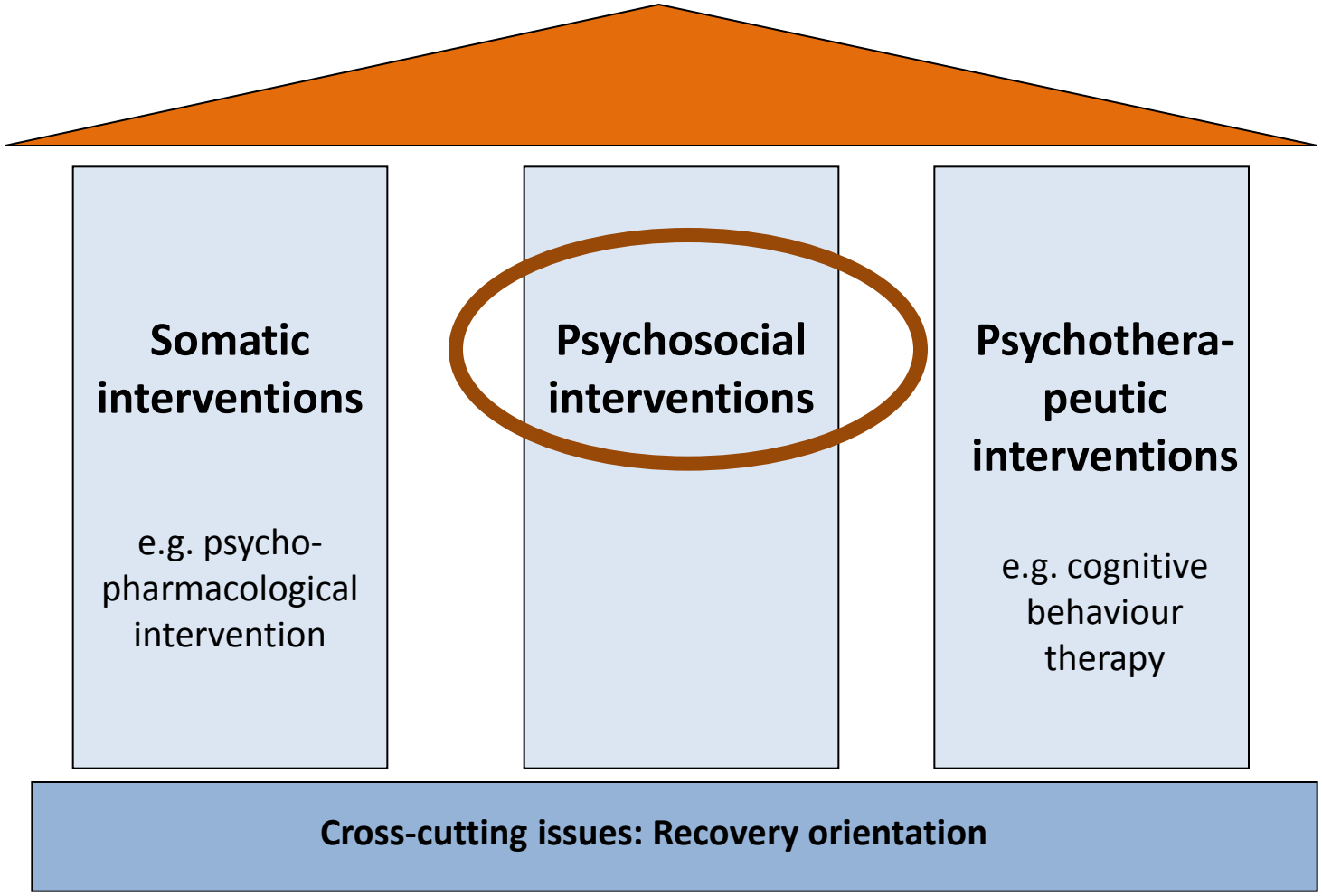
❸ Psychosocial interventions neglected in disease-specific guidelines

❹ Mental health care not fully integrated



DGPPN

Psychosocial interventions are a core component of treatment



DGPPN

Cross-cutting issues

- Therapeutic milieu
- Empowerment
- Recovery
- Peer-led interventions
- Self-help interventions

System level interventions

- Multidisciplinary team-based psychiatric community care
- Case management
- Vocational rehabilitation and participation in work life
- Residential care interventions

Single interventions

- Psychoeducation
- Social skills training
- Arts therapies
- Occupational therapy
- Movement therapy and sports

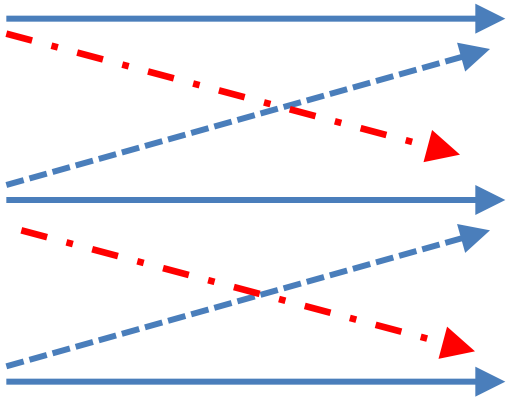
FROM EVIDENCE TO RECOMMENDATION

Quality of the evidence

high
Meta-analyses
RCTs

moderate
Controlled studies
Observational studies

low/very low
Expert opinion



Strength of recommendation

A Strong recommendation ⇑⇑

B Recommendation ⇑

C Open recommendation ⇔

Good Clinical Practice

Criteria for down- or up-grading (consensus group)
- consistency of evidence
- clinical relevance of effect sizes
- benefit-to-risk ratio
- ethical issues
- patient preferences
- availability of evidence from German trials

Development of guideline supervised by **Association of Scientific Medical Societies in Germany (AWMF)**, 17 experts, 40 stakeholder groups, evidence search **June 2009-Feb 2011**

DGPPN

I Cross-cutting issues

- **a) Therapeutic milieu**
- Empowerment
- Recovery
- **b) Peer-led interventions**
- Self-help interventions

II System level interventions

- Multidisciplinary team-based psychiatric community care
- Case management
- Vocational rehabilitation
- Residential care interventions

III Single interventions

- Psychoeducation
- Social skills training
- Arts therapies
- Occupational therapy
- Movement therapy and sports

Ia Milieu therapy

… comprises measures that contribute to the therapeutic atmosphere in the course of treatment. Milieu therapy provides a **context** in which treatment interventions can be implemented and treatment aims are reached. Milieu therapy is important in **shaping therapeutic environments** particularly in inpatient and day-hospital care and in any treatment environment focusing on daily living activities

EVIDENCE - EXAMPLE

A CULTURE OF ENQUIRY: RESEARCH EVIDENCE AND THE THERAPEUTIC COMMUNITY

Jan Lees, Nick Manning, Ph.D.,
and Barbara Rawlings, Ph.D.

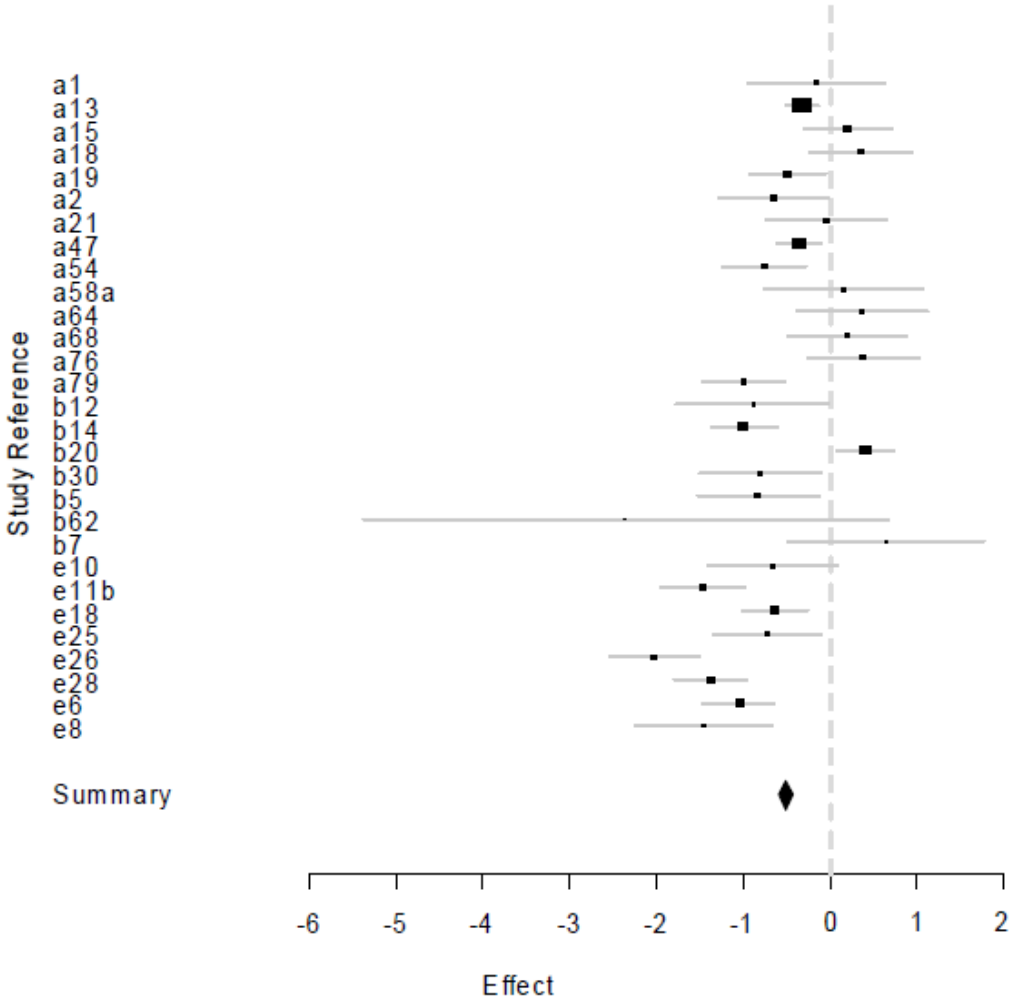


FIGURE 1. Forest plot.

This paper presents data from a systematic review and meta-analysis of 29 published studies of therapeutic community effectiveness using controls, including 8 RCTs.

The overall summary log odds ratio is -0.512 (95% ci: -0.598 to -0.426), which indicates a **strong positive effect for therapeutic community treatment**.

Psychiatric Quarterly, Vol. 75, No. 3, Fall 2004

RECOMMENDATIONS

Recommendation:

In all psychosocial interventions knowledge on the optimum therapeutic milieu should be taken into consideration.

Level of recommendation: CCP

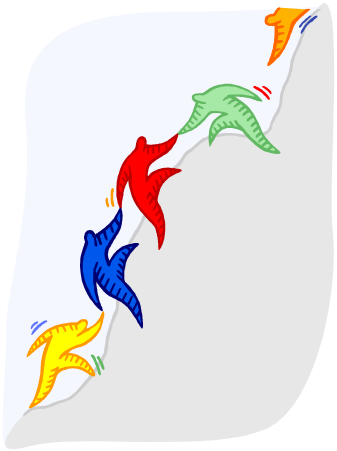
Recommendation:

Treatment in a therapeutic community can be considered for certain people with severe mental illness. This concept is not restricted to inpatient care settings.

Level of recommendation: CCP

Ib Peer-led interventions

„Peer support programs are based on the rationale that people who have the ‚lived experinence of mental illness' are uniqueliy qualified to provide support and hope to others grappling with similar challenges" (Mueser et al. 2013)



1. Peers involved in guideline development process (user and carer representation: Bundesverband der Angehörigen psychisch Kranker e.V./ Familien-Selbsthilfe Psychiatrie [BApK], Bundesverband Psychiatrie-Erfahrener e.V. [BPE])
2. **No systematic literature search and review**
3. Peer-to-peer approach considered in guideline

EVIDENCE - EXAMPLE

Davidson et al. 2006: Peer Support Among Adults With Serious Mental Illness: A Report From the Field

Schizophrenia Bulletin vol. 32 no. 3 pp. 443–450, 2006

Table 1. Randomized Trials of Peer-Delivered Conventional Services and Supports

Study	Program and Sample Description	Outcomes	Conclusions
Solomon et al.[40]	Compared 2 intensive case management teams serving a total of 96 participants: (1) staffed by non-peers, and (2) staffed by peers	Functioning, symptoms, social support, hospitalizations, quality of life, satisfaction, and working alliance	No significant differences were found between conditions.
O'Donnell et al.[44]	Compared 3 case management conditions serving a total of 119 participants: (1) standard case management, (2) client-focused case management, and (3) client-focused case management with addition of peer advocate	Functioning, disability, quality of life, burden of care, service satisfaction, number and duration of hospitalizations, crisis visits, and compliance with treatment and services	No significant differences between the groups on measures of functioning, disability, quality of life, service satisfaction and burden of care. Clients receiving client-focused case management reported
Clarke et al.[45]	Compared 3 conditions serving a total of 1 participants: (1) standard case manageme peer-based case management, and (3) usu		
Davidson et al.[36]	Compared 3 conditions offering social supp a total of 260 participants: (1) matched v peer volunteer and received $28 per mon pay for social/recreational activities, (2) matched with non-peer volunteer and rec $28 per month to pay for social/recreatio activities, and (3) received $28 per month for social/recreational activities		

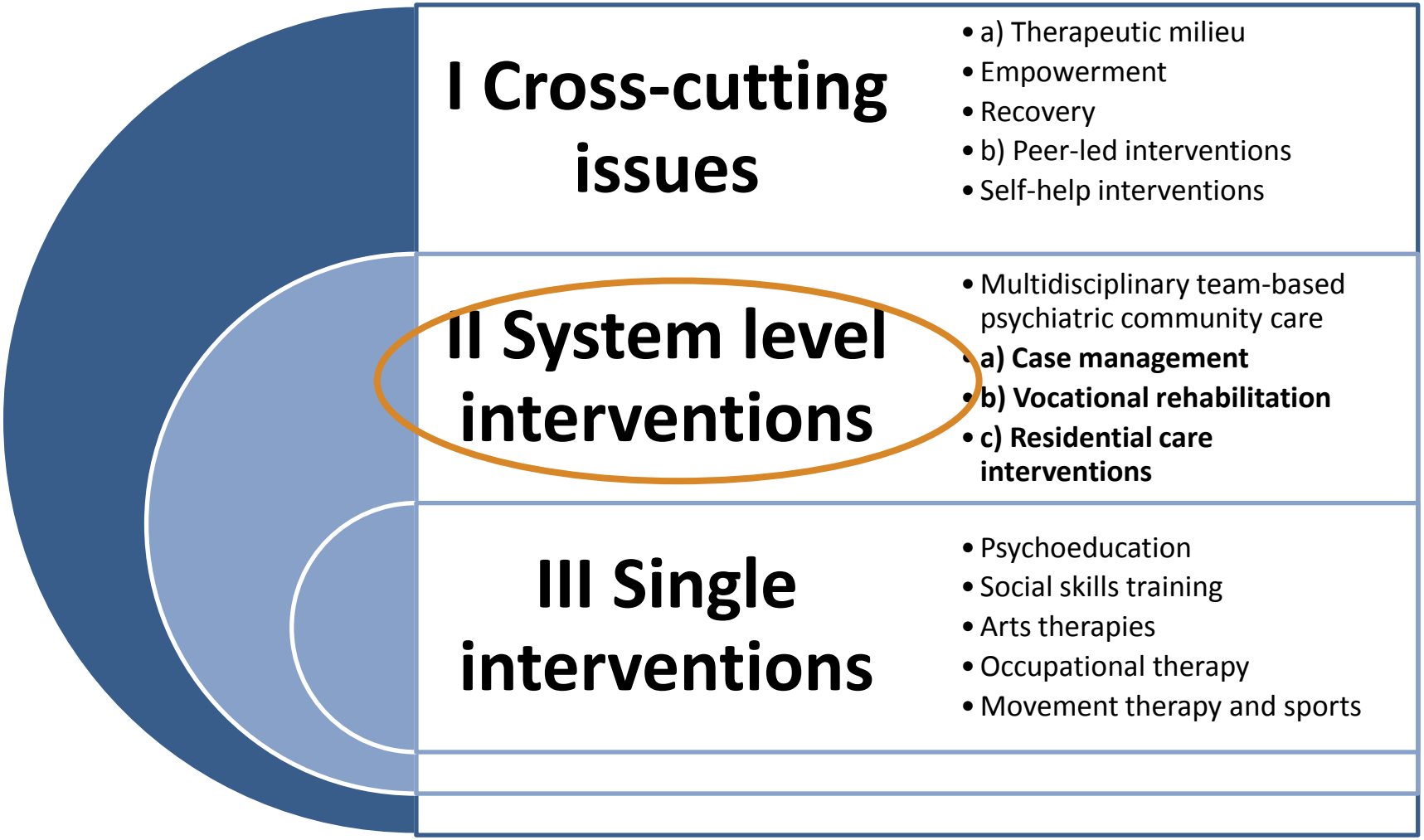
This article reviews data from 4 RCTs demonstrating few differences between the outcomes of conventional care when provided by peers versus non-peers.
The authors conclude by suggesting that **peer support is early in its development as a form of mental health service provision and encourage further exploration and evaluation of this promising, if yet unproven, practice.**

Summary and statement

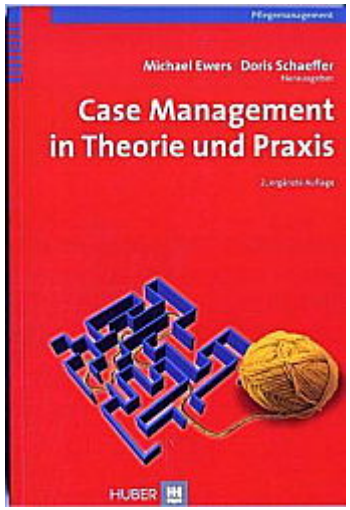
- Many modes of delivering peer support: mutual support groups, consumer-run services, peer support services administered in clinical settings
- Evidence insufficient, positive effects regarding need for inpatient treatment, social contact, satisfaction with treatment and adherence

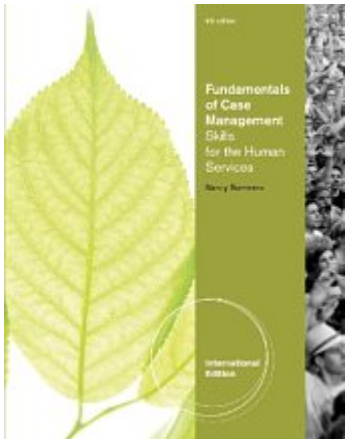
Statement:

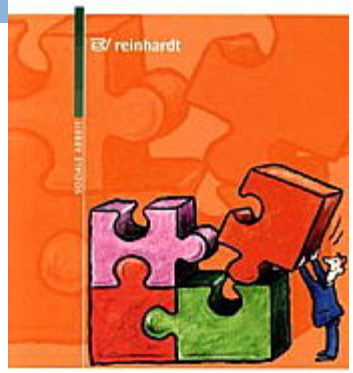
☞ **Peer support can improve contact with patients and relatives and treatment adherence**


I Cross-cutting issues
• a) Therapeutic milieu
• Empowerment
• Recovery
• b) Peer-led interventions
• Self-help interventions
II System level interventions
• Multidisciplinary team-based psychiatric community care
• a) Case management
• b) Vocational rehabilitation
• c) Residential care interventions
III Single interventions
• Psychoeducation
• Social skills training
• Arts therapies
• Occupational therapy
• Movement therapy and sports

IIa Case Management







Löcherbach • Mennemann • Hermsen (Hg.)
Case Management in der
Jugendhilfe

EVIDENCE

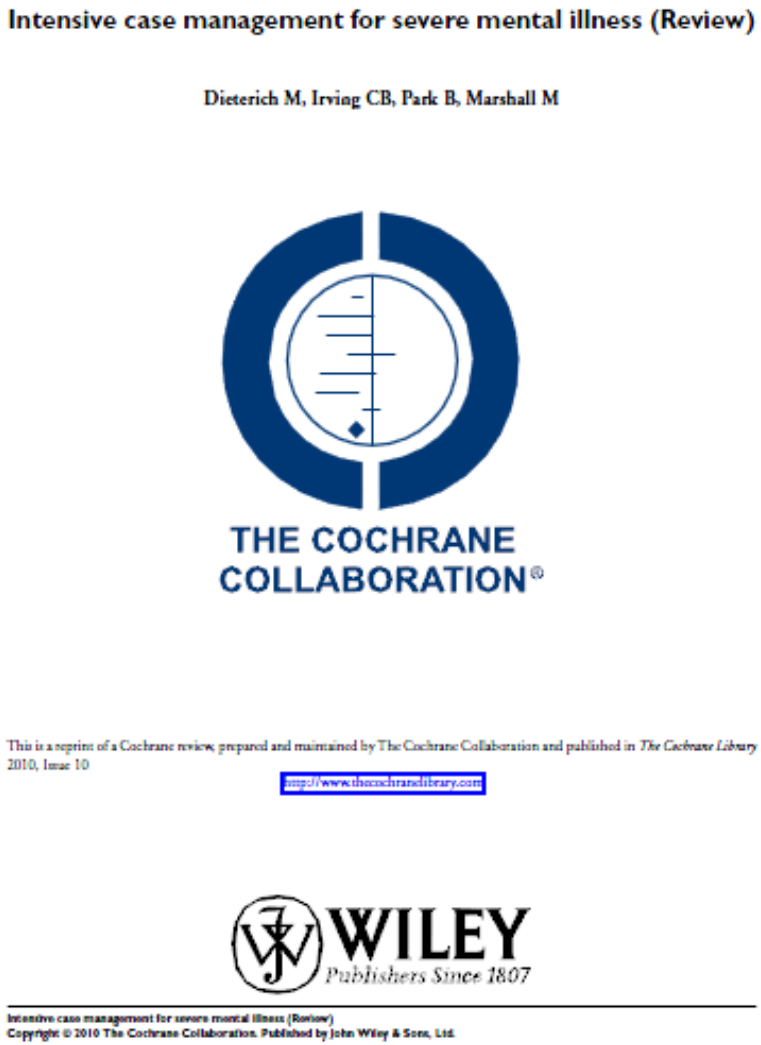
DGPPN

	Marshall et al. 1998	Ziguras & Stuart 2000	Burns et al. 2007 ICM	Dietrich et al. 2010 ICM	NICE 2009 Schizo-phrenie ICM
Illness variables					
↓ Mortality	~	n.a.	n.a.	~	n.a.
↓ Symptom level	~	++	n.a.	~	~
↑ Generic well-being	n.a.	n.a.	n.a.	+	n.a.
Treatment variables					
↓ Inpatient readmissions	-	-	n.a.	+	n.a.
↓ inpatient treatment duration	-	++	++	++	n.a.
↓ Treatment drop-out	++	++	n.a.	++	++
↑ Medication adherence	++	n.a.	n.a.	+	n.a.
Social inclusion/ exclusion					
↑ social functioning	~	++	n.a.	~	~
↑ employment	n.a.	n.a.	n.a.	~	n.a.
↓ imprisonment, incidents of violence	~	n.a.	n.a.	~	n.a.
Satisfaction and QoL					
↑ Patient satisfaction	n.a.	++	n.a.	++	n.a.
↑ Carer satisfaction	n.a.	++	n.a.	n.a.	n.a.
↑ Quality of life	~	k.A.	k.A.	~	n.a.
↓ Carer burden	n.a.	++	n.a.	n.a.	n.a.
Cost-effectiveness					
↑ Cost-effectiveness	n.a.	+	n.a.	++	n.a.

Effects of case management on various outcome parameters

ICM: Intensive Case Management
++: significant advantage of experimental over control group
+: trend toward superiority of experimental over control group, or small sample
~: both groups similar
-: disadvantage in experimental vs. control group
n.a.: not assessed
↓: reduction, ↑: increase

EVIDENCE


Intensive case management for severe mental illness (Review)

Dieterich M, Irving CB, Park B, Marshall M

THE COCHRANE COLLABORATION®

This is a reprint of a Cochrane review, prepared and maintained by The Cochrane Collaboration and published in *The Cochrane Library* 2010, Issue 10

http://www.thecochranelibrary.com

WILEY
Publishers Since 1807

Intensive case management for severe mental illness (Review)
Copyright © 2010 The Cochrane Collaboration. Published by John Wiley & Sons, Ltd.

Authors' conclusions

ICM was found effective in ameliorating many outcomes relevant to people with severe mental illnesses. Compared to standard care ICM was shown to **reduce hospitalisation** and **increase retention in care**. It also **globally improved social functioning**, although ICM's effect on mental state and quality of life remains unclear. ICM is of value at least to people with severe mental illnesses who are in the sub-group of those with a **high level of hospitalisation** (about 4 days/month in past 2 years), and the intervention should be performed close to the original model.

It is not clear, however, what gain ICM provides on top of a less formal non-ICM approach.

We do not think that more trials comparing current ICM with standard care or non-ICM are justified, but currently we know of no review comparing non-ICM with standard care and this should be undertaken.

SUMMARY OF EVIDENCE

Convincing evidence

- Reduction of treatment discontinuation rate
- Higher satisfaction among patients and carers

Recommendation:

Case management cannot be recommended for the routine care of every patient, but should be applied after checking specific preconditions (e.g. low density of community-psychiatric services and/or high inpatient care utilization). ***Grade B, Evidence level Ia***

Conflicting/

Weak evidence

(ICM [Dieterich 2010])

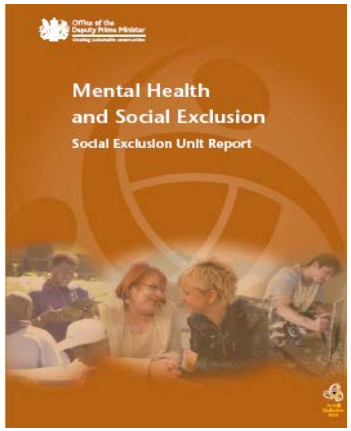
- Clinical and social outcomes
- Medication adherence
- Cost-effectiveness

IIb Vocational rehabilitation

„First train then place“ vs. „First place then train“

Pre-vocational Training (PVT)

➲ the pre-vocational training approach defines various phases from occupational therapy to practical placements to general labour market jobs



Supported Employment (SE)

➲ defines direct placement in a competitive job as the prime target

➲ The SE approach requires clear motivation to work in the patient and skills in supporting people with mental illness in their jobs

➲ **Individual placement and support (IPS)** is a manualized version of the supported employment model

Evidence on Supported Employment

DGPPN

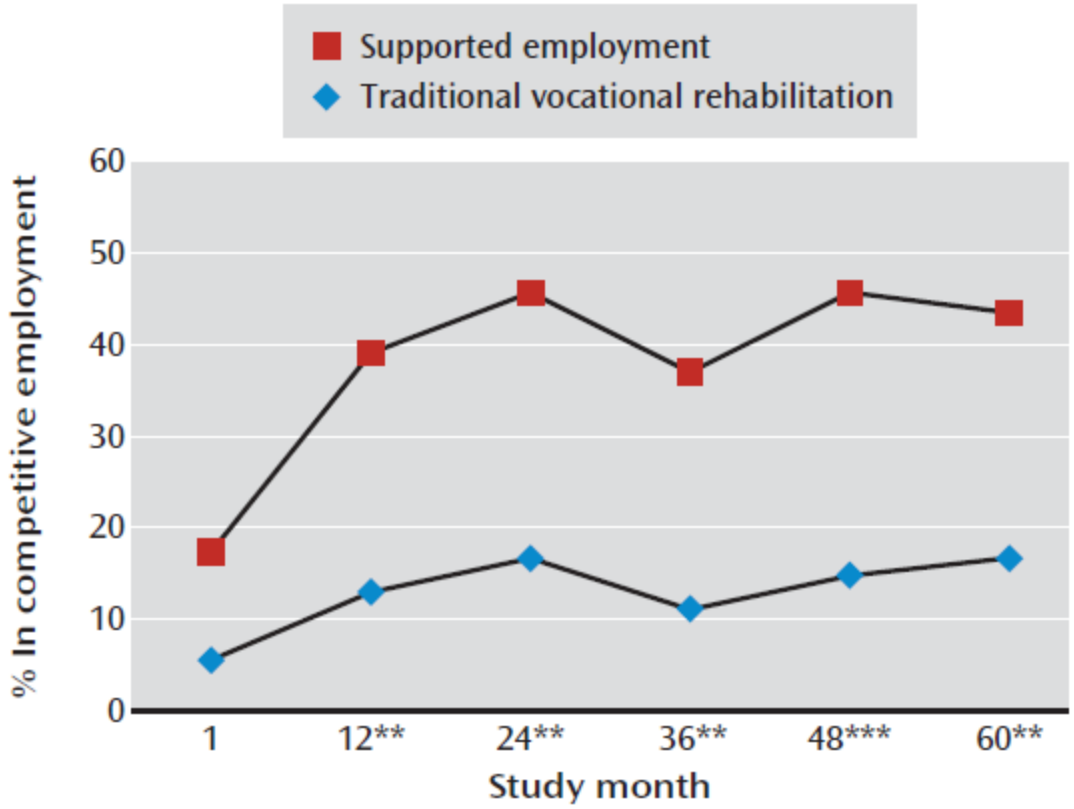
	Reviews					RCTs		
	Crowther 2001 (Cochrane Rev.)	NICE LL Schiz. 2009	Twamley 2003	Bond 2008	Campbell 2009	Cook 2005	Burns 2009	Howard 2010
↑ Employment rates general labour market	++	++	++	++	++	++		+
↑ Weeks p.a. in work				++	++			
↑ Ø monthly working hours	++	++		++		++		~
↑ Ø monthly income	++					++		~
↓ Time to first job				+				
↑ Employment duration					++			~
↑ Job satisfaction								~
↓ In-patient admissions							+	
↑ Self-efficacy								~
↑ Quality of life							~	~
↑ Met needs								~
↑ General functioning							~	
↓ Psychiatric symptoms	~		~				~	
↓ Intervention cost	contradictory	-						
↓ Total treatment cost	contradictory	+						

- **In international studies strong superiority of SE over traditional *first-train-then-place* interventions for vocational outcomes**
- **In Germany no evidence of effectiveness of SE (based on controlled trials)**

DGPPN

Long-Term Effectiveness of Supported Employment: 5-Year Follow-Up of a Randomized Controlled Trial

FIGURE 2. Year-by-Year Rates of Competitive Employment Among Participants in Supported Employment and Traditional Vocational Rehabilitation Programs



**p<0.01. ***p<0.001.

The **beneficial effects of SE** on work at 2 years were sustained over the 5-year follow-up period.

Participants in SE:

- were more likely to obtain competitive work than those in traditional vocational rehabilitation (65% compared with 33%)
- worked more hours and weeks
- earned more wages
- had longer job tenures
- were less likely to be hospitalized
- had fewer psychiatric hospital admissions
- spent fewer days in the hospital.

Hoffmann et al. 2014

Supported employment for adults with severe mental illness (Review)

Kinoshita Y, Furukawa TA, Kinoshita K, Honyashiki M, Omori IM, Marshall M, Bond GR, Huxley P, Amano N, Kingdon D

DGPPN

Main results

A total of 14 RCTs were included in this review (total 2265 people). In terms of our primary outcome (employment: days in competitive employment, over one year follow-up), supported employment seems to significantly **increase levels of any employment obtained** during the course of studies (7 RCTs, n = 951, RR 3.24 CI 2.17 to 4.82, *very low quality of evidence). SE* also seems to **increase length of competitive employment** when compared with other vocational approaches (1 RCT, n =204, MD 70.63 CI 43.22 to 94.04, *very low quality evidence).*

SE also showed some advantages in other secondary outcomes. It appears to **increase length (in days) of any form of paid employment** (2 RCTs, n = 510, MD 84.94 CI 51.99 to 117.89, v*ery low quality evidence) and **job tenure** (weeks) **for competitive employment** (1 RCT, n = 204, MD 9.86 CI 5.36 to 14.36, very low quality evidence) and **any paid employment** (3 RCTs, n = 735, MD 3.86 CI -2.94 to 22.17, very low quality evidence). Furthermore,* one study indicated a decreased time to first competitive employment in the long term for people in supported employment (1 RCT, n = 204, MD -161.60 CI -225.73 to -97.47, *very low quality evidence). A large amount of data were considerably skewed, and therefore* not included in meta-analysis, which makes any meaningful interpretation of the vast amount of data very difficult.

WILEY

Recommendations

- For people with SMI who want to work in competitive labour markets, supported employment programs with rapid job placement and on-site-support should be available ***(Grade B, Evidence level Ia)***
- Pre-vocational training programs ("first train then place") should be available for a subgroup of people with SMI, financial incentives increase effectivenes. Effectiveness is increased by focusing on motivation and rapid placement ***(Grade B, Evidence level Ib)***
- Vocational rehabilitation should put a stronger focus on avoiding job loss. Therefore, onset of a psychiatric illness requires early inclusion of adequate services **(GPP)**
- Completed education / professional training is essential for people with SMI. Adequate vocational training opportunities should be available close to patients' residential environments **(GPP)**

DGPPN

IIc Residential services

Individuals with SMI frequently identify **income and housing as the most important factors in achieving and maintaining their health** ……., which forms the foundation on which a person can establish a daily routine and begin to address other life issues [Kyle & Dunn 2008]

EVIDENCE

Systematic reviews

- Macpherson et al. 2009 (Cochrane Review): inclusion of 1 RCT
- Chilvers et al. 2006 (Cochrane Review):
No studies included
- Kyle & Dunn 2008: Inclusion of 4 RCTs
- Taylor et al. 2009: inclusion of 18 studies
- Bitter et al. 2009: inclusion of 11 studies
- NICE schizophrenia guideline 2009: no studies included

Individual studies (RCT)

- Knapp et al. 1994

Non-randomized individual studies

1. quasi-experimental design (comparison of different residential services)
-Priebe et al. 2009
-Kallert et al. 2007

2. Dehospitalization studies
-Kaiser et al. 2001
-Franz et al. 2001

3. further individual studies
-Richter 2010
-Leisse & Kallert 2003

Consider evidence from international studies

Available studies show:

(+) staying in 24h/ day-supported living facilities decreases length of in-patient stay (vs. standard in-patient care) (II)

Kyle & Dunn 2008

(+) living in residential facilities decreases number of in-patient days in persons formerly homeless or suffering from SMI (II)

Kyle & Dunn 2008

(+) increase of self-dependence and decrease of negative symptoms in residential facilities encouraging self-supply (III)

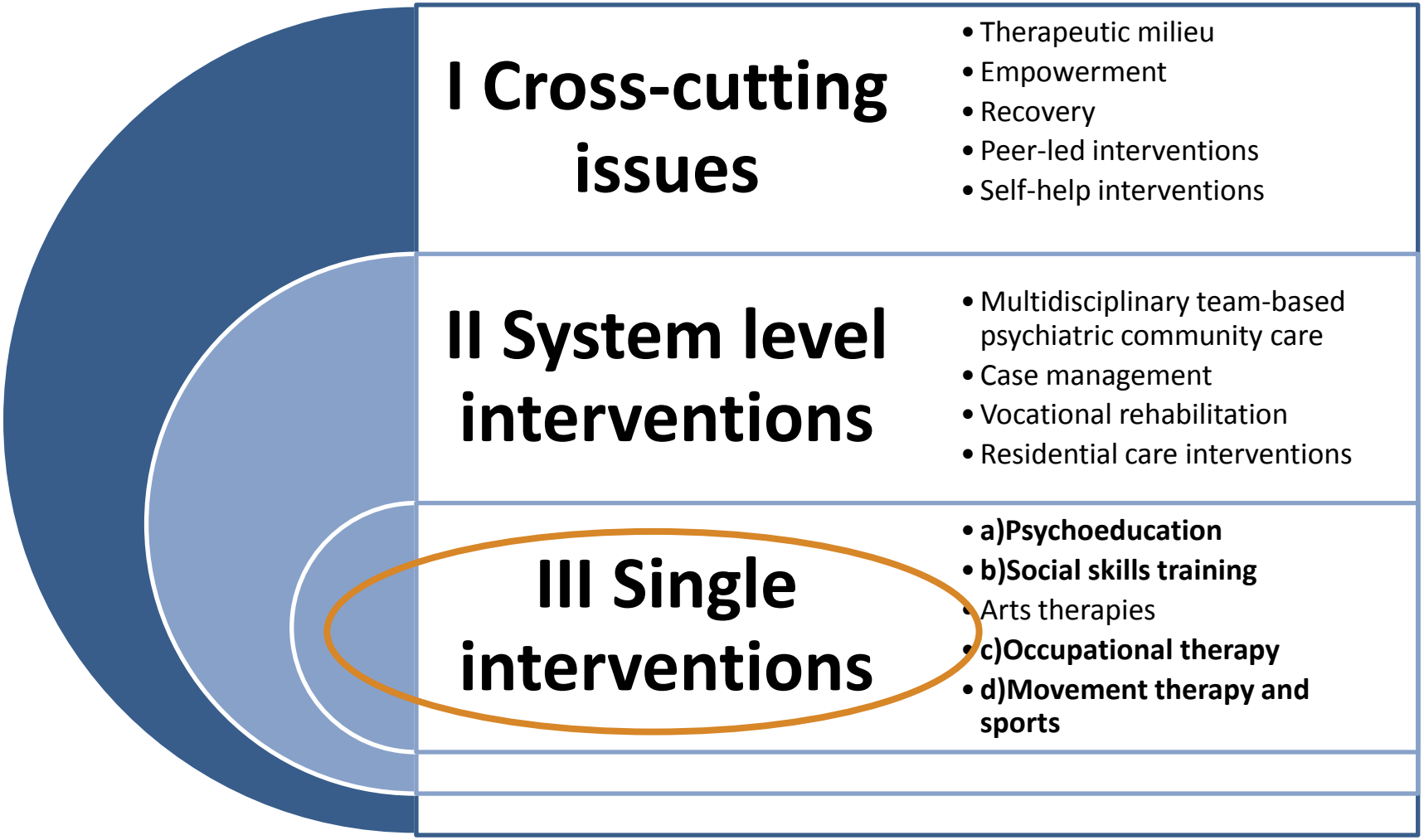
Llewllyn-Jones at al 1999, Macpherson et al 2009

(→) little quality-of-life differences between types of facility found (III)

Recommendations

- **Institutionalisation should be avoided: adverse effects increase and quality of life decreases with level of institutionalisation [strong recommendation: A, *upgrading*]**
- **Potential for deinstitutionalisation should be checked at regular intervals [clinical consensus]**

- There should be differentiated types of living/ residential arrangements with a focus on participation and autonomy. The type of support should depend on individual needs [weak recommendation: 0, Evidence level III]
- Supported living facilities should be community-based to improve social inclusion [clinical consensus]


I Cross-cutting issues
• Therapeutic milieu
• Empowerment
• Recovery
• Peer-led interventions
• Self-help interventions
II System level interventions
• Multidisciplinary team-based psychiatric community care
• Case management
• Vocational rehabilitation
• Residential care interventions
III Single interventions
• a)Psychoeducation
• b)Social skills training
• Arts therapies
• c)Occupational therapy
• d)Movement therapy and sports

IIIa Psychoeducation

DGPPN

Evidence: Effects of psychoeducation (PE) interventions from meta-analyses

			Meta-analysis NICE schizophrenia guideline 2009		
k=number of studies included	Pekkala & Merinder 2002 k=10	Lincoln et al. 2007 k=18	PE vs. any control intervention k=16	PE vs. standard care k=8	PE vs. active intervention k=8
Illness-associated variables					
↓ suicidality	n.a.	n.a.	~	~	n.a.
↓ symptomatic impairment (general)	~	+	++[1]	~	++
↑ compliance with medication	++[1]	~	++[1]	++[1]	~
↑ illness insight	~	n.a.	n.a.	n.a.	n.a.
↑ acquisition of knowledge	++[1]	++	n.a.	n.a.	n.a.
Treatment-associated variables					
↓ risk of relapse and inpatient readmission	++	++	~/(++[1])	~/(++[1])	~
↓ inpatient treatment duration	n.a.	n.a.	++[1]	++[1]	n.a.
↓ treatment discontinuation	~	n.a.	~	~	~
Social functioning and quality of life					
↑ social functioning	++	~	++[1]	++[1]	++[1]
↑ quality of life	++[1]	n.a.	n.a.	n.a.	n.a.
Carer-associated variables					
change in coping/carer burden	~	n.a.	n.a.	n.a.	n.a.
↓ high expressed emotion	++[1]	n.a.	n.a.	n.a.	n.a.

++: significant advantage in experimental group compared to control group, +: trend to superiority without significant difference in experimental group compared to control group, ~: results comparable in both groups
n.a.: not assessed, ↓: decrease, ↑: increase, [1]: findings based on individual data

EVIDENCE

DGPPN

Effects of family interventions with psychoeducation approach on the basis of meta-analyses

k=number of studies included:	Pitschel-Walz et al. 2001 k=25	Pilling et al. 2002 k=18	Pfammatter et al. 2006 k=31	Pharoah et al. 2006[a] k=43
Illness-associated variables				
↓ suicidality	n.a.	~	n.a.	~
↓ symptomatic impairment (general)	n.a.	n.a.	++	++[1]
↑ compliance with medicatione	n.a.	++	n.a.	++
Treatment-associated variables				
↓ risk of relapse and inpatient readmission	++	++	++	++
↓ inpatient treatment duration	n.a.	n.a.	++	++[1]
↓ treatment discontinuation	n.a.	~	n.a.	~
Social functioning and quality of life				
↑ social functioning	n.a.	n.a.	++	++[1]
Carer-associated variables				
↑ carer knowledge	n.a.	n.a.	++	n.a.
change in coping/carer burden	n.a.	++	n.a.	++[1]
↓ high-expressed emotion	n.a.	~	++	++[1]

++: significant advantage in experimental group compared to control group; ~: comparable results in both groups, n.a.: not assessed
↓: decrease, ↑: increase, [1]: data based on individual findings
[a]: family intervention with a minimum of > 5 sessions compared to standard care

SUMMARY OF EVIDENCE

Provision of knowledge	▪Reduction of relapse and readmission rates ▪Increase in mental (ill) health literacy
+ Carers	▪Stronger effects of PE when carers are integrated
Family interventions with PE elements	▪Effects more constant in family interventions including PE (reduction of relapse and readmisson rates, and medication adherence) ▪Effects on social functioning and aspects of family life

Hints at greater efficacy
- with longer duration of treatment
- in single family interventions vs. joint family interventions (> 1 family)

RECENT EVIDENCE

DGPPN

Psychoeducation for schizophrenia (Review)

Xia J, Merinder LB, Belgamwar MR

This review includes a total of **5142 participants** (mostly inpatients) from **44 trials** conducted between 1988 and 2009 (median study duration ~ 12 weeks, risk of bias - moderate). We found that **incidences of non-compliance were lower** in the PE group in the **short term** (n = 1400, RR 0.52 CI 0.40 to 0.67, NNT 11 CI 9 to 16). This finding holds for the **medium and long term**. **Relapse** appeared to be **lower** in PE group (n = 1214, RR 0.70 CI 0.61 to 0.81, NNT 9 CI 7 to 14) and this also applied to **readmission** (n = 206, RR 0.71 CI 0.56 to 0.89, NNT 5 CI 4 to 13). Scale-derived data also suggested that PE promotes **better social and global functioning**. In the **medium term**, treating four people with schizophrenia with PE instead of standard care resulted in one additional person showing a **clinical improvement**. Evidence suggests that participants receiving PE are more likely to be **satisfied with mental health services** (n = 236, RR 0.24 CI 0.12 to 0.50, NNT 5 CI 5 to 8) and have **improved quality of life**.

This is a reprint of a Cochrane review, prepared and maintained by The Cochrane Collaboration and published in *The Cochrane Library* 2011, Issue 6

http://www.thecochranelibrary.com

RECOMMENDATIONS

☞ Every person with severe mental illness has the right to obtain adequate information about the illness, its causes, the course of the disease, and various possibilities for treatment. The awareness of the patient is the basis for cooperative clinical decision making and is a prerequisite for health-improving behavior. People should obtain this information in their mother tongue. **(GPP)**

☞ Psychoeducation can also be offered a trialogue forum and psychosis seminar. **(GPP)**

☞ Structured psychoeducational programmes aimed at knowledge acquisition about the illness and reduction of relapses should be offered and integrated into a complex, long-term treatment program. The psychoeducation should be repeated as required. (***Grade B, Evidence level Ia)***

☞ Psychoeducation programmes must incorporate the family. Dual focus, as well as single focus, approaches have been found to be effective. (***Grade A, Evidence level Ia)***

☞ Empirical evidence for the effectiveness of psychoeducational interventions is based on studies of group settings. Psychoeducation is also possible in individual settings. **(GPP)**

IIIb Social skills training

DGPPN

Evidence

Systematic reviews and meta-analyses

- Pilling 2002: inclusion of 9 trials
- Pfammatter 2006: inclusion of 23 trials
- Kurtz & Mueser 2008: inclusion of 22 trials
- Meta-analysis of NICE Schizophrenia Guideline 2009: inclusion of 23 trials
- Roder 2006: Integrated Psychological Treatment Programe, inclusion of 7 RCTs

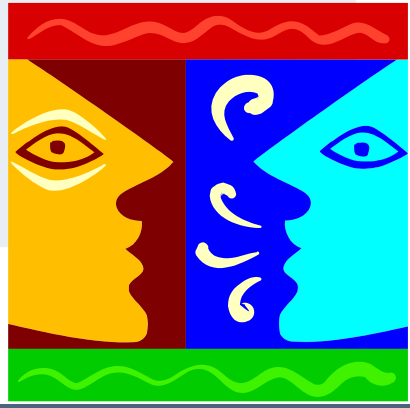
Individual trials

Current RCTs

- Horan 2009
- Galderisi 2009
- Xiang 2007
- Kern 2005
- Hogarty 2004/2006

RCTs addressing specific aspects

- Silverstein 2009
- Glynn 2002
- Kopelowicz 2003
- Moriana 2006
- Granholm 2005



EVIDENCE

DGPPN

Effects of social skills training, meta-analyses, varying outcome parameters

	Pilling et al. 2002	Pfammatter et al. 2006	Kurtz & Mueser 2008	NICE schizo-phrenia guideline 2009	Roder et al. 2006
Illness-associated variables					
↑ social skills	+	++	++	~	n.a.
↑ social functions	++[1]	++	++	~	++
↓ symptomatic impairment (general)	n.a.	++		~	++
▪ negative symptoms			++	+	
▪ other symptoms			~	n.a.	
↑ quality of life	++[1]	n.a.	n.a.	~	n.a.
Treament-associated variables					
↓ risk of relapse and inpatient readmission	~	++[1]	++	~	n.a.
↓ inpatient treatment duration	n.a.	n.a.	n.a.	~	n.a.
↓ treatment discontinuation	~	n.a.	n.a.	~	n.a.
Further psychological variables					
↑ self-confidence	n.a.	++	n.a.	n.a.	n.a.
↑ cognitive functions	n.a.	n.a.	n.a.	n.a.	++

++: significant advantage in experimental group compared to control group, +: trend to superiority without significant difference in experimental group compared to control group, or small sample, ~: findings comparable in both groups, n.a.: not assessed
↓: decrease, ↑: increase; [1]: data related to individual findings

Summary of evidence

DGPPN

Strong evidence	• Improvement of social skills • Improvement of social functioning
Limited evidence	• Improvement of psychopathological symptoms, negative symptoms in particular • Strengthening of self-consciousness, reduction of feelings of worthlessness • Reduction of relapses and patient drop-out
No evidence	• Reduction of positive symptoms • Reduction of inpatient treatment duration • Cost-effectiveness

RECOMMANDATIONS

☞ As severe mental illness is often accompanied by impairments in daily skills and social functions, and thus, participation in society is markedly impaired, interventions to improve social skills (self-care, family, leisure activities, work, social participation) are an important element in treatment. (GPP)

☞ **If social impairments are present, training of social skills should be offered to improve social competence. (Grade A, Evidence level Ia)**

☞ The social skills training should be adjusted to the individual needs of the client and integrated into a complex, long-term treatment program (GPP)

IIIc Occupational therapy

Evidence from randomized controlled individual studies as of 1990:

- Cook et al. 2009
- Reuster 2002/2006
- Buchain et al. 2003
- Liberman et al. 1998
- Kopelowicz et al. 1998
- Wykes et al. 1999
- Längle et al. 2006

Eviden

- Dunc

- **Evidence** on occupational therapy characterized by:
  - small number of controlled trials
  - small samples
  - few outcomes assessed in more than a few trials
- Only small number of high-quality positive trials, high-quality trials required

RECOMMANDATIONS

- Occupational therapy should be offered according to the individual needs of the patient and integrated into a complex, long-term treatment program.
Grade B, Evidence level Ib

IIId Sports and movement therapies

- **Sports and movement therapies,** in this guideline, refer to movement programmes with behavioural components planned by therapists and provided in defined doses to individual patients or patient groups (www.dvgs.de)
- In **Germany** sports and movement treatment programmes have been provided in inpatient and community settings for >50 years, and this approach goes back in the history of psychiatric care
- **Sports therapy** has somatic and functional focus, movement therapies emphasize emotional expression, there are programmes with an educational and psychosocial focus, e.g. movement therapy (emphasis on communication and 'mototherapy')

EVIDENCE

DGPPN

Movement interventions for people with schizophrenia

Systematic review:

- Gorczynski & Faulkner (2010): Inclusion of 3 RCTs

Randomized controlled trials

- Pajonk 2010
- Nitsun 1974
- Goertzel 1965
- Maurer-Groeli 1976
- Röhricht & Priebe 2006
- **Hátlová und Bašny 1995**

Non-randomized controlled trials:

- Knobloch 1993
- Deimel 1980

Movement interventions for people with depression

Randomized controlled trials:

- Martinsen 1985/1989
- Blumenthal 1999
- Babyak 2000
- Knubben 2007
- Veale 1992
- Pinchasov 2000

Movement interventions for mixed diagnostic patient groups (schizophrenia and bipolar affective disorder):

- Pelham et al. 1993 (RCT)

EVIDENCE: MOVEMENT/ SPORTS INTERVENTIONS IN PEOPLE WITH SCHIZOPHRENIA

DGPPN

Exercise therapy for schizophrenia (Review)

Gorczynski P, Faulkner G

THE COCHRANE COLLABORATION®

Main results

Three randomised controlled trials met the inclusion criteria. Trials assessed the effects of exercise on physical and mental health. Overall numbers leaving the trials were similar. Two trials compared exercise to standard care and both found exercise to significantly improve negative symptoms of mental state (Mental Health Inventory Depression:1RCT, n=10, MD 17.50 CI 6.70 to 28.30, PANSS negative: 1RCT, n=10, MD -8.50 CI -11.11 to -5.89). No absolute effects were found for positive symptoms of mental state. Physical health improved significantly in the exercise group compared to those in standard care (1RCT, n=13, MD 79.50 CI 33.82 to 125.18), but no effect on peoples' weight/BMI was apparent. One trial compared exercise with yoga and found that yoga had a better outcome for mental state (PANSS total: 1RCT, n=41, MD 14.95 CI 2.60 to 27.30). The same trial also found those in the yoga group had significantly better quality of life scores (WHOQOL Physical: 1RCT, n=41, MD -9.22 CI -18.86 to 0.42). Adverse effects (AIMS total scores) were, however, similar.

- Inclusion of 3 RCTs (N=96)
- Experimental interventions: physical training, primarily aerobic
- Control interventions: standard treatment (TAU) or yoga
- significant positive effects (vs. TAU): positive and negative symptoms, depression, anxiety, physical fitness, body fat
- Yoga shows superiority over physical training with respect to a number of outcomes

This is a reprint of a Cochrane review, prepared and maintained by The Cochrane Collaboration and published in *The Cochrane Library* 2011, Issue 6

http://www.thecochranelibrary.com

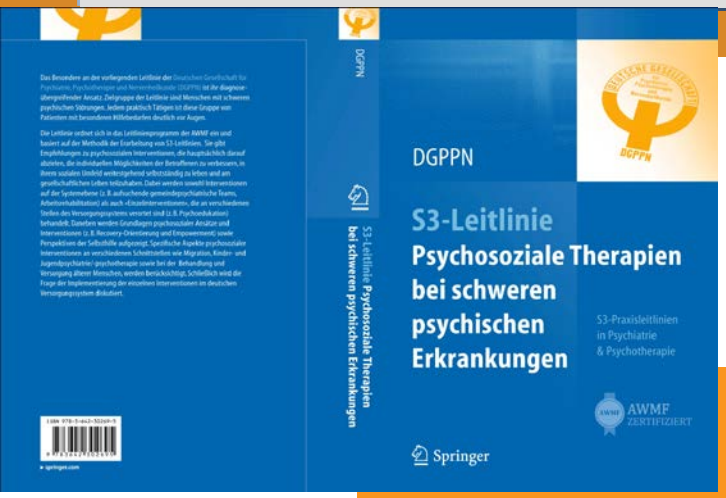
RECOMMANDATIONS

For people with Schizophrenia

☞ In treating schizophrenia, movement-oriented interventions should be used and adjusted to the condition, individual needs and physical fitness of the patient and integrated into a multi-modal complex treatment program. ***Grade B, Evidence level Ib***

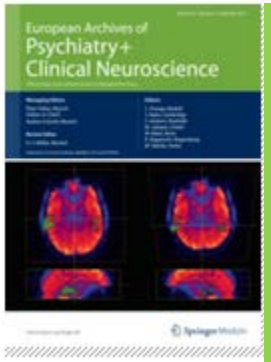
☞ In treating schizophrenia, body-oriented psychotherapy should be used. ***Grade B, Evidence level IIa***

S3 Guideline Psychosocial Therapies for people with severe mental illness



DGPPN
Deutsche Gesellschaft für Psychiatrie und Psychotherapie, Psychosomatik und Nervenheilkunde

Gesundheit fängt im Kopf an.



Gühne et al.: S3 guideline on psychosocial therapies in severe mental illness. Evidence and Recommendations. (accepted)

Gliederung:

I. Grundlagen psychosozialer Interventionen: Therapeutische Beziehung, Milieutherapie, Grundsätzliche Aspekte — anzeigen

II. Systeminterventionen — anzeigen

III. Einzelinterventionen — schließen

1. Psychoedukative Interventionen für Betroffene und Angehörige, Peer-to-peer-Ansätze und Trialog
   - Vortrag_Psychoedukation [PDF; 796 KB]
2. Training von Alltags- und sozialen Fertigkeiten
   - Das Training sozialer Fertigkeiten bei schweren psychischen Erkrankungen - ist es wirksam?; Psychiatrische Praxis 2012 [PDF; 193 KB]
   - Vortrag Training sozialer Fertigkeiten [PDF; 1,1 MB]
3. Künstlerische Therapien
   - Künstlerische Therapien bei schweren psychischen Störungen; Nervenarzt 2012 [PDF; 267 KB]

http://www.dgppn.de/dgppn/struktur/referate/versorgung0/s3-leitlinie-psychosoziale-therapien-bei-schweren-psychischen-erkrankungen.html

S3 Guideline Psychosocial Therapies for people with severe mental illness

Conclusions:

- High-quality evidence (meta-analyses and/ or RCT): strong/ simple recommendations (all system interventions, psychoeducation, skills training, arts therapies, movement therapy and sports)
- Weaker evidence: residential interventions, occupational therapy, therapeutic milieu, recovery and empowerment → further research required
- Dominance of Anglo-American studies → transfer of findings to other countries not trivial
- Psychosocial treatment teams must be integrated in community mental health (and inpatient) teams as they provide essential components of care

t.becker@uni-ulm.de