Increasing access to psychological treatments for mental illness

In The Lancet Psychiatry, Daniel Freeman and colleagues report a psychological treatment for fear of heights. The treatment entailed a fully automated virtual reality (VR) system, and the study population was an accessible and easy-to-engage sample of participants. The findings were impressive with respect to engagement (90% of participants received the full course of treatment) and outcomes (large between-groups effect size of Cohen’s d=2.0 on the primary outcome, maintained at follow-up). These findings are good news for people struggling with a fear of heights (and possibly other similar anxiety disorders), but what do they mean for the psychological treatment of people with more severe and enduring mental health problems, such as psychosis?

Psychological treatments for patients with psychosis face many challenges, because access to the treatments can be restricted and the treatment might generate only small effects. Symptom-specific treatments targeting either paranoia or auditory hallucinations are generating promising outcomes that might increase effect sizes, but their delivery in traditional face-to-face formats by expert therapists will do little to increase access (even when technology is utilised, such as in AVATAR therapy). VR is a promising method for delivering psychological treatments to patients with psychosis, but can a fully automated delivery system increase access? And are greater effects also possible because of the virtual exposure to everyday situations that are experienced as threatening? As we consider these possibilities, at least two caveats can be held in mind.

First, the novel aspect of the study by Freeman and colleagues is full automation of the treatment, through introduction of a coach within the virtual world. The virtual coach acts as a therapist and guides the patient through the treatment, thereby negating the need for a therapist to be physically present. Indeed, the authors suggest that such treatments could be used by patients at home in the future (presumably, with no clinical or technical staff present). In a world of rapid technological advancement, this idea might not be too far-fetched. But, is the virtual coach necessary? None of the quotes by patients mention the virtual coach explicitly, which raises a question about the added value of this specific component of the treatment. The pioneers of psychological treatments for severe mental illness need to evaluate the specific contributions made by the novel components of their treatments. This curiosity could be extended to explore the added value of case formulation, or the visual representation of the auditory hallucination in AVATAR therapy. Dismantling and other novel trial designs can offer processes through which the active components of treatments can be identified, and can lead to the roll-out of treatments that are no more resource-intensive or complex than is needed to generate some benefits to patients.

Second, the demographics of the trial participants suggest that this patient population was very different from people with severe mental illness who we see typically in secondary-care mental health services within the UK’s National Health System (NHS)—eg, most of the participants were employed. What additional support might patients with severe mental illness need to engage with a fully automated VR system? Might the immersive experience of VR be more suited to patients with some psychotic experiences (eg, those with paranoia) rather than others (eg, those distressed by hearing voices)? How might the traumatic roots of a patient’s psychotic experiences influence engagement with threatening situations in the virtual world that might be linked to the trauma? There seems to be much to learn in these respects.

A final consideration relates to the future availability of technological interventions within NHS mental health services that are remote from centres of research excellence. One could be inclined towards scepticism in this respect. However, the i4i Mental Health Challenge Award—a £4 million grant from the National Institute for Health Research—has been awarded to Freeman and his team not only to develop and evaluate VR treatments for patients with psychosis but also (clinical and cost-effectiveness of the intervention permitting) to begin the process of implementation within the NHS. Freeman and colleagues’ study represents the latest step in an impressive programme of research that has the potential to transform the provision of psychological treatments to patients with various mental health problems.

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Cognitive behavioural therapy for clozapine non-responders

In The Lancet Psychiatry, Anthony Morrison and colleagues present the findings from their Focusing On Clozapine Unresponsive Symptoms (FOCUS) randomised clinical trial, in which they compared 9 months of cognitive behavioural therapy (CBT) for psychosis with treatment as usual for patients with schizophrenia who had not responded to treatment with clozapine. No between-group differences occurred for the primary outcome of Positive and Negative Syndrome Scale (PANSS) total score at 21 months (mean difference −0·89, 95% CI −3·32 to 1·55; p=0·48), Morrison and colleagues concluded that the results did not support a recommendation to routinely offer CBT to all people who meet criteria for clozapine-resistant schizophrenia, but that a pragmatic trial might be indicated for some individuals.1

Reports of CBT being used to treat psychosis date back to the middle of the 20th century.2,4 Initial trials of this treatment focused primarily on medication-refractory patients with schizophrenia; thus, a review in 2000 addressed the use of CBT specifically in this patient population.5 Furthermore, the early studies targeted the symptoms (delusions and hallucinations), that define poor response to medication. CBT trials have since been extended to a broader range of patients earlier in their treatment course and the design of such trials has improved. CBT for psychosis is included in the UK National Institute for Health and Clinical Excellence guideline for both psychosis and schizophrenia in adults, and is recognised as an evidence-based practice by the Substance Abuse and Mental Health Services Administration in the USA.6

The FOCUS trial represents an important addition to the understanding of CBT for psychosis, and incorporated several notable characteristics. First, the trial returned to the origins of CBT; ie, focusing on patients who were medication-resistant as defined by their resistance to clozapine, the only antipsychotic medication indicated for treatment of patients with medication-refractory schizophrenia. Treatment for these patients represents a major challenge for the field. Second, as a pragmatic trial done across a range of settings in the UK, it has enhanced generalisability of the results. Finally, the study was well designed and executed, with randomisation controlled to eliminate potential bias in allocation to treatment condition, CBT following a manual with clearly described training, and masking of the outcome assessments. Additionally, attrition between the end of treatment at 9 months and at 21-month follow-up was low.

However, the choice of 21 months for the primary outcome measure, 12 months after the end of treatment, raises the question of how we should establish treatment efficacy in such studies. An important model for pharmacological treatments is the study of treatment discontinuation or relapse prevention. In such studies, individuals who have shown a response to a medication are randomly assigned to continue or discontinue that medication and are assessed for relapse or a return of the relevant symptoms. Findings from previous trials show consistently that those who continue medication fare better in terms of symptoms, as well as relapse or readmission to hospital, than those who discontinue.7 By contrast, for many psychosocial