Commentary

Julian Leff

The Thorn Initiative was put together by a group of people, most of whom were researchers who had conducted randomised controlled trials on various kinds of social treatments. Isaac Marks had worked on assertive community treatment (ACT), whereas my experience was in family work for schizophrenia, as was that of Nick Tarrier. In addition, Tarrier had carried out a recent trial of cognitive approaches to reducing delusions and hallucinations. It was rather like trying to turn an assemblage of prima donnas into a chorus, and it is a tribute to the personal qualities of Jim Birley that he succeeded in this seemingly impossible task.

One of the reasons for the successful melding of this disparate group of researchers was that we all faced the same problem of disseminating social treatments. Unlike pharmaceutical treatments, they are inherently unpatentable and hence of no commercial interest. If the advantages proven to be conferred by family work were the result of a new antipsychotic drug, the pharmaceutical company owning it would launch a massive and prolonged advertising campaign to promote it. Furthermore, a social treatment cannot simply be prescribed as can a medication. It is essential to establish training courses and to make these accessible on a national level. This was the overriding motivation for the Thorn Initiative.

Form of the Thorn Initiative

In his account, Kevin Gournay has not given sufficient emphasis to the model of dissemination of training that informed the Initiative from the beginning. This was a cascade model, based on the premise that some of the trainees coming to the London and Manchester centres would be of sufficient calibre to establish satellite training centres in their home bases. This was an additional reason why it was preferred that two candidates were selected from each peripheral centre, since the setting up and running of a training centre would be beyond the capacity of a single individual. To equip them for this task it was necessary to develop a training programme for trainers, and this is now up and running as a Level 3 course in the London centre. The pattern of development in the Manchester centre has been rather different. It has taken much longer than expected to establish a network of satellite centres, but there are now eight centres operating, with more coming on stream.

The selection of trainees is rigorous since we are looking for a range of qualities. These are primarily to do with clinical skills, including sensitivity to the problems and needs of patients with psychoses. For this reason role play is incorporated in the interview. We are also selecting for the personal qualities needed in a course leader, although not all trainees can be expected to develop satellite training centres. It is a curious fact, and a source of continuing concern, that relatively few trainees come from the Maudsley hospital even though the training programme is on site.

Content of the Thorn Initiative

After completing our second trial of family work for schizophrenia, Elizabeth Kuipers and I felt that the evidence for the efficacy of this approach was strong enough to begin developing a training course. We did this with the assistance of Dominic Lam, and

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the course was well established by the early 1990s. During the same period, a training course in family work was developed in Manchester following the trial conducted by Nick Tarrier and his colleagues. Consequently, when the Thorn Initiative was first set up, the training courses in family work that were already running in Manchester and London could be readily incorporated. Subsequent controlled trials of this intervention conducted in the USA and China provided additional evidence for its efficacy, and in time it was recognised as evidence-based by the Cochrane Collaboration. Hence, its inclusion in the Thorn training was clearly justified.

Although a number of successful trials of ACT had been published prior to its inclusion in the Thorn Initiative, subsequent research, quoted by Kevin Gournay, emphasises the necessity for adequate training in the techniques of case management. It has also become clear that it is not the amount of time spent with the patient that is crucial, rather what the case manager does during that time. It is also important to realise that ACT is not a treatment, like family work or cognitive therapy, but a way of organising services to meet the patient's needs.

The third main component of the Thorn course was a cognitive approach to delusions and hallucinations. Including this treatment was a risky strategy since only preliminary results of the trial by Tarrier and colleagues had been published. Since then the findings of three trials have confirmed its efficacy, particularly for that group of psychotic patients who are resistant to all existing antipsychotic drugs.

As Kevin Gournay writes, recent additions to the programme have been modules on medication management, dual diagnosis disorder and forensic problems. As yet, there is no strong body of research evidence for the efficacy of these inputs, but there is an obvious conflict between the pressing needs for training in the management of today's salient clinical problems and the time it takes to accumulate convincing evidence for the value of social treatments. Under such pressure, it is likely that mistakes will be made, but so far the contents of the Thorn training have proved to be judiciously selected.

Barriers to implementation

Although the cascade model has been a successful strategy for disseminating the training, Thorn trainees have encountered problems from an unexpected source. On returning to their home base after completing the training, many have found it difficult to put into practice what they have learned. This has been partly due to managers' insisting that they continue with the same case-load they had previously, thus not allowing them the time they need for newly learned procedures. Trainees have also complained of absence of staff who have the necessary experience to supervise their clinical work. These problems will be solved in time as experience of the training spreads across the country, but at present they cause considerable frustration, which can lead to trained staff leaving their workplace to find a more congenial position.

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