Accredited Training in Psychosocial Interventions for Psychosis:
A National Survey

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Foreword

The availability of psychosocial interventions (PSI) in the treatment and care of people with psychosis and their carers can no longer be considered optional within mental health services. NICE guidance on the treatment of schizophrenia asserts that cognitive behavioural therapy (CBT) and family interventions should be available to all who require them. In addition, the mental health Policy Implementation Guide recognised that psychosocial approaches should be inherent within all Early Intervention for Psychosis services. However, for this guidance to be translated into practice requires the mental health workforce to be equipped with adequate skills and competencies to deliver these approaches. Training in the basics of CBT for common mental health problems can be found in some of the pre-registration training programmes for mental health workers, yet this does not often extend to providing skills to deliver CBT for service users with psychosis. Moreover, teaching on family interventions is unlikely to be covered at all.

The NIMHE National PSI Implementation Group was established with the launch of the National Institute of Mental Health in England in 2002. The group is associated with the national workforce programme and aims to ensure evidence based psychosocial interventions for psychosis are available to individuals and their families across England. For this to succeed requires accessible, high quality, post qualification training across the country. The first PSI training programmes were established in 1992 in the form of the two 'Thorn' programmes in London and Manchester. Ten years later Brooker (2002) ascertained that PSI training had flourished with 27 undergraduate and 5 Master level courses being provided across England. Since then however, no further work has been carried out to determine whether this growth in training has continued and to determine whether university accredited PSI training is accessible nationwide.

This report provides a recent update on the availability of university accredited PSI type training across the eight NIMHE regions, showing the courses provided, the level at which they are accredited as well as an overview of the teaching content. What it highlights is the lack of consistency in the availability of PSI training across England revealing and with some regions having a broader range of training and higher numbers of training places than others. There is a risk that this variance in training could ultimately lead to discrepancies in the provision of evidence based care across the country. The information contained in this report should be of interest to those tasked with planning, delivering and commissioning local education and training: ensuring the workforce are appropriately equipped to deliver essential services

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Introduction

Psychosocial interventions, including family work and cognitive behavioural therapy, are integral to the design and delivery of recovery orientated evidence based mental health services for people with psychosis (NICE 2002). Psychosocial intervention training for mental health staff is widely available, but little is known about the extent and distribution of training across England, or of the detail of individual programmes. To remedy this, the NIMHE National PSI Implementation Workgroup conducted a survey of university accredited PSI education/training in January 2006. Twenty-six courses were represented in the returns from the eight regions served by CSIP Regional Development Centres. The findings of the survey are outlined in the following report. Implications for the dissemination of PSI are considered and a series of recommendations presented.

Background

Psychosocial Interventions (PSI) focus upon people who experience a psychosis and include at least one of the following components; an integrated bio-psycho-social /stress vulnerability model of psychosis, structured outcome measure based assessment, cognitive behavioural therapy, psychological management of symptoms, cognitive behavioural family interventions and/or medication management (Brooker & Brabban 2004). The evidence for the efficacy of these approaches is largely drawn from studies that have found participation in family intervention (FI) and cognitive behavioural therapy (CBT) to be associated with a range of benefits, including reduced risk of relapse and improved mental state (Pilling *et al* 2002).

Initiatives to train the mental health workforce in England in these interventions date back to 1992 with the development of the first 'Thorn' programmes at The Institute of Psychiatry, London and The University of Manchester. Funded by the Sir Jules Thorn Charitable Trust, the aim of these courses was to equip community psychiatric nurses to work effectively with people with severe mental health problems. Drawing on the available evidence at the time, the curricula of these programmes adopted a stress vulnerability conceptualisation of psychosis and focused upon case management, family intervention and the psychological management of psychotic symptoms (O'Carroll *et al* 2004). Evaluations of early PSI training courses found that they were associated with benefits for students undertaking the courses and the families that they worked with (Brooker *et al* 1994) but that some students experienced difficulty in integrating PSI within their routine practice. One obstacle cited was the lack of recognition of the value of PSI from colleagues and managers (Fadden 1997).

The potential of PSI to enhance outcomes for those with psychosis who use services and their carers is now, however, recognised at a national level. Guidance regarding the implementation of the specialist teams proposed by the National Service Framework for

Mental Health (DoH 1999) identifies PSI as core business for practitioners working in early intervention, crisis resolution and assertive outreach teams (DoH 2001). Furthermore The National Institute for Clinical Excellence (NICE 2002) guidelines for the treatment of schizophrenia recommend family interventions and cognitive behavioural therapy (CBT) are offered to all individuals with this diagnosis.

More recently, the White Paper *Our health, our care: A new direction for community health services* (DoH 2006a), recognising the role of psychological therapies for complex conditions such as psychosis, has promised greater provision of such interventions.

Access to PSI for people who experience psychosis and their carers requires that the mental health workforce has access to high quality educational and training programmes but also that services are configured to support the widespread dissemination of these interventions (Fadden 2006). Education programmes should be grounded in the values-based and evidence-based practice outlined in the *Essential Shared Capabilities* (DoH/SCMH/NIMHE 2004) and informed by contemporary research developments.

There are now eleven Thorn accredited psychosocial intervention courses in England (Thorn National Steering Group UK 2005) and reports of other psychosocial intervention programmes have been published (e.g. Bradshaw *et al* 2003). While PSI training has proliferated (Brooker 2002), the extent of university accredited PSI training across the country remains unknown. Furthermore, while changes in the Thorn curriculum have been recognised, for example, the focus upon service level implementation of PSI (Thorn National Steering Group UK 2005), it is unclear how other PSI programmes have responded to the significant developments in values-based and evidence-based practice observed since the inception of the first PSI training programmes.

Rationale for the survey

The NIMHE National PSI Implementation Workgroup was initially established in 2002 (as The NIMHE National PSI Implementation Workgroup) with the aim of enhancing the dissemination of evidence based PSI for people with psychosis (Brooker & Brabban, 2004). The current NIMHE National PSI Implementation Workgroup is made up of representatives from each NIMHE regional development centre and key stakeholders who have an appreciation of PSI and associated implementation issues (Brooker & Brabban, 2003).

In order to determine the extent, distribution and characteristics of PSI training in England the NIMHE National PSI Implementation Workgroup undertook a survey of accredited PSI training courses in January 2006.

Method

A questionnaire comprising of 13 questions and a topic checklist was compiled and distributed by the group to all departments thought to offer university accredited PSI education and training courses in their region. Questions asked respondents to provide detail of their programme, including course title, duration, academic award, number of places available per annum, nature of funding and qualifications of programme lead. A 20 item topic guide synthesising values-based practice (DoH/SCMH/NIMHE 2004) and the current evidence (Pilling *et al* 2002) was included in the questionnaire. Respondents were asked to identify the topics which were taught specifically within their curriculum or taught thematically, throughout the programme. The rationale for differentiating between these two methods is that there are some aspects of PSI, usually relating to values-based practice that should be pervasive throughout the curriculum. For example, recovery should feature in accounts of the course of psychosis, in assessment to ensure individual service user goals and aspirations are revealed, in the implementation of culturally acceptable practice and so on. In recognition of the crucial role of supervision in training (Bradshaw 2002) and implementation post training (Fadden 1997) respondents were asked to reveal whether supervision was provided internally, that is, by the programme team, or externally, for example, by practitioners within their place of work. To capture whether the unique contribution that services users and carers can make to mental health training programmes (Tew *et al* 2004) is a key feature of PSI programmes, respondents were asked to indicate whether service users and carers were involved in the delivery of teaching.

Programme leads who had not returned the questionnaire by the deadline were contacted again by group members (via email) and prompted to return the questionnaire.

Key findings

Twenty-seven questionnaires were returned. Two questionnaires were excluded from the analysis; the first describing a full time pre-registration nursing programme, the second, a non-accredited course. The remaining 25 responses report on 26 PSI accredited training courses in England (one return reported upon two courses). The summary presented below includes 28 training courses as two of the courses are delivered on two sites. In the absence of a national database or register it is not possible to establish the total number of PSI training courses in England at this time. However, it is clear that that the findings here do not represent complete provision. For example, only four of the eleven Thorn accredited psychosocial intervention training courses are featured in the summary below. (Although it is possible that some of the eleven accredited courses are not current.)

The report will begin by providing a summary of the questionnaire returns from each region. Findings regarding course title, duration, academic award, number of places available per annum, nature of funding and qualifications of programme lead will then be presented. The implications of the findings of the survey will then be considered and a number of recommendations made.

Regional summary of PSI training programmes

The following section summarises the responses to the questionnaire for each NIMHE regional development centre. Questionnaires were returned from all eight regions. Summaries are presented in tables outlining the accrediting institution, course/module title, academic qualification and duration of programme. The number of training places available each year, for each programme is presented; with those in bold denoting funded places.

North East, Yorkshire and Humber

The survey identified nine PSI training courses in the North East, Yorkshire and Humber region which encompasses one of the largest geographical areas of all eight development centres, with a population of almost seven and a half million people. Detail of individual courses is presented in Table 1. A range of programmes are offered within this region, from short courses lasting only a few days to full undergraduate and postgraduate degree programmes. A total of 299 places are available each year with 272 of them funded by commissioners.

Institution	**Course/module title**	**Academic qualification**	**No. of places per annum***	**Duration**
University of Teeside	PSI– an introduction	UCPD	**50**	6 days
	Developing PSI in Mental Health	UCPD	**60**	15 weeks
University of Manchester (North East, Yorkshire and Humber Region)	PSI for people experiencing severe and enduring mental health problems	40 undergraduate credits	27	20 days
University of Sheffield	Principles of PSI	20 undergraduate credits	**12-20**	15 days
University of Sheffield/Linksworth	PSI	Postgraduate diploma/MSc	**15-20**	2-3 years
Leeds Metropolitan University	PSI in Psychosis	Diploma/BSc	**24**	16 months
University of York	Health Care Practice (PSI)	BSc	**20**	18 months
	PSI– Core Values	Detail not supplied	**55-60**	Detail not supplied
University of Sunderland	PSI: Integrated approaches to recovery	Postgraduate certificate/postgraduate diploma/MSc	**18**	1-3 years

Table 1. Accredited PSI training courses in North East, Yorkshire and Humber
* figures in bold denote funded places

North West

The nine returns from the North West region described eight courses. The North West Regional Development Centre serves the counties of Cheshire, Merseyside, Lancashire, Cumbria, and Greater Manchester. The courses range from short courses to undergraduate and postgraduate degree programmes. A total of 290 places are available in the North West with 210 of them attracting funding.

Institution	Course/module title	Academic qualification	No. of places per annum*	Duration
University of Chester	PSI in mental health	40 undergraduate credits	**60**	15 weeks
University of Manchester	PSI for people experiencing severe and enduring mental health problems	40 undergraduate credits	40	20 days
Liverpool John Moores University	PSI for health and social care professionals	undisclosed number of undergraduate & postgraduate credits	**40**	10 weeks
University of Central Lancashire	University advanced certificate in PSI	40 undergraduate credits	**20**	24 weeks
Edge Hill, Faculty of Health	Introduction to PSI and cognitive behavioural therapy	15 undergraduate credits	5-20	15 weeks
	Psychosocial intervention and family work	30 undergraduate credits	5-20	6 months
University of Manchester	PSI for Psychosis	Undergraduate diploma/BSc(Hons)	**60**	12 – 18 months
	PSI for Psychosis	Postgraduate diploma/MSc	**30**	24 – 30 months

Table 2. Accredited PSI training courses in North West region
* figures in bold denote funded places

Eastern

The Eastern Development Centre serves the six counties of Bedfordshire, Cambridgeshire, Essex, Hertfordshire, Norfolk and Suffolk. Only one questionnaire was returned from this region describing a university based course offering undergraduate and postgraduate PSI training. All 14 places per annum are funded. There is at least one other PSI programme currently running within the Eastern region but no further information is available at the time of writing this report.

Institution	Course/module title	Academic qualification	No. of places per annum*	Duration
University of Hertfordshire	PSI (Mental Health)	BSc/MSc	**14**	18 months (BSc) 24 months (MSc)

Table 3. Accredited PSI training courses in Eastern region
* figures in bold denote funded places

East Midlands

The East Midlands Development Centre serves Leicestershire, Nottinghamshire, Derbyshire, Lincolnshire, Northamptonshire and Rutland. Two questionnaires were returned from this region. A total of 34 funded places were identified on a short course and an undergraduate degree programme. The NIMHE workgroup is aware of one other PSI programme in the East Midlands but no further detail is available.

Institution	Course/module title	Academic qualification	No. of places per annum*	Duration
De Montfort University (Leicester)	PSI in Mental Health	15 undergraduate credits	**10**	15 days
University of Nottingham	Health Studies (PSI for Psychosis) (Thorn)	BSc	**24**	2-5 years

Table 4. Accredited PSI training courses in the East Midlands
* figures in bold denote funded places

West Midlands

Only one return was received from the West Midland region featuring a five day course followed by on-going supervision available at a local level, and focusing on behavioural family therapy. 300 funded places are available on this course each year.

Institution	Course/module title	Academic qualification	No. of places per annum*	Duration
Meriden West Midlands Family Programme/University of Birmingham	Behavioural Family Therapy-Working with families	10 M level credits	**300**	5 days

Table 5. Accredited PSI training courses in the West Midlands
* figures in bold denote funded places

South East and London

One return from the South East and London regions provided detail of a programme accredited by Thames Valley University, offering 40 funded places per annum on two sites.

South East

Institution	Course/module title	Academic qualification	No. of places per annum*	Duration
Thames Valley University/Berkshire	PSI for Psychosis	DipHE/BSc	**20**	2 years

Table 6. Accredited PSI training courses in the South East
* figures in bold denote funded places

London

Institution	Course/module title	Academic qualification	No. of places per annum*	Duration
Thames Valley University/London	PSI for Psychosis	DipHE/BSc	**20**	2 years

Table 7. Accredited PSI training courses in the London region
* figures in bold denote funded places

There are a further two PSI programmes currently available within the London region.

South West

Of the four returns from the South West, two programmes in the South West are accredited by the University of Plymouth. One is delivered from within the University while the other is delivered in partnership with two local NHS and Social Care Trusts. 37 places in the South West are fully funded and the remaining 19 are partially funded.

Institution	Course/module title	Academic qualification	No. of places per annum*	Duration
University of Plymouth	Cognitive behavioural therapy for psychosis; assessment, family & individual	60 undergraduate or M level credits	**25**	1 year
Somerset Partnership NHS & Social Care Trust/University of Plymouth	Family Interventions (Research, Skills, Theory) in Psychosis	60 undergraduate credits	11 (partially funded)	1 year
Cornwall Partnership NHS Trust/University of Plymouth	Family Interventions (Research, Skills, Theory) in Psychosis	60 undergraduate credits	8 (partially funded)	1 year
Bournemouth University	PSI for Psychosis (Thorn)	BSc	**12**	2 years

Table 8. Accredited PSI training courses in the South West
* figures in bold denote funded places

There is at least one further programme within the South West.

Overall summary

In total, the survey revealed 1033 places available on PSI training courses in England. The majority of training places are available in the north of England with 57% (n=588) of training places being located in the North West and North East, Yorkshire and Humber regions. 32% (n=331) of places are available in the East and West Midlands with the primary provider being the Meriden West Midlands Family Programme. 11% (n=114) of places are offered within the Eastern, South East and South West regions. As stated earlier it is unclear whether this summary represents the full provision of PSI training in England at the present time and the actual distribution of training places may be different from the picture presented here. Of the 1033 places identified, 87% (n=899) of the training places available are fully funded by commissioners suggesting a significant investment in workforce development.

Further detail regarding the above PSI training courses is featured below. The findings of the survey regarding programme curriculum, qualifications of the programme leads, assessment of competencies and provision of supervision are presented.

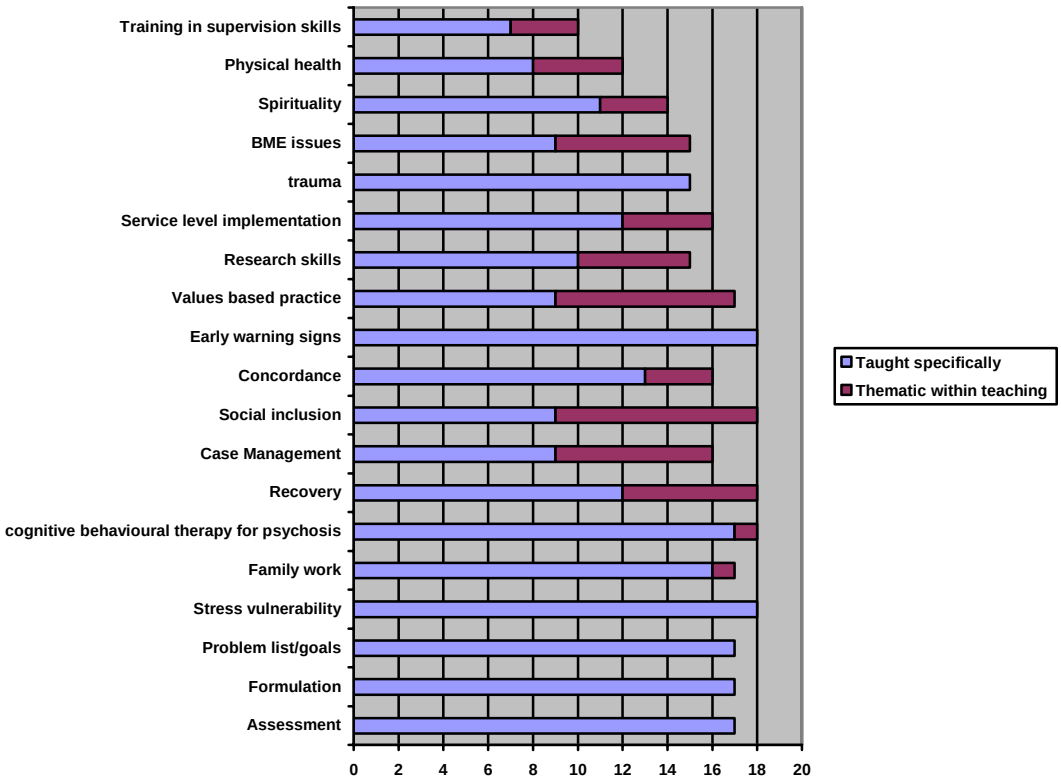
Curricula

PSI curricula should be informed by values-based and evidence-based practice. The shared values and capabilities that all staff working in mental health should possess have been outlined in The *Ten Shared Capabilities – A Framework for the Whole of the Mental Health Workforce* (DoH/SCMH/NIMHE 2004). The evidence base for PSI has evolved since the introduction of PSI training in 1992. For example, the first randomised controlled trial of cognitive behavioural therapy for psychosis was published in 1993 and since that time the findings of more than 20 trials have been reported in the literature (Tarrier & Wykes 2004).

The topic guide outlining the content of PSI curricula was completed by 18 of the programme leads.

The information supplied regarding the inclusion of specific topics is depicted in the figure 1 and discussed in further detail below.

Figure 1



Definitions of psychosocial intervention vary but usually acknowledge the stress vulnerability conceptualisation of psychosis (Zubin & Spring 1977) as a unifying feature. All PSI programmes teach students this model explicitly.

With regard to the values underpinning the application of PSI, all but one programme teach values based practice with 47% of these programmes teaching values–based practice thematically. Recovery and social inclusion feature in all PSI programmes, being taught thematically in 33% and 50% programmes respectively. While training in cultural competencies remains high profile (DoH/NIMHE 2003) only 83% of programmes address Black and Ethnic Minority (BME)/equality and diversity matters within their curricula, 60% do so thematically. 78% of programmes include spirituality, 29% of these programmes teaching spirituality explicitly.

94% of programmes include specific teaching on structured assessment, formulation and the collaborative development of problem lists and goals. The one programme that excludes

these three aspects of PSI is an introductory short course which does not assess skill acquisition.

With regard to the traditional Thorn curriculum; 83% of programmes continue to teach case management. Family work continues to feature in the majority of programmes (94%) although is not included in one short PSI programme. The inclusion of cognitive behavioural therapy for psychosis in all programmes is likely to reflect the emerging evidence that this model of psychological treatment is effective in reducing the positive (Zimmerman *et al* 2005) as well as the negative symptoms (Rector & Beck 2001) associated with a diagnosis of schizophrenia. All courses teach early warning signs monitoring/relapse prevention. The introduction of service level PSI implementation in 94% of courses may constitute an attempt to overcome the organisational barriers to the dissemination of psychosocial interventions cited in the literature (e.g. Fadden 1997).

The inclusion of concordance therapy (sometimes referred to as medication management) within PSI curricula is controversial. There are only a small number of randomised controlled studies (for example, Gray *et al* 2004) which support its application with this group. Nevertheless it is included in 89% of PSI courses.

The recent attention to the poor physical health of people who are diagnosed with schizophrenia (DoH 2006b) is reflected in the inclusion of physical health in 78% of programme curricula.

The relationship between trauma and psychosis is now the subject of much research (Read *et al* 2005). There is emerging evidence of the role of early traumatic experiences in the development of psychosis (Read *et al* 2001) and the experiencing of trauma in response to facets of psychotic experiences and hospitalisation (Harrison & Fowler 2004). 83% of programmes teach trauma explicitly.

Although only 25% of courses constitute full academic programmes (lead to the award of an undergraduate or postgraduate degree in PSI) 78% of programmes include teaching in research methods and critical appraisal.

The topic least likely to feature in curricula is training in supervision skills with only 56% of programmes providing training in the skills required to offer PSI supervision. It seems that there is an assumption that graduates of PSI training courses automatically acquire the values, knowledge and skills to supervise others in this modality.

The role of supervision in PSI education and training is considered further below.

Supervision

Structured supervision of the casework undertaken by students is an essential element of PSI training (Bradshaw 2002). Supervision in early Thorn courses was provided by members of the programme team to small groups of approximately five students (O'Carroll *et al* 2004). While there are clearly advantages to the provision of this internal supervision, in that its quality can be monitored and students receive feedback from the team who will assess their clinical skills, the model has a clear limitation in that supervision is usually terminated when the course ends (Bradshaw 2002). Problems in accessing supervision after training have been identified as contributing to the limited dissemination of behavioural family therapy (Fadden 1997). In order to overcome these barriers and also manage the increasing number of students accessing PSI training, other models of PSI supervision have been proposed. For example, Bradshaw *et al* (2006) describe the use of workplace based triad supervision in addition to supervision provided by the programme team.

The questionnaire distributed asked programme leads to indicate whether supervision was provided internally and/or externally. 78% of the programme leads who gave details of the provision of supervision provide internal supervision during training. 57% of programmes that offer internal supervision also make use of external supervision. 11% of programmes rely upon external supervision only. 17% of programmes do not provide supervision internally or use external supervision.

Programme leads

It could be argued that the qualifications and PSI experience (both past and current) of the programme lead and teaching team are likely to impact upon the quality of PSI training and its outcome. At a minimum, programme leads should have successfully completed training in PSI and have a track record of psychosocial intervention practice, ideally ongoing. For example, lecturer practitioner roles allow lecturers to remain in practice part time while full time university based staff may hold honorary contracts with local mental health service providers to allow continued PSI practice.

The survey asked respondents for the qualifications of the programme lead. The majority of programme leads are qualified mental health nurses although social workers, clinical psychologists and occupational therapists also hold these positions. From the responses given, it was only possible to confirm that 21 out of the 28 programme leads identified had qualifications in PSI. The survey did not ask leads to detail their current clinical practice so it is not possible to determine whether programme leads and members of the teaching teams remain clinically active while providing PSI training.

Service user/carer involvement

The major contribution that those with personal experience of mental health problems and services can bring to PSI and other mental health education and training programmes is clear. The Mental Health in Higher Education Project has recommended a broad strategy of user involvement including the direct delivery of learning and teaching, course/module planning, programme management, the recruitment and selection of students, practice learning, student assessment, course evaluation and participation (Tew *et al* 2004).

The brief nature of the current survey precluded detailed examination of service user and/or carer involvement, however, programme leads were asked whether service users and/or carers were involved in the direct delivery of learning and teaching. 86% of programmes providing information regarding this confirmed service user involvement in teaching.

Assessment of competencies

In a recent scoping review commission by the NIMHE National PSI Implementation Workgroup, Brooker & Brabban (2004) found that participation in PSI training was associated with a number of potential benefits including positive changes in knowledge, attitudes and beliefs as well as the skills and behaviour of mental health practitioners. Furthermore, there is evidence that PSI training has a positive impact on the service users and carers PSI practitioners work with (Brooker et al 1994).

The survey asked programme leads to specify the nature of the assessment used in their programmes. Data regarding assessment were available for 23 programmes. The answers provided were generally brief and it is therefore not possible to comment at length upon assessment of a range of competencies. All accredited courses include at least one assessment. 48% of courses include an assessment of clinical competency as well as knowledge competencies. It is possible that other competencies are assessed within the range of assessment methods adopted but this cannot be confirmed from the responses given. The methods by which clinical competencies are assessed include recording of PSI sessions with service users and carers and a video taped role play interaction with service users/carers. The survey did not reveal the measures used to assess clinical competencies or the thresholds used by individual programmes to indicate clinical competence.

39% (n=11) of courses lead to the award of an undergraduate or postgraduate qualification while the majority of other courses award a number of academic credits.

Discussion

This is the first time that a survey of this kind has been attempted within such a short timescale. It is the most comprehensive review of university accredited PSI training in England conducted to date. While the short aspect of the questionnaire may have enhanced completion rates, the brief nature of the survey precluded the collection of detailed information about individual programmes. For example, the survey revealed only limited data regarding the range of competencies assessed.

The return is likely to be an under representation of current PSI training provision in England in spite of assertive attempts to prompt programme leads to return the questionnaire.

Furthermore eight of the questionnaires that were returned were not completed in full, so the data relating to curriculum, supervision and so on is limited to 18 programmes.

The following discussion therefore is limited to the programmes that returned the questionnaire although the recommendations generated are equally applicable to all accredited PSI training courses across the country.

Discussion of key findings

The survey confirms a substantial investment in PSI education and training in England and that a significant number of funded places are available on PSI education and training programmes. The majority of these places are located in the North of England although it is possible that this artefact reflects differential rates of questionnaire return rather than actual provision.

PSI programmes, generally, follow a generic PSI curriculum. Developments in the literature appear to have been assimilated with an emphasis upon family intervention and cognitive behavioural therapy, consideration of the role of trauma in psychosis and attention to the physical health of this population. Two programmes specifically focus upon family work; the Family Interventions (Research, Skills, Theory) in Psychosis (FIRST) course and the Meriden Behavioural Family Therapy Programme; while one short course does not include family work at all in its curriculum.

More than 2000 therapists have been trained in behavioural family therapy in the West Midlands since 1998. The focus of training goes beyond the knowledge and skills to facilitate family therapy to include those required to ensure widespread dissemination. Interestingly a survey conducted by *Rethink* in 2003 (Pinfold & Corry 2003) found carers in the West Midlands to report significant improvements in service provision and higher levels of

satisfaction with the information received regarding their relative's mental health problem than anywhere else in the UK (Fadden 2006). The findings of the *Rethink* survey suggest that the provision of high quality focused training to a significant number of the workforce can make an impact upon dissemination.

The FIRST programme in the South West combines systemic approaches with psycho-educational family therapy and also attends to the dissemination of PSI. Training takes place in situ to multidisciplinary teams and considers the wider context within which PSI will be practised (Burbach and Stanbridge 2006).

The success of these two programmes supports the inclusion of service level implementation within PSI training, which appears to be integral to many training courses now.

It is not possible to complete a comprehensive audit of the curricula of the PSI programmes which returned the questionnaire against the *Ten Essential Shared Capabilities for Mental Health Practice* (DoH/SCMH/NIMHE 2004). However, the findings of the survey, for example, that neither service user/carer involvement nor BME issues feature universally, suggest that *essential shared capabilities* are not yet core features of all PSI curricula.

It is therefore likely that the assessment of competencies is limited. Almost half of all PSI education and training courses assess clinical competence, the survey did not reveal the rating scales used to assess these competences or the minimum criteria set by different programmes. Consequently it is not possible to map PSI programmes against the level descriptors of the Knowledge and Skills Framework (2004b). There is, however, wide variation in the number of assessments of clinical competencies. Some programmes assess the development of skills at different stages of therapy and across different treatment modalities while others assess skills at one time point only.

Supervision

The survey revealed vast differences in the provision of supervision from none at all in some programmes to a combination of internal and external supervision. The exclusion of supervision from any programme is a matter of concern, particularly as three of the four programmes not providing supervision require students to be working in a psychosocial way with service users/families for the duration of the programme.

Recommendations

In the light of the findings of this survey the NIMHE PSI Implementation Work Group proposes the following recommendations be considered by all stakeholders involved in the commissioning and provision of PSI training, the commissioning and provision of psychosocial interventions for people with psychosis and those involved in the evaluation or inspection of the above. Specific stakeholders include:

- The Healthcare Commission
- Regional Development Centres.
- Workforce Planning and Development agencies.
- Strategic Health Authorities.
- Chief Executives of Mental Health Trusts
- Training Departments within Mental Health Trusts
- Mental Health Service Commissioners.
- Universities accrediting/providing PSI courses.
- Mental Health Service User and Carer organisations.

Recommendations

1 A comprehensive, in depth survey of PSI education and training provision in England is called for. The survey needs to include the mapping of programme outcomes against the *Essential Shared Capabilities* and a typology of PSI skills such as the one presented by Brabban (2001).

2 A core curriculum grounded in good practice, the current evidence/values base and UK mental health policy is required to inform the design of PSI education and training programmes in England. The curriculum should set out the core competencies required of practitioners completing different levels of PSI training.

3 All PSI programmes should be able to demonstrate meaningful service user and carer involvement. This should extend beyond the provision of direct teaching to curriculum design, recruitment and selection of students, practice learning and supervision, student assessment and programme evaluation.

4 All PSI programme leads should have received training in PSI and demonstrate that they remain up to date with developments in this area. Programme leads and those teaching on PSI courses should be practice based or remain clinically active.

5 Clinical supervision should feature in all skills based PSI programmes. Strategies to facilitate access to clinical supervision post training should be integral to this process.

6 This report focuses on accredited training courses in PSI for psychosis, but all stakeholders must attend to the factors that promote the implementation of PSI following training, both within course curriculum and local mental health service provision.

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