Training in Psychosocial Interventions within Early Intervention Teams:
A National Survey

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Foreword

Rhetoric or reality? Early intervention is currently the top government mental health priority. Furthermore the provision of psychosocial interventions is one of the defining qualities of a modern EI service. This makes this review of training for PSI timely and its messages particularly important for those involved in developing the mental health workforce.

Since it first appeared in the NSF adult mental health (1999) EI service provision has steadily grown but less quickly than the government's planned development trajectory. This prompted an EI Recovery Plan (Duncan Selbie Feb 2006) recently reinforced by the NHS Operating framework (section 2.19) and by the Healthcare Commission as a PCT commissioning target 07/08. However it is neither the number of teams nor the number of cases on the books that will tell us whether the policy imperative to develop Early Intervention services in England is really working. What will ultimately define success is the quality of the care provided. And a workforce that sees PSI as a core provision in many ways defines the key ethos and values required to deliver EI effectively. Indeed such trained workers are likely to be culture carriers for the changes that define EI provision from more traditional approaches.

Commissioning is not only driven by policy guidance. Interest has been further stimulated by recent evidence that EI services can offer significant savings when compared to standard care[1]. This evidence combined with that of clinical effectiveness shows that investment early in the patient and family pathway reaps rewards downstream in terms of reduced readmission, lower NHS costs and better patient outcomes. Without an investment in the quality of care provision we will not unlock these rewards, and key to delivering that is to ensure we have a workforce skilled in PSI.

There are encouraging signs in this report of wide accessibility to training by current EI services but also concerns that effecting change in clinical behaviours can still be elusive. What is clear is that a strong base for PSI training has been created but that this requires significant consolidation through greater coordination and investment if we are to meet the workforce development agenda for this national priority.

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Introduction

In 1999 the Department of Health's National Service Framework for Mental Health recommended the prompt assessment of young people at the first sign of a psychotic illness. This was in light of growing evidence that early assessment and treatment could reduce long term levels of morbidity (Singh *et al*, 2005). Subsequently, early intervention services were introduced as policy as part of the NHS Plan (DoH, 2000) with agreed financial support alongside.

The outline and requirements of an early intervention service were later set out in the accompanying Policy Implementation Guide (PIG) (DoH, 2001); this suggested the aims, principles, service structure and skill mix of the proposed teams. Within it proposed that fifty discrete, specialist early intervention services should be in place across England by April 2004, these would cater for a population of approximately one million people each and assess around 150 new cases each year. It recommended that each service would be comprised of three or four teams with a maximum service caseload of 450 (DoH, 2001).

It was recommended that these new Early Intervention services should have two closely related targets:

- Shortening the length of time between the onset of the disorder and treatment (Duration of Untreated Psychosis or DUP). Current guidance is set to a service median of less than three months, with an individual maximum of less than six months (DoH, 2003).

- All young people with psychosis aged 14 – 35 years should receive Early Intervention services for 3 years (DoH, 2003).

Early Intervention is defined as a paradigm of care for young people with a first episode of psychosis. This comprises of early detection of psychosis, reduction in treatment delay and phase specific treatment (during the first three years of illness). Early intervention (EI) teams are highly specialised entities (Marshall *et al,* 2004) that provide effective and appropriate interventions as well as being competent to work sensitively to address the distinct needs and everyday culture of this client group (SCMH, 2003). Skills in psychosocial interventions are seen as essential for practitioners working with individuals with an early psychosis (Craig, 2003). These skills should be utilised and tailored to the needs of young people with a view to facilitating recovery. Interventions used in EI teams tend to be more psychosocially orientated than standard treatments developed for later stages and the more persistently ill subgroups with the disorder (McGorry *et al,* 1996).

It is essential that early intervention services deliver the fundamental components of the approach faithfully, as defined by the evidence, if the intended outcomes are to be achieved. Therefore, practitioners working in early intervention services need to be highly skilled with the values, knowledge, experience and attitudes that are pertinent to working with young people (SCMH, 2003).

Rationale for Study

A Delphi study carried out by Marshall et al in 2004 looking at essential elements of an early intervention service found a strong consensus view amongst experts that CBT and family interventions were indeed "essential" elements of such a service. Prior to this however, a number of reports had pointed to potential deficits in skills amongst practitioners. In 2002 the National Institute for Clinical Excellence (NICE) reported that there was a skills gap relevant to the care of all patients with psychosis. Additionally, a survey carried out by Singh *et al* in 2003 of adult and child & adolescent mental health services found that staff had insufficient skills to deliver appropriate specialist interventions such as cognitive behavioural therapy, family interventions, vocational employment services and dual diagnosis care to individuals presenting with a first episode of psychosis. This was backed up by Craig (2003) who suggested that few staff in Early Intervention services for psychosis were trained and competent to deliver psychosocial interventions. Fadden *et al* (2004) have also suggested that practitioners working in new early psychosis services are often drawn from community teams and other established mental health settings and often lack the confidence and skills when working with young people in the early phase of psychosis.

This view of the skills deficit amongst staff is particularly worrying especially since the Department of Health (2006) suggest that a key ingredient for early intervention services is motivated staff with specialist skills to deliver best quality evidence based practice.

The NIMHE Psychosocial Interventions (PSI) Implementation Workgroup was established in 2002 with the primary aim of increasing the availability of evidence based approaches for psychosis in routine practice, addressing obstacles that can hinder implementation (Brooker & Brabban, 2004). The National Institute of Mental Health (England) (NIMHE) PSI Implementation Workgroup within the Care Services Improvement Partnership (CSIP) is made up of representatives from each NIMHE regional development centre alongside key stakeholders who have an appreciation of psychosocial interventions and associated implementation issues (Brooker & Brabban, 2003). In light of the above reports the group commissioned two surveys to be conducted in 2006, one to identify the level and type of available accredited PSI training available across England and the second to determine the level of PSI training within EI teams. This report outlines the findings of the latter of these two.

Method

Members of the NIMHE PSI group were asked to liaise with Early Intervention representatives at their local Regional Development Centre and to distribute a brief survey style questionnaire to EI teams within that region. The questionnaire asked for details of the number of staff in the team, the composition of the team, the number of practitioners who had undergone some form of accredited PSI training and the training programmes that had been attended.

Teams who had not returned the questionnaire by the deadline were subsequently prompted for a response.

Results

The results of the survey relate to Early Intervention in Psychosis services in operation in England on the 1st April 2006.

Figures gathered from Public Health Observatory (in press) suggest that there are currently 127 teams in existence across England, however, eight of these teams were in development and had not recruited clinical staff by March 2006. Therefore, in reality it appears that 119 EI teams were in operation at the time of the survey. A total of 52 questionnaires were returned from EI services in England for the present survey, representing 44% of the total number of teams. Table 1 shows the number of returns from each of the Regional Development Centres compared to number of teams that are reported to exist in that patch. The highest proportional return was from the South West, where 10 teams provided details of the skills within their services. This represents 85% of the total number of teams in that patch. Only one questionnaire was returned from both the East Midlands and the South East regions.

Table 1: Questionnaires returned from each RDC patch

Region	Frequency	Percentage of Returns	Reported Number of Existing Teams	Percentage of Existing Teams
NEYH	11	21	21	52%
NW	11	21	19	58%
Eastern	4	8	11	36%
E Mids	1	2	9	11%
W Mids	8	15	18	44%
SE	1	2	10	10%
SW	11	21	13	85%
London	5	10	18	28%
Total	**52**	**100.0**	**119**	**44%**

Team Composition

Of the 52 returns that reported on an existing service, the overall number of workers who provided input into each EI service ranged from one to an incredible 84. Removing this high

figure as an outlier, the range drops for one to 31, with a median of 8 practitioners per team and a mode of six.

The percentage of teams with input from the various professional groups is reported in table 2. All but one team had input from the nursing profession and that specific 'team' of one was made up of a single occupational therapist. Over half of the teams that reported back had input from social workers, clinical psychologists and occupational therapists. Three teams had employed assistant psychologists without a qualified clinical psychologist working in the same team. Surprisingly only 46% of EI services had input from support workers and only 42% had specific psychiatry provision.

Table 2: Percentage of Teams having input from each professional group

Profession	Percentage of Team with input specified from each professional group
Nursing	98%
Social Work	60%
Clinical Psychology	56%
Assistant Psychologists	21%
Psychiatry	42%
Occupational Therapy	51%
STR/Support Workers	46%
Employment Workers	10%
CAMHS/Youth Workers	10%
Pharmacists	4%

Training in Psychosocial Interventions within Teams

Out of the 52 questionnaires that were returned from EI services, only two reported that there was no one in their team who had undergone any training in psychosocial interventions (PSI) for psychosis whatsoever; one of these was in the London Region and the other in the North West. Overall, from the questionnaires that were returned it appeared that a relatively high

Table 3: Mean percent of team with some level of PSI training per Region

Region	Number of Returns	Mean Number in the Team	Mean % of Team with PSI training
NEYH	11	15	61%
NW	11	15	46%
Eastern	4	13	26%
E Mids*	1	3	44%
W Mids	8	11	57%
SE*	1	20	55%
SW	11	6	76%
London	5	9	27%

* Regions with only 1 return are shown but have not been assessed as indicative of the region.

percentage of the teams had some form of PSI training. This was highest in the South West Region where on average it appeared that three quarters of staff in EI teams had received training. It should be noted however, that this region also had the lowest average team size, with a mean of only six. Of the four teams that returned questionnaires in the Eastern region (representing 36% of the teams), there were proportionally fewer members of the team who had received PSI training, however, most of those that had, were trained to degree level or higher.

Type of Training

As one would expect, the type of training that team members had undergone, tended to reflect the training programmes that were provided locally. In the North East & Yorkshire Region, where there are currently four HEI PSI programmes available, every EI team employed someone who had done PSI training at either degree level or higher. Similarly, questionnaires returned from teams in the North West showed that a high percentage of teams in this region had benefited from the COPE training programme (Bradshaw *et al,* 2003). Although only five teams returned questionnaires in the Eastern region, the returns showed that each team had members with Thorn (Gamble, 1997) or CBT training within. In the London region, only one of the five teams that responded had no one in the team with any accredited PSI training.

Table 4: Percent of Teams with staff trained in PSI per region

Region	% of Teams with staff with short course training in PSI	% of Teams with staff with degree/ PG Cert/Dip level training in PSI	% of Teams with staff with MSc level training in PSI	% of Teams with staff with specific Family Intervention training	% of Teams with staff with specific CBT training
NEYH	63%	82%	54%	9%	27%
NW	-	82%	64%	-	27%
Eastern	-	75%	25%	25%	50%
E Mids*	-	100%	-	-	-
W Mids	13%	30%	50%	50%	50%
SE*	100%	-	-	-	-
SW	-	45%	-	64%	63%
London	-	80%	-	20%	40%

* Regions with only 1 return are shown but have not been assessed as indicative of the region.

Table four shows that proportionally more EI teams in the South West regions had team members with specific CBT training (63%) as opposed to generic PSI training. The South West and West Midlands regions also host specific training programmes in Family Interventions for psychosis: this may explain why there were a higher percentage of EI teams in these two areas with staff who had undergone this type of training.

Discussion

The results of the EI service survey should be interpreted with some caution. It is impossible to determine whether those questionnaires that were returned were representative of EI services across England in general, or were skewed in a particular direction. It is possible that teams who placed a stronger emphasis on PSI training were more likely to complete the questionnaire, which could have led to a positive bias in the results. In addition, although the results provide evidence of the level of PSI training in EI teams across England, this does not necessarily correlate with the level at which psychosocial interventions are being *implemented* or the level of competence at which this is being done. Several studies have shown that PSI training in itself does not guarantee a change in practice (Kavanagh *et al,* 1993; Fadden, 1997; Brooker *et al*, 2003). A number of barriers within a service can lead to problems with implementation, including case load size, competing demands, lack of supervision etc, in addition low levels of confidence and competence to deliver interventions can be a hindrance. Brooker and Brabban (2004) found that although there was strong evidence to show that staff did develop skills during PSI training, the level of skill development was disappointing. Particular studies looking at the development of Cognitive Behavioural Therapy (CBT) skills during PSI training revealed that these had often been developed to only a moderate level during training and that trainees were not implementing key elements of the therapeutic approach (Devane *et al,* 1998; Repper, 1998).

The Mental Health Policy Implementation Guide (PIG) (Department of Health, 2001) makes it clear that the ethos of an Early Intervention Team should be truly bio-psychosocial in nature. Assessment should go wider than a mental state examination and should incorporate social, psychological, familial and occupational aspects. The PIG also makes it explicit that a full range of evidence based interventions should be available to service users and their carers, including CBT and Family Interventions. It is promising therefore that of the 49 teams that did respond, only two teams were without anyone in the team who had undergone some form of PSI training. This figure is independent of the input provided by clinical psychologists who possess knowledge and skills in evidence based psychological therapies. Fifty seven percent of the teams that responded to the current survey had a psychologist working as part of the team and this is possibly an under-estimate since the Public Health Observatory (Tiffin & Glover 2007) survey found that 73% of teams had dedicated input from a Clinical Psychologist. Unfortunately, owing to a lack of available data on levels of training in other mental health teams it is impossible to compare levels of training in EI teams with other functional and community mental health teams.

In terms of the type of PSI training received, the survey showed that this tended to reflect what was available locally. In the North of the country, where there has been continued investment in postgraduate training in PSI (incorporating both CBT & Family Interventions) from local Workforce Development Directorates and their predecessors, over 80% of teams

had staff who had undertaken this. In these regions over half of the team members had received some form of PSI training. The investment in specific family intervention (FI) training in the South West and the West Midlands regions was also evident from the returns. Fifty percent of teams in the West Midlands and 64% of teams in the South West had staff who had attended specific FI training (as opposed to generic PSI programmes). Interestingly these same two regions also had a high percentage of teams with staff who had attended CBT training. Training in CBT in these regions ranged from in service courses to masters level programmes.

Less than 30% of teams returned the survey in the Eastern and London regions, however, in those teams that did, once again the majority of teams reported that they had team members with PSI training at undergraduate level or higher. Fifty percent of the teams in the Eastern region and 63% of teams in London also had staff within who had trained in CBT.

As would be expected, it appears that practitioners make use of training that is available locally. Where there has been an investment in generic PSI programmes, staff tended to receive generic training that incorporates both individual CBT as well as family interventions. Where specific 'PSI' training programmes are not available, then it appears that staff will attend specific CBT or Family Intervention Programmes. Although it could be argued that some training is better than none, providing only focused CBT or FI training programmes (as opposed to generic PSI training) may lead to problems if teams focus on one type of intervention rather than both. Brooker *et al* (2003) found that staff trained in CBT were more likely to prioritise work with individuals above work with families, this was opposed to PSI trained staff who recognised both types of intervention as equally important.

The high level of PSI related training within EI services that was found in this survey could have been predicted to some degree. A number of studies looking at the implementation of PSI and specifically Family Intervention skills post training (Fadden, 1997; Brooker *et al*, 2003 Bailey, 2003) have highlighted a number of 'barriers and boosters' that hinder or help this. These include having access to availability of the appropriate types of families/clients, having sufficient time without competing demands, integration of the work with caseloads or other responsibilities, lack of supervision and support, plus a critical mass of trained staff within the team. It would seem that the nature of EI services provides many of the pre-requisites for effective implementation. Case loads are capped, the work is centred on helping individuals with psychosis and their families (the focus of PSI training), supervision and peer support is more likely to be available where a number of the team have undergone training, and the philosophy of EI services is in keeping with a psychosocial approach. For this reason, staff who have undergone PSI training and who have felt unable to implement their skills in other settings are often attracted to EI services. Here they feel they can work alongside like-minded individuals and can utilise their skills.

In light of this and due to the design of the brief survey style questionnaire it is therefore difficult to draw accurate conclusions to explain why some EI teams have no or few PSI trained practitioners. However, some assumptions may be drawn based on existing evidence from the literature.

The tight Government timescale for the establishment of early intervention teams neglected to take into account the lack of sufficient experts in the field able to lead such developments locally (Newstead & Kelly 2003). The rushing of such service development in order to receive funding may have been a reason for the lack of appropriately skilled practitioners being recruited to the teams.

Despite the shift towards PSI being available routinely since the early 1990's (Brooker 2001), it could be argued that there are still insufficient practitioners trained in these skills across the entire mental health service system. Craig (2003) suggests that there are few staff trained and competent in PSI to deliver these interventions. This in turn would have an impact on the successful recruitment of PSI trained practitioners to EI teams. The survey may be reflecting this trend from a national perspective.

It may be reasonable to assume that the EI teams in areas of the country where there is a lack of access to a local PSI training programme may have struggled to recruit appropriate numbers of PSI trained practitioners. There is a need to map PSI course training provision against the regional EI PSI skills provision identified in this study to see if the regions reporting low percentages of PSI skilled Practitioners mirrors a low PSI training availability in those particular regions.

Families can play a significant role in the recovery of their relative following the onset of a first episode of psychosis (Addington *et al* 2005). Recognising this, the PIG (DoH 2001) stipulates that Family Intervention (FI) should be provided to families as part of the overall early intervention package (Fadden 2006). It is therefore promising to see that high numbers of teams have staff who have received FI training via a specific FI training programme or through generic PSI training. Nevertheless, it is now recognised that some aspects of traditional FI training may be unhelpful with families of young people experiencing a first episode psychosis (Slade *et al,* 2003). This is due to conventional family interventions being developed for families of service users who have lived with the impact of psychosis over a longer term. Therefore, there is currently a need for HEIs and alternative trainers to develop and provide specific Family Intervention training that is more suited to the needs of clients and their carers using EI services. Additionally, it is important that staff who have received all forms of PSI training continue to update their knowledge and skills to ensure their practice is in line with the current evidence base.

In conclusion, the ever increasing evidence base suggests that PSI approaches are an important part of the package of care offered to individuals with a First Episode of Psychosis and their families (Edwards *et al,* 2005). Overall the current survey showed that the majority of services do appear to recognise the importance of this approach and have appropriately trained members of staff within local EI teams. Nevertheless, there is still room for improvement. The skill mix of local EI teams should be examined and monitored regularly to ensure teams have the capability to deliver high quality, evidence based interventions. In addition training providers and commissioners need to work collaboratively to ensure appropriate levels and types of PSI training are available locally for those who require it. Finally, staff training and development incorporating clinical supervision must be prioritised locally to ensure EI services are delivering all that was promised.

Recommendations

Based on the above study the following recommendations need to be considered:

- There needs to be national agreement of the skill mix of EI teams, incorporating core competencies of all EI workers as well as specialist skills that should be available within EI services.

- Accredited training programmes should be available locally to train staff in the skills required to deliver appropriate high quality, evidence and values based practices. These should be supported by local Workforce Development Directorates to ensure the consistency of available training nationally and to reduce the risk of skill dilution.

- EI Service planners and managers should consider it mandatory to recruit PSI skilled practitioners into EI teams with the knowledge and ability to deliver individualised, psychosocial packages of care and to provide clinical supervision to others in the team.

- An overall national assessment of EI services is required to determine the fidelity of service provision in relation to EI PIG guidance (DoH, 2001).

- National targets should incorporate the types of intervention available within EI services as well as outcomes.

- More first episode specific Family Intervention training programmes such as that offered by Meriden in the West Midlands need to be developed and delivered.

- EI practitioners must keep up to date with the latest research in the field and engage in on going training and supervision to enhance their skills and competencies.

- Further research needs to be carried out to determine the level of PSI training and competencies found in other mental health teams, including assertive outreach, crisis intervention and community mental health teams.

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