Early Intervention in Psychosis Services

The role Clinical Psychologists can play
Acknowledgements

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This important briefing paper addresses both the rationale for and importance of early intervention and the key potential position for Clinical Psychology and psychological interventions within one of the newest areas of mental health service development, early intervention services. Written by Clinical Psychologists with considerable expertise in the early intervention field, this offers an authoritative opinion on the unique and critical role of Clinical Psychology in the development, delivery and evaluation of early intervention services. It is an informed guide which will assist commissioners and service managers to understand the importance of employing Clinical Psychologists within early intervention services for their unique expertise and contribution to service development, team functioning and core clinical interventions. Equally importantly, it encourages Early Intervention Team Managers and Clinical Psychologists considering or developing psychological roles within early intervention services to maximise the potency and value of their unique specialist psychological skills in ensuring the psychological needs of first episode clients and their families are met appropriately.

The paper commences with a succinct overview of early intervention policy, features and service models. The main body addresses the varied potential areas of input for Clinical Psychologists in health promotion, service development and research as well as direct and indirect clinical roles. It also emphasises the importance of psychological formulation and intervention for young people with first episode psychosis and their families. In particular, how psychological formulation and models can influence the culture of early intervention teams to ensure they are psychologically focussed and inform the range and nature of clinical interventions that are offered. Several key issues are addressed including the role of psychologists in awareness raising and early detection of psychosis, the potential value and limitations of employing Clinical Psychologists in generic case management roles and the value of Clinical Psychology expertise and training distinct from specialist skills of team colleagues from other professional backgrounds who may also be trained in the delivery of psychosocial and family interventions. These potential roles are discussed in the context of resource limitations, best use of specialist psychological expertise and training and the overall skill mix within an early intervention team.

Early intervention service development and delivery offers both challenges and opportunities for Clinical Psychologists. It is an area of mental health service development where psychologists have already begun to make their mark and where psychological expertise and contributions can be successfully deployed. I hope this may encourage and support the employment and proliferation of Clinical Psychologists within early intervention services and establish a psychological model firmly within the heart of early intervention team culture and service delivery.

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Executive Summary

This briefing paper is intended for professional staff, service managers, commissioners of services (in health and social care) and providers of community facilities for young people, who are involved in the provision or planning of Early Intervention in Psychosis (EIP) services. It aims to clarify the position of clinical psychology in relation to EIP services and describes the appropriate role, function and organisation of clinical psychologists working within EIP services.

- Clinical psychology supports the need for EIP services for young people and adults experiencing severe mental health difficulties for the first time. EIP services should seek both to support the personal integrity of service users and their families and secure their inclusion in society.

- A diverse multi-disciplinary specialist team is the optimal model of service delivery in EIP services. The team should work in close collaboration with all other agencies that have responsibility for the well-being, sustenance and development of young people and early adults especially joint work with CAMHS.

- EIP services are based on a bio-psychosocial model, and the use of a formulation driven approach. This increase in emphasis on psychological approaches over more traditional approaches makes a clinical psychologist an essential part of the core team. The role should include supporting the team in maintaining a more engaging and accessible ethos and identity than in traditional services.

- For clinical psychologists to make the maximum contribution to the service they need to be based within the core team, but arrangements must be in place to ensure they retain their professional links with psychologists in other parts of the wider service.

- Clinical psychologists bring an unique breadth and depth of theory-based knowledge about psychological interventions to EIP services. Other team members trained specifically in psychosocial interventions should complement, not replace, clinical psychologists.

- The potential range and complexity of the clinical psychologist’s role suggests an experienced and autonomous practitioner (Consultant) should be recruited especially where they are the only psychologist.

- EIP is an evolving area and clinical psychologists have a key role and the necessary skills to contribute to both research and service development.

- Service users and families should be fully involved in service development, management and evaluation.
Section 1: Background

1.1 The Policy Context

The National Service Framework for Mental Health (DoH, 1999) emphasised the need for current practice to take account of the evidence that early assessment and treatment of first episode psychosis can reduce levels of morbidity. The NHS National Plan (DoH, 2000) reinforced this commitment by setting a target to establish 50 specialist EIP services across England by 2004 for young people aged between 14 and 35 to be available to them within the first three years of their experience of psychosis. The Mental Health Policy Implementation Guide on EIP services (DoH, 2001) provided a detailed template for the development of this provision. More recent guidance contained in the Sainsbury Centre for Mental Health document A Window of Opportunity (SCMH, 2003) and an expert briefing published by NIMHE (NIMHE, 2003) build on these commitments. The importance of early intervention is prioritised in the Early Psychosis Declaration (2004) (formerly the Newcastle Declaration) jointly issued by the World Health Organisation and the International Early Psychosis Association (WHO & IEPA, 2004). The wider position of clinical psychology in relation to the needs of people who experience psychosis and other serious mental health problems can be found in the British Psychological Society publication Recent Advances in Understanding Mental Illness (Kinderman & Cooke, 2000).

1.2 The Distinctiveness of EIP Services

The key features of EIP services are:

- The early detection and assessment of frank psychosis.
- The early allocation of a key worker to enhance engagement and rapport with service users and their family. Ideally the key-worker remains in service user contact throughout the critical first three years.
- An assertive outreach model of service which supports the input of a multi-disciplinary group of mental health professionals and education, employment, housing and social participation specialists.
- A comprehensive and collaborative assessment plan, driven by the needs and preferences of the service user and their family and friends is established to clarify the nature and levels of services to be provided.
- The management of acute psychosis includes using low dose atypical antipsychotic medication, relapse prevention planning and the structured implementation of a formulation driven approach to the understanding of psychosocial issues.
- Family and friends are actively involved in the engagement, assessment, treatment and recovery process.
- Clear social inclusion strategies are deployed at the whole systems level to facilitate service users’ needs to retain their involvement in or rapidly re-engage in further education, employment, independent housing and social participation as part of their recovery.
The service users’ fundamental needs, e.g. physical health, housing, finances, and practical support are fully addressed to ensure that quality of life is maximised.

Assessment and the treatment of co-occurring problems such as depression, suicidality, social anxiety, PTSD, etc., are addressed at the same time as assistance with psychosis is provided.

Positive images of young people with experience of psychosis are promoted.

A flexible approach is taken to retaining EIP services beyond the three year critical period.

Close links are established with local community mental health teams and other relevant services to ensure the longer term support of those service users who require it beyond the critical period.

The service should be operated using an integrated multi-disciplinary approach.

1.3 Models of Service Delivery

The Mental Health Policy Implementation Guide on EIP services (DoH, 2001) and A Window of Opportunity (SCMH, 2003) describe models of EIP service delivery. Broadly speaking, three models have been discussed in the UK. Their advantages and disadvantages are related to their variability of fidelity from the optimal model outlined in The Mental Health Policy Implementation Guide. We describe each and the place of clinical psychology within them.

1.3.1 Community Mental Health Team (CMHT) model

This model describes the use of ring-fenced early intervention time, via designated workers or via each worker in the CMHT having a smaller than usual caseload enabling them to spend more intensive working time with people experiencing their first episode of psychosis. The advantages here are minimal expenditure and close existing links with other local provision. The disadvantages include likely difficulties in developing and sustaining an appropriate ethos which requires a consistent assertive outreach approach. This can be easily undermined in CMHTs by time leaking into competing service tasks that reduce quality time for the target population, and the practical problem of ensuring sufficient in-depth work is undertaken with the target population to allow the full development of highly specialist EIP skills. Where CMHTs provide specialist services to people with a psychosis this model has some attractions but it remains the case that in many parts of the UK CMHTs are only able to provide very limited access to clinical psychologists with specialist experience in working with psychosis, although this is improving.

1.3.2. Hub and Spoke model

The hub contains specialist workers which may be a small specialist EIP team in an area of high levels of first instance psychosis, with spokes into areas of lower incidence. The ‘spokes’ are formed of workers embedded in CMHTs supported by their opposite numbers in the ‘hub’. The ‘spokes’ could also be embedded in other services such as primary care. The advantages of this model again include good local connections with existing services and some highly specialist ring-fenced EIP specialists to support fidelity to an optimal model of service. This may
also be a useful model in many rural areas. The disadvantages are similar to those of the CMHT model where there is high demand competing for limited resources, at least within the ‘spokes’. The chances of maintaining the core functions of an optimal service are again likely to be compromised. In this model, specialist clinical psychology input would need to form part of the hub, with the other specialist staff. A specialist post in the ‘hub’ is most likely to ensure the recruitment of a clinical psychologist with specialist expertise in working with people experiencing psychosis.

1.3.3 Specialist Team

This is the model proposed in *The Mental Health Policy Implementation Guide*. The advantages are fidelity to the ideal model of service because of the specialist teams’ capacity to control the implementation of all the EIP core functions. This model also makes it more likely that the required specialist EIP skills are quickly and efficiently acquired in an appropriate service ethos. The disadvantages include the additional cost and the potential impact on the rest of the mental health system as there may be a risk of ‘asset stripping’ existing services when recruiting. In this model, clinical psychology would operate as a core member of the team, having a similar role to a clinical psychologist based in the hub of the ‘hub and spoke’ model. Historically, other roles known to be carried out effectively by clinical psychologists in this model have included team leader. A post in this kind of team would be an efficient use of a clinical psychologist and is likely to be attractive to staff, thereby reducing recruitment difficulties.

1.4 Service of Choice

A specialist team is probably the optimal service delivery model at this point in time in most settings. In rural settings and other areas with a low incidence of first onset psychosis the ‘hub and spoke’ model may be more appropriate. Other innovative and socially inclusive service configurations, such as teams embedded in generic youth services (e.g. Insight in Plymouth), should also be considered. Attending to the structural aspects of service design in models like this can reduce perceived stigma and have been shown to enhance access and social integration.

1.4.1 The EIP Staff Team

For EIP to work at its best an integrated multi-disciplinary team with an appropriate mix of expertise is necessary to deliver a high quality and effective service. All team members bring three sets of attributes to their work: the core functions of their profession, specialist training in specific interventions, and different life experiences and social background (Watts & Bennett, 1983). There should be a mix of gender, sexuality, and ethnicity within the staff team. There should also be the fullest possible service user and family involvement in service development and evaluation.

Both *The Mental Health Policy Implementation Guide* (DoH, 2001) and *A Window of Opportunity* (SCMH, 2001) recommend that clinical psychology should be an essential part of any EIP service whatever the service model chosen. The exact nature of the work of clinical psychologists, as with other professions, should depend on service users’ assessed needs and wishes and on the availability of complementary work undertaken by other team members.
Section 2: The Core Functions and Specialist Skills of Clinical Psychologists

The Faculty recommends services take account of the following potential roles and functions that clinical psychologists can undertake.

2.1 Primary Prevention

The early detection of psychosis is a complex clinical task requiring the experience and specialist knowledge of a range of professional staff. The accurate recognition of the prodromal phase of psychosis requires the empirical assessment of a combination of neuropsychological and psychopathological variables (Larsen et al., 2001). Clinical psychology training prepares its practitioners to address these issues but in the context of a thorough grounding in normal human development, in particular the crucial issues for this population regarding the transition from adolescence into adulthood. In particular it is important but difficult to accurately distinguish an initial psychotic episode from a presentation of some other non-psychotic adolescent process. Clinical psychologists are, therefore, well placed to provide useful insights into the EIP team’s determination of the presence or absence of a psychotic process and can assist in discovering the likely antecedents and consequences of service users’ distress whatever its cause.

2.2 Care Co-ordination

The Mental Health Policy Implementation Guide (DoH, 2001) suggests that care co-ordinators within an EIP service may include a clinical psychologist. It also states that the team should provide all the interventions required in the optimal model. This is to some extent a contradiction in terms when it comes to clinical psychology. Although we accept that a personal appreciation of the skills, role pressures and constraints of being a care co-ordinator are valuable assets, employing a clinical psychologist as a whole-time care co-ordinator is not an effective use of their specialist skills. Clinical psychologists should only act as care co-ordinators where there is a clear case for a psychological approach to this activity.

To enable clinical psychologists to provide early detection assessments, specialist therapy, clinical supervision, case consultancy and group work, their activities as care co-ordinators should be kept within clear limits. Exactly how each clinical psychologist should apportion their time depends on a variety of factors, which should take account of the prioritised needs of the team and its skill mix, the prior experience and range of expertise of the psychologist concerned, their training needs and whether they are full or part-time. In most other ways clinical psychologists should be full team members and may take part in appropriate out of hours activities such as first assessments, crisis intervention, etc. However, where it has proved possible to only employ a clinical psychologist part-time, services should give very careful consideration to using their limited time only in pursuit of their specialist assessment, intervention and research skills.
2.3 Direct Clinical Work

A major strength of clinical psychology is its systematic approach to the development of skills in the six core competencies of the therapy process: engagement, assessment, formulation, intervention, relapse prevention, and evaluation. The systematic application of these core competencies persists whatever therapeutic orientation a psychologist may take. The role of psychological and neuropsychological assessment is a crucial starting point for service users and their families to exercise the choice to engage in psychological interventions that are known to be effective in reducing the distress of people with a variety of serious mental health problems. Individually tailored psychological interventions can help people cope with psychotic experiences such as hearing voices and distressing thoughts and beliefs and:

- understand their difficulties in a broader life context and, therefore, learn to cope more effectively;
- contribute to enabling people to give up self-defeating behaviours such as drug and alcohol misuse;
- reduce self-harm and attempted suicide.

In addition to these very personal matters, psychological interventions can also:

- facilitate informed choice about treatment and other aspects of service users’ lives;
- facilitate relatives’ understanding and improve family relationships;
- help identify relapse signatures and therefore maximise effective support thus preventing relapse;
- support the development of strategies to reduce social disability consequent on the discrimination and prejudice often experienced by people with mental health difficulties.

The foundation of psychological interventions carried out by clinical psychologists is the use of a psychological formulation that draws on the evidence base of ‘academic psychology’ combined with a therapeutic model of choice derived from an up to date understanding of the relevant literature moderated by clinical experience.

Clinical psychologists have a breadth of psychological knowledge to draw on in their work. This includes a wide range of models of psychological difficulties and a range of associated therapies.

A clinical psychologist in an early intervention team can draw on this range of possibilities singly or in combination, to work in individually tailored ways with service users who may present with a complex mix of mental health issues. These may include, amongst others, childhood physical, emotional and sexual abuse, trauma, adjustment problems, disability and co-occurring diagnoses. In addition to clinical psychologists working in specialist teams, their colleagues working in child and adolescent mental health services will also be well placed to provide advice, training and consultation for staff working with an EIP service’s younger clients with a psychosis.
Clinical psychologists seek a collaborative relationship with the service user to enable them to make useful sense of their past and current experiences, to normalise their ordinary experience and engender hope. *The NICE Guidelines on Schizophrenia* (NICE, 2002) require access for all service users in receipt of a diagnosis of schizophrenia to six months of CBT and/or Family interventions as the minimum standard.

### 2.4 Indirect Clinical Work

The most important contribution clinical psychologists can make to the key role of EIP teams is in helping to develop the formulation of service users’ difficulties. To provide this input for all EIP team service users they need to be fully integrated into the team structure. Clinical psychologists also have a role in consultancy to individual team members and the team as a whole, for example, in promoting the psychological understanding and management of challenging behaviour and in helping to develop team protocols on such matters. Clinical psychologists may also be called upon to harness team strengths using insights gained from a psychodynamic or systemic model to enable teams to reflect on and understand their own working processes. These processes have been shown to have both positive and negative effects on the effectiveness of communications between staff and their service users. Clinical psychologists also have skills that should be used in the training and supervision of other professional groups. Clinical psychologists will in turn benefit from the consultation, supervision and training provided by their colleagues in other disciplines.

### 2.5 Research and Evaluation

Early intervention research and evaluation is still in its infancy. To date, most research has come from Australia, Scandinavia and Canada. This research is promising but preliminary. There is both the need and an opportunity for further research to be conducted in the UK. Clinical psychologists have the necessary skills to conduct both quantitative, and increasingly, qualitative research and to be involved in the evaluation of service outcomes.

It is a requirement within the EIP Policy Implementation Guide that all early intervention services conduct audits to evaluate clinical and social outcomes. A number of substantial research departments within England have established records of psychological research and innovation in the field of psychosis. These have had a considerable impact on the adoption of CBT, family work and relapse prevention in the NHS. The further development of new treatments is a vital component of the early intervention paradigm and clinical psychologists should be supported to take responsibility for and in some instances occupy leadership roles in establishing local research capacity in this field.

### 2.6 Service Development

The optimal EIP service model places a considerable emphasis on psychosocial factors in mental health. Clinical psychologists have often sought to be major contributors to the development of EIP services to ensure that this core focus is both fully developed and maintained in hard pressed clinical practice. For example, work in Birmingham, Hull, and Northumberland have led the field until now. Clinical psychologists in these services have historically succeeded in playing a key role in supporting the setting up and leadership of diverse multi-disciplinary provision. It is clear from this experience that they should be included in local steering groups working towards setting up further early intervention services in the future.
2.7 Summary

The inclusion of clinical psychology as a core EIP service profession is an essential
element of the EIP model of choice, whatever its configuration. The particular
importance of including clinical psychology within EIP services stems from
training and expertise in operating within a formulation driven approach, a core
feature of the optimal EIP model. This coupled with their pre-qualification
training experience across the lifespan which includes an understanding of the
psychosocial issues involved in the transition from adolescence into adulthood
place psychologists in an unique position to contribute to the assessment and
treatment functions of EIP services. Their grounding in CBT across the full
spectrum of adult mental health difficulties coupled with further training in the
use of CBT for psychosis and, increasingly, training in family therapy, place
clinical psychology at the heart of a well functioning and diverse multi-
disciplinary team. The Psychosis and Complex Mental Health Faculty supports a
number of professional networks (Assertive Outreach, In-Patient Services, etc.),
one of which is for clinical psychologists working in EIP. The network is
developing psychosocial capacity in EIP through collaboration and the
dissemination of best practice.¹

¹ The national network of psychologists working in EIP services can be contacted by e-mailing Julia Renton at julia.renton@
blct.nhs.uk or via the Faculty pages of the BPS/DCP website (www.bps.org.uk/dcp/sub-branch-websites.cfm).
Section 3: Psychosocial Intervention (PSI) Practitioners and Clinical Psychologists

The relative positions of PSI practitioners and clinical psychologists working together in EIP services can sometimes require clarification. Professional staff with formal PSI training are an asset to EIP services. Their contribution, at the level of the interventions used, can overlap with those of clinical psychologists. As professional groups, however, they offer different but complementary provision.

PSI practitioners are trained in three aspects of care: case management, which is about models of service intervention, family interventions which may be based on a behavioural or cognitive behavioural model, and individual interventions which are based on a cognitive model. Most PSI practitioners will also have an existing professional training, which is usually gained over three years. PSI training is post-qualification and usually part-time, one or two days a week for up to two years. This training is generally regarded as an introduction to or a foundation in psychological work using a single therapeutic model (CBT) with a specific service user group (people with schizophrenia and their families). The training generally does not qualify practitioners to conduct CBT for psychosis in its broadest sense. Expert supervision and further training in CBT are usually recommended following such training.

The training model for clinical psychologists is three years full-time at undergraduate level often followed by two years or more as an assistant, followed by three years full-time post-graduate doctoral training. The training covers mental health issues across whole lifespan including a wide range of therapeutic work relevant to EIP including interventions with children and young people, adults and older adults as well as people with learning disabilities, using a range of therapeutic models based on a variety of theoretical orientations and evidence bases. This breadth and depth is designed to ensure clinical psychologists can generate innovative, individually tailored interventions for people experiencing a psychosis and also effectively address their co-occurring problems and very complex presentations.

The optimal composition of an EIP team is diverse and multi-disciplinary and should, therefore, include both clinical psychologists and trained PSI practitioners drawn from a range of professional backgrounds.

Section 4: Conclusions

EIP services are an exciting and innovative approach to working with people experiencing first onset psychosis. Clinical psychology should be a central part of EIP services whatever model of organisation is followed. Many of the core functions of optimal EIP services utilise clinical psychology skills, most notably a formulation driven approach and psychologically based interventions. Clinical psychologists should be core team members, should exercise an appropriate level of influence and provide support for the wider psychosocial ethos of EIP. Clinical psychologists are committed to EIP services and have a track record of leading and advocating for a diverse multi-disciplinary approach.
References


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