



Practice Development

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An evaluation of education and implementation of psychosocial interventions within one UK mental healthcare trust

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An evaluation of education and implementation of psychosocial interventions within one UK mental healthcare trust

Psychosocial interventions (PSI), though recommended in the NICE guidelines for schizophrenia and bipolar affective disorder, are not routinely available to people with a serious mental illness in the UK. Education and training initiatives to equip mental health professionals with skills in PSI have grown over the last decade; yet the literature indicates serious problems in implementation of PSI in routine service provision. This paper examines on a local level the factors which support and limit the education and practice of PSI in one UK mental healthcare trust. It reports on a survey of trainees and their managers which aims to evaluate the impact of a PSI training programme and practice development strategy on staff, managers and service provision. The key findings are: a high rate of implementation of PSI by PSI-trained staff in the Trust; a strong association between PSI training and career progression for staff; and the support mechanisms which are most effective in the education and implementation of PSI. The paper concludes that certain measures and support mechanisms have facilitated the successful implementation of PSI with positive outcomes for staff and service provision. Further recommendations are made identifying measures which facilitate the implementation of PSI through an integrated education and practice development strategy owned by all stakeholders.

Keywords: evidence-based practice, practice development, PSI implementation, psychosocial interventions training/education, THORN, workforce development issues

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Practice development

Introduction

Background of psychosocial interventions education for mental health practitioners

Access to psychosocial interventions (PSI) by people who have a diagnosis of severe and enduring mental illness is now widely recognized as integral to effective and responsive mental health services (NICE 2002, Layard 2004, Rethink 2006). PSI is a term used to describe collaborative work with service users which integrates a range of medical, social and psychological evidence-based interventions delivered within the recovery perspective (Brooker & Brabban 2004, NIMHE 2005). Collaborative assessment, cognitive-behavioural therapy (CBT) for psychosis, structured family intervention, medication management and management of symptoms and relapses are core elements of PSI. Government guidelines recommend that PSI, in particular CBT and family work, should be routinely implemented by services across different clinical settings, for instance, in acute inpatient units and in establishing Early Interventions in Psychosis Services (EIPS) (DoH 1999, 2001, 2002a,b, 2004a,b, 2006, NICE 2002). Such interventions have been shown to be effective in optimizing treatment concordance, improving clinical outcomes in service users, reducing relapse rates and the impact of mental health problems, thus promoting recovery (e.g. Gray *et al.* 2001, Mueser *et al.* 2002, NICE 2002, Pilling *et al.* 2002). The routine clinical provision of PSI results in a higher standard of care through evidence-based effective treatments and improved clinical, social and personal outcomes for service users. Successful implementation of PSI requires a workforce who are appropriately trained and supported.

Implementation of PSI – challenges and obstacles

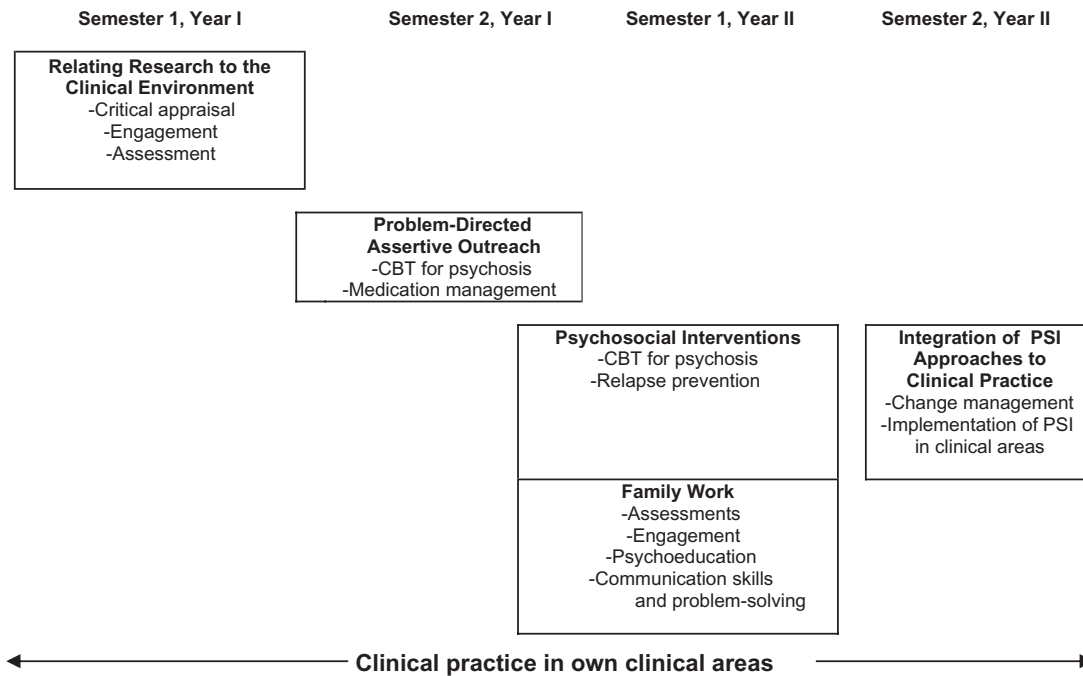
The evidence base indicating the clinical effectiveness of PSI has grown increasingly strong over the last 20 years resulting in the recommendation that such interventions should be routinely implemented (NICE 2002). However, there has been simultaneous attention in the literature to the difficulties and challenges associated with the incorporation of PSI into routine mental health service provision (e.g. Fadden 1997, Brooker & Brabban 2003, Forrest & Masters 2004, Forrest *et al.* 2004). The challenges are multifactorial and are primarily con-

cerned with the workforce development and education (Brooker *et al.* 2002, Brooker & Brabban 2004, Forrest *et al.* 2004); clinical and managerial leadership (Cook 2001, McCann & Bowers 2005); and the impact of limited resources on service development in the context of increasing demands (McCann & Bowers 2005). Mental health services are currently challenged by policy, service user and professional drives. These range from initiatives to establish EIPS with practitioners trained in PSI (Brabban & Kelly 2006) to integration of the principles of the recovery approach and evidence-based practice into all levels of service delivery (e.g. Repper & Perkins 2003, Kelly & Gamble 2005, NIMHE 2005, DoH 2006). However, only a small proportion of the workforce is trained in such interventions (Layard 2004), and it is likely that only a percentage of these are practising their specialist skills (Brooker & Brabban 2004).

PSI training in Berkshire Healthcare Foundation Trust

The Berkshire Healthcare Foundation Trust (this will be referred to as Trust in this paper) has commissioned the local Thames Valley BSc(Hons)/Higher Education Diploma Psychosocial Interventions for Psychosis programme (THORN-accredited, this will be referred to as PSI programme) with support from the Thames Valley Strategic Health Authority (SHA) since 2002. In order to address the established difficulties in transferring PSI knowledge and skills from classroom to clinical practice, Thames Valley PSI programme has instigated mechanisms to enhance PSI practice development and address the recognized barriers to implementation. First, the PSI Programme Leader/Education and Practice Lead was appointed jointly by the Trust and its partnership university, Thames Valley University, with a specific remit not only to lead the PSI programme, but also to promote PSI practice development initiatives. Second, over the past few years, there has been significant investment in the integration of PSI in the Trust. The Trust has adopted a strategic approach to address implementation barriers and ensure integration of PSI into routine clinical practice. This includes synchronizing education, training and practice development initiatives in order to develop a workforce fit for purpose (Sin *et al.* 2003, Gamble *et al.* 2005).

To date, there have been four intakes (three graduate cohorts, one current) with a total of 33

**Figure 1**

Structure of psychosocial interventions for psychosis programme. CBT, cognitive-behavioural therapy; PSI, psychosocial interventions

trainees. The programme is recognized not only for its value as an academically rigorous post-qualifying programme, but also for training mental health practitioners who act as change-agents in the implementation of evidence-based practice into routine service provisions (DoH 1999, Brooker & Brabban 2003). The Thames Valley PSI programme has a strong emphasis on practice development in front-line services. Trainees practise the evidence-based skills and knowledge with service users and carers throughout the training programme with intensive practice support and clinical supervision. Trainees are also required to produce an integration project through which an aspect of evidence-based practice is implemented in their own clinical area tailored to the local needs of service development, service users' and carers' views. Figure 1 outlines the PSI programme structure incorporating the five compulsory modules.

Aims of the evaluative study

As the Thames Valley PSI programme is now entering its fifth intake, the evaluative study was commissioned in order to evaluate its impact to date on staff, managers and service provision and thus plan the further development of services and the PSI

programme itself. The study was designed to evaluate the impact of PSI training and practice development initiatives on clinical service development, support perceived by the trainees and the extent of infiltration of skills and knowledge back to the clinical service areas.

Methodology

Two questionnaires (one for PSI trainees, one for their managers) were developed to collate both quantitative and qualitative data. The questions addressed barriers to PSI implementation identified in the rapidly growing body of literature in the field (e.g. Brooker & Brabban 2004, Forrest *et al.* 2004) in addition to local issues concerning the PSI practice development strategies.

Both questionnaires covered the following:

- demographic details;
- local PSI practice development strategies;
- support in relation to the PSI programme;
- experience of barriers to PSI implementation in practice.

The trainees' questionnaires covered in addition:

- employment and promotion;
- nature and level of PSI implementation;

- impact of PSI training on professional practice and development.

The managers' questionnaires covered in addition:

- impact of staff PSI training on the team/service.

All samples of trainees and their respective managers were identified and sent the appropriate questionnaire from the Trust Workforce Development Department. The sample was identified and approached from March to April 2006, with an initial 4 weeks for response. A reminder via email was sent to all from the Trust Workforce Development Department towards late April, with another 3 weeks for late response.

Summary of demographics of participants

Out of the four previous and current intakes, 16 managers who have supported a total of 26 trainees were identified. Students who withdrew from the programme have been excluded from the study (seven over the 4-year duration).

In total, 11 out of 16 managers (69%) responded and completed questionnaires. Of the 11 respondents, five were male and six were female, with an average age of 43 years and an age range of 37 to 50 years. The majority described their own ethnicity as white, one as Asian, one as black African and one respondent did not specify their ethnicity. Most of the managers are employed by the Trust with a background in mental health nursing, though there were also two occupational therapists and another one of unspecified professional background. One manager was of social work background employed by Social Services within the integrated services. There were also managers in joint or tripartite appointment between the Trust, the Local Borough and the Primary Care Trusts. The range of their experience as a manager was between less than 2 years to just under 10 years, with the majority having worked as a manager for the last 4 years. Nearly 70% of the respondent managers have supported more than one staff member in undertaking the PSI programme, with one manager having supported six staff members.

In total, 15 out of 26 trainees responded (58%). The average age of the respondents is 40 years, with an age range from 25 to 54 years. Female trainee-respondents outnumbered male by a ratio of 2:1. The majority were of white Caucasian ethnic background, with one trainee of black African ethnicity

and one of mixed race ethnicity. Ten trainees were of a mental health nurse background, three were social workers and two occupational therapists. The range of post-qualifying experiences was between just over 1 year to beyond 20 years. All staff from the Trust undertook the PSI programme at the post-qualifying honours degree level. Out of the sample of 26 trainees, 14 had completed the PSI programme, six were due to complete in 3 months, and six were halfway through the programme.

Survey findings

Employment and promotion

A high rate of promotion was found among those trainees who completed the survey. Three did not respond to this question. Ten of the 15 (67%) respondents obtained a new position, seven of whom received a promotion. The number reporting no change may reflect the fact that some of the respondents are current students on the programme. Eight (of 12 respondents to this question, 67%) respondents felt there was a strong association between their change of employment and PSI training. Four (33%) felt the association between training and career progression was weak-moderate.

PSI practice and activity

The trainees report on PSI activities indicated that the highest participation rates were in clinical practice. In total, 86% of respondents reported provision of CBT and medication management, and 93% practised structured collaborative assessments and family interventions. In total, 80% of respondents were involved in the development of new services such as early intervention and home treatment teams. Activities relating to teaching, supervision and research were practised by roughly a third of the respondents. Further details on the trainees' PSI activities are summarized in Table 1.

PSI practice development strategy

The Trust's practice development strategy found to be most helpful by trainees was clinical supervision (10 out of 15 respondents, 67%). Access to PSI clinical specialists who are trained, experienced and active in PSI practice was positively rated by trainees (65%). Policies to support PSI implementation, for example, the policy of Family Work for Psycho-

Table 1
PSI activities reported by trainees

Activity	Results
Teaching on PSI programme	34% (n = 5)
Teaching in short PSI training	27% (n = 4)
Acting as a PSI supervisor	40% (n = 6)
Active involvement in a research project/publication of project	34% (n = 5)
Delivering structured family interventions using the psychoeducational model (individual/groups)	93% (n = 14)
Providing CBT for clients who have problems with psychotic symptoms	86% (n = 13)
Helping clients with medication management (use of evidence-based tools is expected)	86% (n = 13)
Performing systematic assessments on clients and carers using a battery of evidence-based tools	93% (n = 14)
Involvement in developing new services e.g. EIPS, HTT	80% (n = 12)
Others	
Involved in establishing a hearing voices group	13% (n = 2)
Involved in clinical care pathway for rehabilitation service	7% (n = 1)
Involved in dual diagnosis service	7% (n = 1)

CBT, cognitive-behavioural therapy; EIPS, Early Interventions in Psychosis Services; HTT, home treatment team; PSI, psychosocial interventions.

sis Service, were considered instrumental in supporting practice, addressing operational issues such as release of staff time and continuous clinical supervision for advanced practice (65%). The PSI Practice Development Network, a forum in which all PSI-trained staff come together to pool skills, ideas and resources to facilitate implementation, was also considered helpful (60%). Involvement in training and research in PSI fields was not rated as significant by trainees (50%).

PSI programme recruitment and support mechanisms

Managers found communication from the programme leader and recommendation from others to be the most helpful recruitment method and most influential in their decision to support their staff in undertaking PSI training. Training brochures and email advertisement of the course was considered less significant. Managers also reported that replacement money to backfill the PSI trainees' time away from the clinical team and communication from the programme leader were the most helpful support systems attached to the PSI programme.

The support systems in place for trainees on the PSI programme were on the whole highly rated as being helpful. The trainees, in contrast to the managers, did not view the replacement money as helpful. They found the practice and development roles of the programme leader to be the most helpful support system. The trainees ranked the support mechanisms as follows:

1. programme leader support in both academic and clinical settings (80%);
2. peer support (67%);
3. PSI Practice Day (60%);
4. clinical supervision (60%);
5. PSI events (53%);
6. PSI practice development network (53%);
7. replacement money (33%).

Impact on clinical environment and professional development

In regard to the perceived impact of PSI training on individual clinical practice and service provision in a wider sense, all trainees reported that they gained a significant level of confidence and competence. A total of 73% reported collaborative working with both service users and families/carers and 86% the implementation of evidence-based practice adopting the recovery philosophy as highly significant changes in their routine clinical practice. The use of a structured approach and the recovery perspective were also seen as important developments in practice as a result of PSI training.

Managers identified the most significant changes in professional practice of trainees being increased inclusion and collaboration with service users and carers and use of evidence-based tools in routine clinical services. A total of 64% managers also observed in PSI trainees increased confidence and competence, especially over dissemination of knowledge and skills to others in the multidisciplinary teams and increased collaborative working with both service users and carers. In total, 75% managers felt that there were benefits to the team and service.

Barriers and obstacles

Managers found that workload pressure and staff shortage were the most problematic barriers in the implementation of PSI. Managers acknowledged that their understanding of the nature and clinical significance of PSI training and implementation

Table 2
Comparative ranking of barriers

Managers		Trainees
Time from service to undertake interventions	1	Integration with caseload or other responsibilities
Scope for trained staff to use their knowledge and skills	2	Time from service to undertake interventions
Integration with caseload or other responsibilities	3	Time taken to complete assessment measures
Sufficient resources available to undertake the interventions (e.g. caseload size, access to assessment and intervention materials)	4	Scope for trained staff to use their knowledge and skills
Time needed before results are apparent	5	Sufficient resources available to undertake the interventions (e.g. caseload size, access to assessment and intervention materials)
Need for long-term commitment to client or family	6	Access to consultation or supervision
Support for the training at highest levels of the organization	7	Availability of TOIL or overtime for appointments
Time taken to complete assessment measures	7	Support for the training at highest levels of the organization
Access to consultation or supervision	8	Need for long-term commitment to client or family
Availability of TOIL or overtime for appointments	9	Time needed before results are apparent

TOIL, time off in lieu.

enabled them to support the trainees. The extent to which managers felt they could facilitate trainees to practise PSI after training was limited by staffing issues and workload pressures across the service. Trainees resumed the same role and function upon course completion, as no procedures are in place to adjust their job description to reflect their new skills and knowledge. The only significant barrier to PSI practice identified by the trainees was that of workload and time. Integration of structured interventions into routine case work was hindered by the demands of high caseloads in addition to other responsibilities. Common obstacles identified in the literature, such as lack of managerial support, the theory-practice gap or lack of availability of tools (Repper & Brooker 2002), were not found to be barriers to practice by the majority of trainees. A comparative ranking of the common obstacles in implementing PSI identified by managers and trainees is presented in Table 2.

Discussion

While the results of this study have much in common with the published literature on PSI training and implementation, this analysis of local factors influencing PSI implementation has produced additional significant findings in three main areas:

- higher level of implementation of PSI practice by trainees;
- a strong association between PSI training and career progression;
- perceived effectiveness of support mechanisms integral to the PSI education and practice.

Given that the local PSI programme (in Berkshire Healthcare Trust) has been running for only 4 years, the findings on the strong association between PSI training and employment and promotion are particularly encouraging. The survey findings clearly indicated that the trainees perceived PSI training as beneficial to their clinical and professional development and career progression. These may reflect the fact that PSI programmes have been designed to equip staff with specific knowledge and skills fundamental to service modernization (Brooker & Brabban 2004). PSI skills are particularly relevant to recent service development initiatives, for example, implementation of the NICE Guidelines with reference to the provision of CBT for psychosis and family work in routine care (NICE 2002) and the establishment of EIPS (DoH 2001, Brabban & Kelly 2006). The nature of the promotions identified tends to reflect the above. New services in the Trust such as EIPS and Family Work Services are largely staffed by PSI graduates whose profile of skills and knowledge satisfy the job descriptions readily. Increased confidence and competence among PSI graduates identified by both the trainees and the managers in this survey [see the fifth section (Impact on clinical environment and professional development) of Survey findings] may also explain the career progression.

The implementation rate of evidence-based collaborative interventions in the Trust is higher than the picture generally projected by published literature in which, despite the proven benefits of PSI training and practice, implementation is problematic (e.g. Baguley *et al.* 2000, Brooker *et al.* 2003, Brooker & Brabban 2004). For example, the majority of studies of post-training implementation of

family interventions in routine clinical practice show implementation rate of between 18% (Kavanagh *et al.* 1993) and 50% (Baguley *et al.* 2000). The factors that may explain the high level of implementation of PSI practice reported in Berkshire (93% reporting delivery of family interventions, 86% practising CBT) are examined below.

Psychosocial interventions trainees evaluated positively the Trust's PSI practice development strategy on the whole. Of the various support measures, the allocation of a PSI-trained clinical supervisor to facilitate safe and effective skills development throughout the training was found to be most helpful (Sin *et al.* 2003). High level of implementation is also associated with a tripartite structure involving regular communications between the trainees, the managers and the Programme Leader.

On a service level, trainees also identified that having the relevant service policies in place, for example, the Family Work for Psychosis policy (Berkshire Healthcare Trust, updated 2005, unpublished policy adapted from Kelly & Newstead 2004) were key factors in facilitating implementation. PSI interventions such as the use of evidence-based tools for systematic outcome-orientated assessment, medication management and relapse prevention have been incorporated into the policies and procedures of EIPS and Family Work Service. Policies and protocols such as these operationalize evidence-based practice in routine service provision.

Learning through clinical practice and clinical skills training is integral to the PSI programme. The Programme Leader is jointly appointed between the university and the Trust to oversee both the education and practice of PSI (Sin *et al.* 2003). The survey findings seem to validate this arrangement. Both managers and trainees identified the clinical and practice development roles of the Programme Leader as significant in the support, recruitment and retention of PSI-trained staff as well as raising the prominence of PSI in the clinical areas within the Trust. Peer support is also highly regarded among the PSI trainees across the Trust. The different perception by PSI trainees and managers with regard to other support measures is worthy of note. For instance, trainees did not rate the replacement money which was funded by the SHA to backfill their time directly to their team as useful while managers attached great value to this. This discrepancy may be due to different perceptions of how such replacement money should be utilized in teams and how far it relieves workload. PSI events, such as

workshops for managers and supervisors, were not perceived to be useful by either managers or PSI staff, possibly due to difficulties in attendance. Overall, managers and trainees seem to rate individual communication and liaison more highly.

Limitations of the study

The results of the survey may not be generalized to other PSI training programmes or regions, as they reflect a unique interaction of regional demographic need, clinical environment, personnel and funding arrangements. The comparative stability of the workforce in Berkshire may impact favourably on implementation rate, for example. Limitations of this study and possible areas of bias are acknowledged. The surveys reflect the views of respondents who may have returned the survey as they are more interested in PSI. Thus, there may be a positive bias in the findings reported. The responses of the past and current students were not analysed separately, and this too may account for a positive bias in PSI clinical activities. The data collated in regard to PSI activities are general rather than specific in nature and the findings are somewhat compromised in terms of the depth of qualitative data, a problem inherent to surveys (Burns & Grove 2005). One of the authors of this study (JS) is the Programme Leader of the PSI programme in the period about which this report is written. Steps have been taken to minimise any bias which may arise from her involvement with the programme. Approach to participants and analysis of findings were conducted through third parties, i.e. PSI specialist outside the Trust and the Programme (ES) and the Trust Workforce Development Department Administrator.

Recommendations and conclusions

The following recommendations identify measures which this study indicates are more likely to increase both the implementation of PSI and access to the identified benefits of PSI for services, practitioners and service users.

Service and strategic level

- Policies and protocols contribute to the successful implementation of PSI in practice, as seen for example in Berkshire Family Work Service. The development of policies to ensure protected time to practise CBT may increase

the rate to which this is practised by PSI-trained staff. The incorporation of assessment tools into routine assessment procedures (e.g. EIPS) could be replicated in other areas such as CMHTs and acute wards.

- Increased support for PSI graduates is needed to aid dissemination of skills to team and wider service.
- Managerial support from service and strategic levels is required to address the identified barriers of implementation, particularly in ensuring the protected caseloads and staffing levels.
- Psychosocial interventions practice and training should be emphasized in service and staff development. Requirements for PSI-trained staff with key skills and knowledge in evidence-based interventions should be incorporated into job descriptions, particularly in new services and in staff appraisals when professional development needs are identified.
- Replacement money should be properly utilized to relieve workload pressures in teams where staffing is affected by attendance on PSI training. Some centralized measures may be required to pool money to address backfill arrangements more effectively.

PSI training

- The PSI programme support structures identified as most helpful – peer support, the protected clinical practice day and clinical supervision arrangements – should be incorporated within the programme delivery.
- The provision of a robust system of supervision post-PSI training for all graduates is crucial to sustain active practice.
- Regular, formal and personal communication between the Programme Leader, managers and trainees using a tripartite structure supports successful implementation.
- Joint reviews of local training needs by the Trust, local stakeholders and the university, in line with the commissioning process, ensures the congruency of local need and training provision. The content and levels of PSI programme may need to be diversified to encourage wider access. This may involve modular provision and training specific to certain interventions (e.g. family work, medication management) or clinical areas (e.g. acute inpatient, forensic, EIPS).

- Greater dissemination of core PSI knowledge and values to the whole workforce is required to foster clinical environments which support implementation. PSI-trained practitioners are more likely to practise PSI skills in a clinical environment which shares the core values, understanding and basic skills of PSI.

Research and evaluation of PSI programme

- Psychosocial interventions training and implementation strategies need to integrate collaborative participation of service users and carers at every stage, particularly in the planning of services, dissemination of the recovery approach and the delivery of training.
- An essential area for further research is evaluating the impact of PSI training and implementation from the service user and carer perspectives.
- Evidence-based interventions should be audited within the integrated governance framework. Regular clinical audits will provide detailed information of the extent of implementation.
- Follow-up qualitative study targeting a smaller sample of trainees and managers should be considered in order to collate more in-depth information on some of the key findings.

References

- Baguley I., Butterworth A., Fahy K., *et al.* (2000) Bringing into clinical practice skills shown to be effective in research settings. A follow up of Thorn training in psychosocial interventions for psychosis. In: *Psychosis – Psychological Approaches and Their Effectiveness*, Ch. 5 (eds Martindale, B., Bateman, A., Crowe, M., *et al.*), pp. 96–119. Gaskell, London.
- Brabban A. & Kelly M. (2006) *Training in Psychosocial Interventions Within Early Intervention Teams: A National Survey*. NIMHE/CSIP: National PSI Implementation Group, Birmingham.
- Brooker C. & Brabban A. (2003) Implementing evidence-based practice for people who experience psychosis: towards a strategic approach. *Mental Health Review* 8, 30–33.
- Brooker C. & Brabban A. (2004) *Measured Success: A Scoping Review of Evaluated Psychosocial Interventions Training for Work for People with Serious Mental Health Problems*. NIMHE/Trent WDC, Trent.
- Brooker C., Gournay K., O'Halloran P., *et al.* (2002) Mapping training to support the implementation of the

- National Service Framework for Mental Health. *Journal of Mental Health* 11, 103–116.
- Brooker C., Saul C., Robinson J., *et al.* (2003) Is training in psychosocial interventions worthwhile? Report of a psychosocial intervention trainee follow-up study. *International Journal of Nursing Studies* 40, 731–747.
- Burns N. & Grove S. (2005) *The Practice of Nursing Research – Conduct, Critique, and Utilization*, 5th edn. Elsevier Saunders, St Louis, MO.
- Cook M.J. (2001) The attributes of effective clinical leaders. *Nursing Standard* 15, 34–37.
- Department of Health (1999) *Mental Health National Service Framework*. DoH, London.
- Department of Health (2001) *The Mental Health Policy Implementation Guide*. DoH, London.
- Department of Health (2002a) *Developing Services for Carers and Families of People with Mental Illness*. DoH, London.
- Department of Health (2002b) *Mental Health Policy Implementation Guide: Adult Acute Inpatient Care Provision*. DoH, London.
- Department of Health (2004a) *The 10 Essential Shared Capabilities – A Framework for the Whole of the Mental Health Workforce*. DoH, London.
- Department of Health (2004b) *Organising and Delivering Psychological Therapies*. DoH, London.
- Department of Health (2006) *From Values to Action: the Chief Nursing Officer's Review of Mental Health Nursing*. DoH, London.
- Fadden G. (1997) Implementation of family interventions in routine clinical practice following staff training programmes: a major cause for concern. *Journal of Mental Health* 6, 599–612.
- Forrest S. & Masters H. (2004) Evaluating the impact of training in psychosocial interventions: a stakeholder approach to evaluation – Part I. *Journal of Psychiatric and Mental Health Nursing* 11, 194–201.
- Forrest S. & Masters H., Milne V. (2004) Evaluating the impact of training in psychosocial interventions: a stakeholder approach to evaluation – Part II: *Journal of Psychiatric and Mental Health Nursing* 11, 202–212.
- Gamble C., Sin J. & Moone N. (2005) *A PSI Implementation Tale: Lessons Learnt from National Perspectives and Local Experiences*. Conference presentation – National THORN Steering Group 'Implementing Psychosocial Interventions – Challenges and Developments' Conference, 8–9 September 2005, London.
- Gray R., Wykes T., Parr A.M., *et al.* (2001) The use of outcome measures to evaluate the efficacy and tolerability of antipsychotic medication: a comparison of THORN graduate and CPN practice. *Journal of Psychiatric and Mental Health Nursing* 8, 191–196.
- Kavanagh D., Clark D., Manicavasagar V., *et al.* (1993) Application of cognitive behavioural family intervention for schizophrenia in multi-disciplinary teams: what can the matter be? *Australian Psychologist* 28, 181–188.
- Kelly M. & Gamble C. (2005) Exploring the concept of recovery in schizophrenia. *Journal of Psychiatric and Mental Health Nursing* 12, 245–255.
- Kelly M. & Newstead L. (2004) Family intervention in routine practice: it is possible! *Journal of Psychiatric and Mental Health Nursing* 11, 64–72.
- Layard R. (2004) *Mental Health: Britain's Biggest Health Problem*. Seminar at the Cabinet Office – 20 January 2005. Prime Minister's Strategy Unity, London. Available at: http://strategy.gov.uk/seminars/mental_health/index.asp (accessed 28 September 2005).
- McCann E. & Bowers L. (2005) Training in cognitive behavioural interventions on acute psychiatric inpatient wards. *Journal of Psychiatric and Mental Health Nursing* 12, 215–223.
- Mueser K.T., Corrigan P.W., Hilton D.W., *et al.* (2002) Illness management and recovery: a review of research. *Psychiatric Services* 53, 1272–1284.
- National Institute for Clinical Excellence (NICE) (2002). *Schizophrenia: Core Interventions in the Treatment and Management of Schizophrenia in Primary and Secondary Care*. NICE, London.
- NIMHE (2005) *NIMHE Guiding Statement on Recovery*. Available at: <http://www.psychminded.co.uk/news/news2005/feb05/nimherecovstatement.pdf> (accessed 12 May 2006).
- Pilling S., Bebbington P., Kuipers E., *et al.* (2002) Psychological treatments in schizophrenia. I. Meta-analysis of family intervention and cognitive behaviour therapy. *Psychological Medicine* 32, 763–782.
- Repper D. & Brooker C. (2002) *Avoiding the Wash-Out: Developing the Organisational Context to Increase the Uptake of Evidence-Based Practice for Psychosis*. Northern Centre for Mental Health Publication Series, Durham.
- Repper J. & Perkins R. (2003) *Social Inclusion and Recovery – A Model for Mental Health Practice*. Bailliere Tindall, Edinburgh.
- Rethink (2006) *Rethink Policy Statement 23: Psychological Treatments for People with a Severe Mental Illness*. Available at: http://www.rethink.org/how_we_can_help/campaigning_for_change/rethink_policy_documents/treatment.html (accessed 22 September 2006).
- Sin J., Moone N. & Wellman N. (2003) Practice development: incorporating psycho-educational family and carers work into routine clinical practice. *Journal of Psychiatric and Mental Health Nursing* 10, 730–734.