Early Intervention in the Real World

Evaluation of a professional development training program for mental health clinicians specialising in early psychosis.

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Abstract

Aims: The Early Psychosis Prevention and Intervention Centre (EPPIC) Statewide Services (ESW) team provides training for multidisciplinary clinicians that specialise in early psychosis across the State of Victoria, Australia. The aim of this paper is to describe the four phase approach utilised by ESW to prepare for and deliver workshops, to report on participants' ratings of the ESW workshops, and to make recommendations for other trainers of early psychosis clinicians.

Methods: Between March 2009 and September 2014, ESW provided 85 training workshops that had a strong focus on evidence-based approaches and international guidelines, and utilised clinical examples of early psychosis interventions. At the conclusion of each workshop, participants were asked to complete a questionnaire that comprised qualitative and quantitative elements. These assessed perceived trainer knowledge, learning, interactivity and specific topic feedback. The focus of this paper will be on describing the quantitative data resulting from these questionnaires.

Results:

A total of 1708 clinicians provided feedback on the 85 workshops. There was a high level of compliance, with 83.0% of workshop participants completing the questionnaires. Feedback was positive across all areas, with the two areas that were most highly endorsed being that presenters 'appeared to know their subject matter well' (endorsed by 98.4% of participants) and that 'topics were explained well' (endorsed by 96.8% of participants).

Conclusions:

Training for early psychosis clinicians that focusses on core clinical topics, is well planned, incorporates feedback from previous training, and is based on adult learning principles, is likely to be effective and well received by early psychosis clinicians.

Introduction

The expansion of specialist early intervention services for first episode psychosis (FEP) in the last two decades has led to the need for increased capacity of the mental health workforce to provide interventions for this population¹. A number of guidelines have been developed that define aspects of care that are considered essential to achieving good clinical and functional outcomes for people experiencing early psychosis²⁻⁶. Within these guidelines, a number of key components have been identified that are recommended for implementation within early intervention services. These include a strong focus on engagement and assessment, and the inclusion of case formulation, psychological therapies, pharmacotherapy and biological interventions, family work, awareness of cultural issues, and case management skills. Staff training and support regarding implementation of these components has been identified as critical to the ongoing provision of safe, effective and high quality care in early psychosis⁷⁻¹⁰.

The following paper describes a research project undertaken to examine participant feedback across a number of early psychosis training workshops facilitated by EPPIC Statewide Services (ESW). It will focus on how workshops were developed and presented, and conclude with recommendations regarding training early psychosis clinicians.

Methods

Setting:

EPPIC Statewide Services (ESW) is a Victorian Government funded service that provides free training and secondary consultation to multidisciplinary early psychosis clinicians working in public mental health within the state of Victoria, Australia. Victoria is the second most populous state in Australia, having almost 6 million people¹¹, over 900,000 of whom are aged 12-24¹².

A key aspect of the work undertaken by ESW is a programme of professional development workshops advertised through an annual training calendar. Information about the training programme is distributed online and in poster format to multiple agencies across the state that work with youth experiencing mental health difficulties.

In addition to the calendar programme, ESW have also provided specialised, tailored training to youth early psychosis services (YEPS) in both regional and metropolitan Victoria, interstate, and internationally. Training has been provided both at the ESW geographic base in Parkville, Melbourne, and in multiple regional settings.

This project was funded within the existing ESW budget, and did not require external ethical approval due to being a quality improvement exercise with entirely de-identified data.

Participants:

Participants were multidisciplinary early psychosis clinicians who attended ESW workshops. Attendance rates by profession, gender and other demographic factors will be described later.

Workshops:

Workshops were developed and facilitated by the ESW team, which is multidisciplinary, comprising four principal trainers, (comprising 2.0 FTE) from Occupational Therapy, Nursing and Clinical Psychology backgrounds. All ESW trainers are senior mental health clinicians with at least 10 years of clinical experience in mental health, and all had previously worked clinically for at least 3 years in specialist early psychosis services. All trainers either had additional qualifications in staff education and training (i.e. Certificate IV in Training and Assessment), or were supervised by staff with this qualification.

Training was designed in accordance with national and international early psychosis clinical practice guidelines, updated according to the research evidence base, and developed in consultation with local subject matter experts and service users. An overview of workshop topics and the synthesis between learning objectives for each workshop and related practice guidelines is illustrated in Table 1.

ESW Trainers were involved both in the design and delivery of the training. For a minority of workshops (e.g..training on comorbid Borderline Personality Disorder, Family Work, Biology, and Neuroscience), local subject matter experts were enlisted to present material, with facilitation by ESW trainers.

-----Table 1 around here-----

The ESW team designed and facilitated workshops with a strong focus on adult learning principles¹³. This model suggests that trainers should generally consider participants as

motivated and self directed, as ‘inquiring’ rather than passive recipients, and should focus on relevant, ‘real world’ based content¹³⁻¹⁵. A further recognition of adult learning theory is that workshops were designed to accommodate a variety of learning styles and included visual, verbal, and experiential components¹⁶. Specifically, this would include audio-visual presentations with handout notes and references, video or audio clips, use of clinical case examples (often drawing from participants’ experience), and service-user question and answer sessions. Experiential learning was facilitated through role play and other exercises to practice core competencies (e.g. attempting differing approaches to modify delusions, practising engagement micro-skills, having a ‘voice hearing’ experience, practising using questionnaires, checklists or templates, and undertaking physical health measures such as waist circumference and blood pressure).

The ‘Four Phases’ of Workshop Development

Development and delivery of the workshops typically occurred in 4 Phases (see Figure 1).

-----Figure 1 around here-----

In order to direct learning material to participants’ needs, Phase 1 (Planning and training need analysis) involved initial consultation to determine the number of participants, and their professional background. As noted above, the majority of workshops were delivered as part of the annual calendar programme. The needs analysis for the annual calendar included review of available practice guidelines, feedback from an electronic survey disseminated to early psychosis clinicians registered with ESW, and review of feedback provided by

workshop participants at the end of each workshop. However, ESW also provided individually tailored training to YEPS, requiring more extensive needs analysis. Agencies would often initially appear unclear regarding the specifics of their needs, and it was not unusual to receive general requests for “staff training”. Therefore, Phase 1 involved consultation to determine details such as; staff demographics, professional background and experience level, level of participant awareness of the topic(s), and awareness of other training that staff had attended.

Burke and Hutchins¹⁷ report a connection between increased transfer of learning, and training aligned with higher level (e.g., departmental and organisational) strategic direction.

Therefore, Phase 1 also involved explicit discussion of organisational structure and reported values of the recipient service. Trainers found it useful to discuss with the key stakeholders any organisational issues or challenges that may have been relevant to participants’ learning. These could include service restructuring, role changes or redundancies, and job security.

Phase 1 would culminate in drafting an initial set of learning objectives designed to meet the identified organisational needs.

Phase 2 of planning involved the design and development of the workshop, including identifying key topics, and allocation of approximate times to each sub-topic. Modifications would be made to allow a final draft which, in the case of external training, would be signed off by the trainers and key stakeholders within the organisation receiving the training.

In addition to developing actual content, phase 2 included consideration of other factors that could influence participant learning, such as planning relevant warm up exercises, scheduling breaks, topic order, and ensuring that time was allocated for feedback and regular recapping of material.

Where feedback was available from previous workshops related to the same topic, this was also incorporated into the training needs analysis, and workshop content would be modified accordingly.

Phase 2 planning also involved specific logistical details around provision of each workshop, with a checklist being developed to assist trainers with this¹⁸. This list was divided into timeframes, each comprising a number of pragmatic issues around training delivery, including; development of PowerPoint presentations (including sourcing research papers, images or video clips to highlight specific messages); identifying appropriate experiential exercises; selecting and disseminating pre-reading or resources for participants; testing of audiovisual equipment (e.g., laptop, speakers, internet connection); identifying available Information Technology support; ascertaining stationery requirements (e.g., marker pens, paper, blu tack, whiteboard, sign-in sheet, specialised feedback forms, name-tags, and certificates); preparing handouts; monitoring participant numbers and demographics; and training room set-up (including, where possible, awareness of participant seating arrangements, room size for break out/ small group work, and catering).

Phase 3 involved the delivery of the workshops. Workshops were generally developed and presented by two trainers, which allowed trainers to alternate between delivering sections of the material, and monitoring participants. This included overseeing participants' attention, and allowed opportunities to elaborate on any points if there was deemed to be any confusion, or truncate sections if participants clearly had a good early grasp of the material.

In addition to presenting the material in accordance with adult learning principles, it also involved ensuring that the physical environment in which training was to occur was as conducive as possible to participant learning. This would involve trainers confirming that the room size was appropriate, that seating and layout were modified for the specific workshop (e.g. to allow for pair or group work) and that heating and lighting were appropriate (which at times involved modifying the colour background of slides for rooms that were especially light or dark) .

The final phase, phase 4 involved evaluation. This consisted of reviewing the completed participant feedback forms at the end of each workshop. In addition, trainers would complete a post workshop debrief at the conclusion of each training event. This debrief included discussing the content of feedback forms, and a review of group dynamics, participant engagement, and identification of barriers to learning.

Evaluation:

Evaluation of the effectiveness of training programs is considered important for quality assurance in health care¹⁹. One of the most helpful and widely used frameworks within which to assess training is the model developed by Kirkpatrick²⁰⁻²⁵. This model proposes that training can be evaluated across four different domains, namely: reaction, learning, behaviour, and results. The focus of this paper equates to level 1 of Kirkpatrick's model, namely, evaluating clinician's reactions to the training. Of specific interest was overall perceived usefulness of the training²⁶ and assessment of the trainer, presentation style, content, and utility of topic-specific subsections.

In order to assess the training, a workshop feedback form was developed (available on request), comprising a standardised format of seven key sections that included both quantitative and qualitative measures. Participants were asked to highlight their preferred responses on a five-point Likert scale ranging from 1 ('none of the time') to 5 ('all of the time') or 1 ('strongly disagree') to 5 ('strongly agree'), with space being allocated for comments.

Domains that were evaluated by the questionnaire included adequacy and appropriateness of the following components:

1. Presentation (e.g., 'things have been explained well in sessions' and 'new ideas were introduced at a rate that allows you to understand them')
2. Interactivity (e.g., 'the interactive components were an effective way to learn' and 'the interactive activities are well related to the sessions topics')
3. Trainer/facilitator (e.g., (the trainer) '...seems to know their subject matter well' and '...presents information in an interesting way')

4. Participants' learning (e.g., 'I have developed skills needed in my professional role' and 'I have gained a good understanding of the subject matter'))
5. Resources (i.e., 'the prescribed pre-session reading was useful')
6. Topics (i.e., participants were asked to rate the usefulness of specific components of each workshop from 1 'not useful' to 5 'very useful')
7. Overall comments

Questionnaires were provided to all workshop participants at the conclusion of each workshop. Participants were encouraged to complete these, with trainers allowing sufficient time for this task, and emphasising that feedback was considered valuable.

From May 2012, the questionnaires also asked participants to record demographic details, comprising; gender, age, professional background, years of experience working in mental health, years of experience working specifically in early psychosis, and percentage time spent undertaking clinical work.

Results

A total of 85 workshops were conducted between March 2009 and September 2014, with feedback forms being completed by 1708 participants. Full participant numbers were available for 76 workshops with 1529 feedback forms received from 1842 confirmed attendees (83.0%). There was a mean number of 24.4 participants per workshop ($SD=6.7$).

Workshop participants.

As noted in the 'Evaluation' section, demographic characteristics were available for participants from May 2012. Data on gender was available for 869 participants, with the majority identifying as female (79.2%, $n=688$).

Data regarding professional background was available for 989 participants, with five main professional groups being represented (see Table 2). Miscellaneous professions included 'counsellor', 'early psychosis clinician', 'youth worker', 'music therapist', and 'mental health practitioner'.

-----Table 2 around here-----

Participant Feedback

The feedback from participants was positive in all domains (Table 3). As some workshops required a more didactic teaching style due to the nature of the material being presented (e.g., those relating to medication guidelines), feedback regarding interactivity received the lowest score, with 87.2% of participants describing that they felt the interactive style was an effective way to learn ‘all of the time’ or ‘most of the time’. The highest-rated areas were those of perceived trainer expertise i.e. ‘The trainer seems to know their subject matter well’, and presentation clarity i.e. ‘things were explained well’, which were endorsed as being met ‘all of the time’ or ‘most of the time’ by 98.4% and 96.8% of participants respectively.

-----Table 3 around here-----

At the conclusion of the training, the majority of participants believed that they had a good understanding of the subject (95.1% agreed/strongly agreed, $M=4.4$, $SD=0.6$, $min=2$, $max=5$), were more motivated with the topic (94.8% agreed/strongly agreed, $M=4.5$, $SD=0.6$, $min=2$, $max=5$), had developed an interest in the topic (91.7% agreed/strongly agreed, $M=4.4$, $SD=0.7$, $min=2$, $max=5$), and had developed the skills needed in their professional roles (89.7% agreed/strongly agreed, $M=4.3$, $SD=0.7$, $min=1$, $max=5$).

Discussion

This research indicates that the training provided to participants by ESW was well regarded across the six key domains. Specifically, the vast majority of participants endorsed the statement that trainers appeared knowledgeable about the material, had clear reasons for including particular topics, and explained key concepts well. We believe that this is largely

related to the emphasis that the trainers placed on meticulously planning the workshops, having an adult learning principle orientation that accounted for individual learning styles, utilising clinical and practical examples from participants' and trainers' own experience, and on incorporating recommendations from previous feedback.

Further experience has led the ESW trainers to allow considerable time at allocated points during training for feedback and revision regarding whether a particular topic required more or less emphasis. Small quizzes were utilised regularly to consolidate knowledge.

Another key foci at the conclusion of training was allowing significant time for discussion around implementation of material learned. Achieving genuine practice change can be challenging and requires more than simply attending teaching events. Therefore ESW training would often include discussion to identify potential barriers either at an individual or service level, and what modifications might be required in order for new techniques, interventions, or models to be adopted by a particular individual or service.

Strengths, limitations and Conclusions

As noted above, a limitation of this research is its primary focus on Kirkpatrick's level 1 training evaluation, that of participant reaction. Therefore, in recognition of the importance of level 2 assessment (participant learning), since October 2013, ESW feedback forms have also included questions assessing participants' pre- and post-workshop knowledge of topic specifics. This has comprised multiple choice and short answer. The authors are currently

writing an evaluation of this knowledge acquisition, and will submit a further paper on this, and on qualitative findings from the research.

Ideally, future research would also include Kirkpatrick's level 3 and 4 evaluation, relating to clinicians' behavioural change in response to training, and the organisational impact of the training. Inclusion of self reported confidence measures has been undertaken in intervention training for eating disorders^{27,28} and depression²⁹, and could be a valuable addition to FEP training evaluation. Measuring organisational change, however, remains challenging within a public mental health setting, and would require significant financial resources and organisational support. Furthermore, it may expose clinical staff and young people experiencing psychosis to higher levels of monitoring, which could impact on confidentiality and engagement with services.

The first significant strength of this research is its size. The authors are unaware of any similarly powered study assessing the acceptability and tolerability of specialised training for FEP clinicians. Secondly, the high compliance rate indicates that the conclusions drawn can be considered representative of participants. The third strength is that we believe that our training model is replicable, and that this approach can be utilised effectively by other services, with the potential to obtain similar outcomes.

There appear to be three key implications from this research relating to developing, presenting and evaluating training for early psychosis clinicians. Firstly, we found that a strong focus on early psychosis specific practice guidelines, updating material regularly with

contemporary research, and input from subject matter experts and service users was highly valuable. Secondly, training design and delivery should incorporate visual, verbal and experiential components and maintain a strong focus on adult learning principles. Perhaps most notably, approaching participants as self-motivated and inquisitive, and maintaining a focus on the practical utility of training appears a key element in obtaining good outcomes. Finally, training that is delivered by experienced staff who are involved in the development of the workshops, and are highly familiar with the content, allows for flexibility in providing the optimum environment for learning by early psychosis clinicians.

As FEP services continue to expand, ongoing staff training and evaluation of the quality of this appears essential. Such assessment will ensure not only that training meets the needs of clinicians, but remains focussed on developing and maintaining clinical skills and encouraging evidence-based practise for professionals working in FEP. This in turn will ensure that young people experiencing psychosis receive the best possible clinical care.

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