Attitudes of Mental Health Workers Towards Early Interventions in Psychiatry

A National Survey

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Abstract: Early intervention (EI) is an effective strategy to improve outcomes of psychiatric disorders, but there is little evidence on mental health professionals' opinions on this approach. Hence, during conferences on this topic, we surveyed participants on the benefits, aims, and barriers to implementation of EI. Participants reported that the most important outcomes of EI were decreasing the risk of long-term social consequences, of severe psychopathological conditions, and chronicization. EI would primarily need to be implemented in the care of psychotic, eating, and mood disorders, whereas the main barriers to EI implementation were the lack of funding and of a prevention-oriented culture. Although these results might be biased by a generic attitude favoring EI, participants showed a very positive attitude towards EI and stated the need of a culture shift towards a more prevention-oriented model in a mental health setting.

Key Words: Early intervention, psychiatry, opinion, mental health workers, implementation

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Early intervention (EI) has been the topic of extensive research in the last years, showing it is an effective strategy to improve the course and outcomes of major psychiatric disorders (Brenner et al., 2010); despite this, there is little information available on how this approach is perceived by mental health professionals in the clinical world.

The majority of international studies have focused on the role of EI for schizophrenia and other psychotic disorders and have shown that a longer duration of untreated illness (DUI) is the strongest predictor of relapse and poor outcomes in these conditions (Barnes et al., 2008; Hill et al., 2012; McGorry et al., 2000; Perkins et al., 2005).

Although most studies on the importance of EI focused on schizophrenia and other psychotic disorders, preliminary evidence suggest that a similar case could be made also for mood disorders, representing an even wider population (Allen et al., 2007; Berk et al., 2007; Christodoulou and Christodoulou, 2007; Ghio et al., 2014, 2015). Hence, some authors have advocated the need to change the paradigm of psychiatric care towards a more prevention-oriented model (Christodoulou and Christodoulou, 2007; McGorry, 2010).

Early diagnosis and care in mental health should be given the same value as in other branches of medicine, but until now the process of implementation and development of EI has been slow and has encountered several problems (McGorry, 2012). For example, several institutions attempted to develop ad hoc services for the early treatment of psychosis (Lloyd-Evans et al., 2011), but this process has shown enormous variability across and within countries and economic resources were often insufficient to support this reform (Catts et al., 2010, Ghio et al., 2012). Besides these issues, the implementation of EI programs might have encountered barriers that were related to personal attitudes or to "cultural resistance" of mental health workers. This can frequently happen in the field of psychiatry, an example being those cases where the implementation of clinical guidelines or managerial reforms failed when tested in the clinical field (Forsner et al., 2010; Saario, 2012). For this reason, the existence of resistance to change of mental health staff constitutes a relevant issue that needs to be acknowledged and explored during changes of health policies (Callaly and Arya, 2005).

Surprisingly, very few studies have examined the attitude of healthcare providers towards EI: two research groups investigated the attitudes of General Practitioners (GPs) on EI for psychosis, showing that up to 81% of GPs deemed these services "very/extremely useful". In these reports, the integration between primary and specialist care was perceived as essential to the success of EI services (Gavin et al., 2008; Renwick et al., 2008). Few studies have investigated the attitudes of mental health workers towards patients at risk for psychosis and showed that their early identification was perceived as a clinically useful, albeit particularly challenging, task (Jacobs et al., 2011; Tor and Poon, 2008; Welsh et al., 2011; Welsh and Tiffin, 2013). However, to our knowledge, mental health professionals have not been surveyed on the utility of EI programs/services in psychosis or other psychiatric disorders. Given these premises, the aim of this study was to investigate mental health workers' opinions on the benefits and barriers of implementing EI in psychosis and other psychiatric disorders.

METHODS

Setting

This survey was distributed in paper form between October 2012 and December 2013 to all participants of six conference meetings, five organized by the Italian Association of Psychiatrists and one by the Italian Association for Early intervention in Psychosis. Participants were psychiatrists, nurses, social workers, and rehabilitators working in the mental health sector, originating from all parts of Italy. All the meetings were part of the compulsory continuing education for mental health professionals and focused on the issue of early intervention in psychiatry.

The study setting could yield a bias in the responses towards a more favorable opinion on EI due to the fact that participants to an EI meeting might have a specific interest and a more positive view on EI than the general population of mental health workers. However, we also considered that, given the scarce dissemination of basic evidence-based knowledge on EI in Italy (Cocchi et al., 2011a; Ghio et al., 2012), the aforementioned setting could be more suitable to collect information

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from sources that had been exposed to at least a basic set of information to form their opinions.

Material

Taking into account the scientific literature on EI in psychiatry, practice guidelines recommendation (Ministry of Health, 2007), and relevant expert opinions (Cocchi et al., 2008), we developed an ad hoc self-reported anonymous questionnaire.

The first part was relative to informant's age, professional role, work place, and years of work experience spent in the psychiatric field. The second part included 12 questions: ten questions (A–J, see Tables 2 and 3) investigated participant opinions on different aspects of early intervention in psychiatry (usefulness, models, barriers to implementation, risk/benefits balance, training), whereas two questions asked specific details on how EI was currently implemented in the respondent's working place.

All questions (A–J), except one (question E), were based on a 4-point Likert scale to estimate how important each item was in respondent's opinion and were structured to have multiple answers (*e.g.*, one could indicate that both psychosis and mood disorders were "extremely important" targets for EI). Choices ranged from "not at all important" to "not very important", "important", and "extremely important".

Data Analysis

The average score for respondents' answers was calculated using the following scale: not all important = 1; not very important = 2; important = 3; extremely important = 4. Answers to each question are reported from the highest to the lowest score in Table 2. We conducted exploratory comparisons between (a) psychiatrists versus other professional figures (psychologists, social workers, and nurses) and (b) professionals employed in inpatient versus outpatient services. For these analyses, *t*-test statistics was used for continuous variables and chi-square for categorical variables. Data analysis was conducted using SPSS v. 16.0.

RESULTS

Sample

Of 765 attendees to the six meetings, 308 filled out and returned the survey form (40.2%). Table 1 summarizes respondents' characteristics:

TABLE 1. Characteristics of the Sample

	Total (n = 308)	SD
Mean age	43.9	±10.3
Years of professional experience	14.9	±10.0
Professional role	Total (n = 308)	%
Psychiatrist	140	45.5
Psychologist	74	24
Nurse	40	13
Others	52	16.9
Missing	2	0.6
Working setting	Total (n = 308)	%
Inpatient	142	46.1
General hospital psychiatric unit	55	17.9
Residential facility	87	28.2
Outpatient	144	46.8
Community Mental Health Center	120	39
Private practice	24	7.8
Missing	22	7.1

they were mostly psychiatrists (45.5%), followed by psychologists (24%), nurses (13%), and other mental health workers (16.9%). The mean age was 43.9 years (SD ±10.3) and the average years of experience in mental health field was 14.9 years (SD ±10). Almost half of the sample worked in outpatient services (46.8%) or in inpatient services (46.1%). Overall, 119 subjects (38.6%) reported the presence in their services of operating protocols for early interventions, most related to early intervention in psychosis (83.2%).

Perceived Clinical Utility of Early Intervention

In the overall sample, psychotic disorders were those for which EI were considered most important, followed by eating disorders, mood disorders, and personality disorders (see Table 2). EI for psychogeriatric diseases and anxiety disorders was considered less important. EI for psychosis was considered "very important" in 85.4% of cases, against 71.4% for eating disorders, 69.8% for mood disorders, 65.3% for personality disorders, and only 42.9% and 36.4% for anxiety and psychogeriatric disorders, respectively.

EI for mood disorders was considered more important among those working in outpatient than in the inpatient setting ($p < 0.05$), whereas compared with psychiatrists, other professional figures considered more important EI for personality disorders ($p < 0.01$) and anxiety disorders ($p < 0.05$).

With regard to the perceived most important outcomes of EI, these were believed to be the decreased risk of long-term social consequences, of severe psychopathological conditions, and chronicization.

Compared with respondents working in inpatient settings, those working in an outpatient setting more often considered, as an important outcome of EI, avoidance of chronicity ($p < 0.05$) and stigma ($p < 0.01$), whereas compared with psychiatrists, other professional figures considered the reduction of the prevalence of the disease ($p < 0.01$) as a more important goal.

EI Implementation in Clinical Practice

Prevention in schools and in the general population and collaborative care programs between mental health and primary care were both considered as important modalities of EI implementation by the majority of the general sample, followed by full-time specialized multidisciplinary teams (see Table 2). Also, most respondents (55.2%) deemed that EI should be provided by a specialized, full-time working team operating within the Community Mental Health Centers (CMHCs) rather than in an external setting. There were some differences based on respondent status: psychiatrists and professionals working in an outpatient setting considered more often important the implementation of a full-time multidisciplinary working team ($p < 0.01$; $p < 0.05$), whereas non-psychiatrists more often indicated collaborative care programs between mental health and primary care as an important target of EI programs.

Regarding the modality of first assessment, the majority of respondents considered in-depth analysis of medical history and involvement of family members as crucial, as well as a series of clinical interview with the patient in the first months. Less importance was attributed to standardized assessment tools, domiciliary visits, or instrumental investigations.

When a subject is identified as at risk to develop a psychopathological condition, psychoeducational and psychosocial interventions are those considered more appropriate.

Barriers to the Implementation of Early Intervention

Lack of funding and staff, together with the lack of a specific prevention-oriented culture of the mental health teams, were considered the main barriers to the implementation of early intervention services (see Table 3). Also, the lack of specific training was considered an important barrier, in particular for non-psychiatrists. Furthermore,

TABLE 2. Attitudes Towards Clinical Utility and Implementation of EI

	All Respondents (n = 308)	Working in Inpatient Setting (n = 142)	Working in Outpatient Setting (n = 144)		Psychiatrists (n = 140)	Other Professionals (n = 166)	
	Mean	Mean	Mean	p-Value	Mean	Mean	p-Value
A—How important do you consider the implementation of early intervention services for the following psychiatric diseases?							
Psychosis	3.86	3.83	3.90	0.091	3.88	3.84	0.309
Eating disorders	3.73	3.75	3.70	0.452	3.71	3.75	0.442
Mood disorders	3.72	3.65	3.78	0.044*	3.77	3.68	0.177
Personality disorders	3.59	3.60	3.58	0.741	3.47	3.70	0.002*
Anxiety disorders	3.35	3.33	3.34	0.951	3.24	3.44	0.014*
Dementia and psychogeriatric disorders	3.17	3.27	3.01	0.008*	3.12	3.20	0.433
B—How important do you consider the following outcomes of an early intervention program?							
Reduce the severity of long-term social consequences	3.81	3.77	3.84	0.164	3.85	3.78	0.220
Reduce the severity of the disease	3.74	3.71	3.80	0.105	3.74	3.75	0.792
Avoid chronicity of the disease	3.74	3.66	3.80	0.015*	3.77	3.70	0.234
Favor therapeutic alliance	3.54	3.51	3.56	0.485	3.49	3.58	0.198
Reduce stigma	3.40	3.27	3.51	0.004*	3.44	3.37	0.364
Reduce the prevalence of the disease	3.27	3.31	3.24	0.506	3.11	3.41	0.002*
C—How important do you consider the following ways to implement early intervention?							
Interventions aimed at prevention in schools and in general population	3.58	3.55	3.61	0.416	3.53	3.64	0.138
The implementation of a collaborative care between mental health and primary care	3.52	3.59	3.43	0.082	3.37	3.64	0.002*
A specialized, full-time multidisciplinary working team	3.16	3.04	3.27	0.016*	3.36	2.99	0.000*
A specialized, part-time multidisciplinary working team	2.62	2.73	2.51	0.031*	2.43	2.79	0.000*
A single psychiatrist dedicated full time to a specific disease	0.56	0.52	0.63	0.155	0.57	0.56	0.878
D—How important do you consider the following assessment tools to favor an early diagnosis?							
In-depth analysis of medical history and involvement of family members	3.77	3.48	3.62	0.064	3.74	3.80	0.256
A series of clinical interviews in the first months aimed at monitoring the evolution of the symptoms	3.56	2.92	3.09	0.071	3.49	3.62	0.066
The implementation of a collaborative care between mental health and primary care	3.50	3.72	3.80	0.157	3.45	3.54	0.226
Use of a set of standardized assessment scales	3.00	3.61	3.47	0.100	3.04	2.97	0.480
Visit the patient together with the general practitioner	2.96	3.47	3.50	0.654	2.77	3.13	0.000*
Use of instrumental investigations	2.80	2.93	2.95	0.882	2.59	2.98	0.000*
E—Which organizational model do you consider the most effective for an early intervention service?[a]				0.051			0.458
A specialized working team within the generalist Mental Health Center	55.2	51.4	61.8		53.6	56.6	
A specialized working team outside the generalist Mental Health Center	27.3	26.8	27.1		31.4	24.1	
The generalist Mental Health Center	2.9	2.8	2.8		2.1	3.6	
A specialized working team within the general hospital	1.6	3.5	0.0		0.7	2.4	
Other	8.1	10.6	4.9		8.6	7.2	
F—How important do you consider the following interventions for a patient at risk to develop a psychopathological condition?							
Psychoeducation	3.67	3.62	2.96	0.032*	3.66	3.69	0.738
Psychosocial intervention	3.59	3.54	3.11	0.419	3.60	3.61	0.907
Individual psychotherapy	3.47	3.49	3.69	0.300	3.34	3.57	0.004*
Group psychotherapy	3.12	3.13	3.45	0.635	2.96	3.26	0.000*
Pharmacotherapy	3.06	3.02	3.13	0.992	3.03	3.09	0.523

[a]Percentage of respondents.

*Significant p-values.

TABLE 3. Attitudes Towards Barriers and Training for EI

	All Respondents (n = 308)	Working in Inpatient Setting (n = 142)	Working in Outpatient Setting (n = 144)		Psychiatrists (n = 140)	Other Professionals (n = 166)	
	Mean	Mean	Mean	p-Value	Mean	Mean	p-Value
G—How relevant do you consider the following barriers to the implementation of early intervention?							
The lack of funding	3.66	3.70	2.78	0.872	3.61	3.70	0.211
The lack of a prevention-oriented culture of mental health teams	3.53	3.50	3.55	0.033*	3.51	3.54	0.715
The lack of staff	3.49	3.40	3.62	0.224	3.54	3.45	0.278
The lack of specific training	3.46	3.39	3.55	0.069	3.36	3.54	0.019*
Doubts about the effectiveness of such interventions	3.16	3.06	3.55	0.508	3.04	3.25	0.024*
H—How relevant do you consider the following difficulties in early engagement to care?							
The stigma perceived by patient and family	3.47	3.48	3.35	0.035*	3.50	3.44	0.397
Poor insight of the patient	3.44	3.47	3.42	0.441	3.39	3.49	0.163
A traditional approach to care of mental health team	3.39	3.24	3.23	0.437	3.46	3.33	0.101
Poor adherence to treatment	3.34	3.37	3.21	0.138	3.27	3.40	0.105
Difficulty in the development of a therapeutic alliance	3.28	3.30	3.29	0.361	3.16	3.36	0.019*
The presence in the service of chronic patients	3.25	3.16	3.54	0.000*	3.28	3.22	0.467
I—How relevant do you consider the following potential risks associated with early intervention?							
Psychiatrization of emotional distress	3.07	3.18	2.67	0.427	2.98	3.15	0.088
Poor knowledge about the efficacy of early interventions	2.99	3.00	3.41	0.418	2.78	3.17	0.000*
The chance of false positives	2.96	2.95	2.96	0.680	2.84	3.06	0.012*
An increase in demand of care	2.71	2.75	2.96	0.876	2.72	2.70	0.802
J—How important do you consider the following forms of training for the implementation of early intervention services?							
Training program within the service	3.64	3.66	3.63	0.422	3.56	3.71	0.033*
Case discussion groups	3.60	3.61	3.56	0.642	3.52	3.67	0.024*
Visiting other centers where early intervention services were already functioning	3.56	3.54	3.61	0.847	3.60	3.53	0.298
Meetings and congresses dedicated to early intervention	3.30	3.38	3.57	0.036*	3.15	3.42	0.000*

*Significant p-value.

important difficulties in the provision of early interventions were considered the stigma perceived by patients and their family, the poor insight of the patient, and a traditional approach to care of mental health teams. The role of stigma and the presence in service of chronic patients were considered more important barriers by respondents working in outpatient than in inpatient settings ($p < 0.01$). Regarding the risks associated with the provision of early interventions, the risk of psychiatric overdiagnosis and a poor knowledge of the efficacy of early interventions were considered the more important.

Training for the Implementation of Early Intervention Services

Training programs within the service were considered the more useful form of training for early interventions, followed by the possibility of visiting other centers where early intervention services are already functioning and by case discussion groups (see Table 3). Less importance was attributed to other forms of training, such as courses, meetings, and congresses. Compared with psychiatrists, other professional figures considered it more important to attend meetings and conferences ($p < 0.01$) and training programs within the service ($p < 0.05$).

DISCUSSION

To our knowledge, this is the first study examining the opinions of mental health professionals on EI in psychiatry. The study sample was representative of the national mental health system because it comprised all mental health professional figures working in different settings from various geographical locations of Italy. The majority of respondents showed an overall positive attitude towards EI in psychiatry, in particular for psychotic, eating, and mood disorders, and perceived the main aims of EI to be the reduction of illness' severity, chronicity, and social impairment. Despite this, only a small part of respondents (about a third) reported that EI protocols were operational in the context of their services, in most cases for patients with psychotic disorders. This is consistent with previous studies indicating a slow diffusion of early interventions in Italy (Cocchi et al., 2011a; Ghio et al., 2012).

Consistent with available evidence, EI interventions for psychotic disorders were considered the most important in clinical practice;

however, respondents indicated that EI should be extended to other mental health conditions. This seems to indicate, despite some differences in the answers of different professional figures or workers from different settings, a general consensus on the need for a more prevention-oriented model. In fact, collaborative care between mental health and primary care as well as prevention in schools and in the general population were considered crucial, and the lack of a specific prevention-oriented culture of mental health teams was perceived as one of the main barriers to the implementation of EI in mental health.

These findings show that the culture of mental health professionals might be changing towards a more EI-oriented model. In particular, this seems to relate in particular to the perceived impact of EI on the prognosis of psychiatric illnesses and on the likelihood of achieving better outcomes for patients. In apparent contrast with this, the respondents viewed the culture of mental health teams in real-world clinical practice as still distant from a change in paradigm of treatment approach. Professionals' opinion revealed the persistence of a net separation in clinical practice between EI and long-term care that is still far from the recent clinical staging model of psychiatric diseases (McGorry et al., 2006). It is likely that the change in attitudes of several mental health professionals towards a more EI-oriented model is not sufficient in its own to change mental health services' treatment policies.

Consistent with this view, several authors have warned of the difficulties of implementing and disseminating evidence-based interventions in Italy (Casacchia and Roncone, 2014; Ruggeri et al., 2008) as well as abroad (Corrigan et al., 2001).

In this regard, it seems appropriate, as was also suggested by respondents, to promote the implementation of training programs within each mental health service to favor the involvement of the whole mental health team in the process of knowledge and change (Corrigan et al., 2001).

Consistent with other studies (Catts et al., 2010; Lester et al., 2009), the lack of funding and staff are also considered important barriers to the development of EI services. This problem seems to be present on a worldwide scale, as even in Australia, which was one of the first countries to start a reform towards EI, implementation has been affected by insufficient allocation of resources to appropriately support the reform focus (Catts et al., 2010). In this regard, it should be also noted that the Italian EI services are being mostly developed according to a "specialist within generalist team" model (Cocchi et al., 2011a; Ghio et al., 2012), mainly due to lack of funding and in contrast with other experiences that favor the implementation of specific and independent outpatient services (Edwards et al., 2002).

The tendency for responders of our sample to consider a "specialist within generalist team" model as the most suitable organizational model to implement EI services might reflect their experience of Italian services. However, it is also likely that mental health professionals perceived the need for a compromise between the needs of an "ideal service" and the existing barriers. This organizational model seems not to adequately tackle the problems of client-perceived stigma, particularly among younger patients (Tanskanen et al., 2011). Indeed, stigmatization was considered by respondents as a fundamental barrier of access to EI services. Overall, when funding is lacking, as is happening at present in Italy, to rely on a cheaper "hybrid" model could represent a viable alternative. However, more efforts should be addressed in the future to make mental health system and policy makers aware that the allocation of funds to specialized outpatient care programs can save on costs by reducing the use of hospital and residential facilities, thus producing net cost savings in the long term (Cocchi et al., 2011b).

Strengths and Limitations

The study sample was representative of the national mental health system because it comprised all mental health professional figures from different settings and various geographical locations of Italy. However, the main limitation of this study is the risk of bias that derives from selecting participants among attendees of conference meetings that were directly focused on EI. On inception of the study, it was discussed that such study setting could yield a bias in the responses towards a more favorable opinion on EI; in fact, participants to an EI meeting might have a specific interest and/or a more positive view on EI than the general population of mental health workers. Therefore, this should be kept in mind when interpreting the results. We acknowledge that future similar studies should include the opinions of mental health professionals who have no specific interest in EI and who would not participate in meetings on this topic. On the other side, we also considered that even among mental health professionals, the dissemination of basic evidence-based knowledge on EI in Italy was still scarce; thus, we aimed at collecting information from sources that had been exposed to at least a basic set of information to form their opinions. Besides, an increased knowledge of EI might entail a higher competence in identifying benefits and barriers of implementing EI service.

CONCLUSION

Overall, Italian mental health workers seem to have an overall positive attitude towards early interventions in psychiatry. Although these findings might represent some professionals' views, they do not necessarily reflect a cultural transition within mental health services: at present, only few EI services exist, and they are limited to the management of early psychosis. The lack of funding and of a specific prevention-oriented culture in the mental health teams could explain the slow diffusion of EI services in Italy.

Professionals' views should be taken into account to help the development of EI services and to favor a more prevention-oriented culture in a mental health setting.

To further extend the knowledge on this issue, further research should survey professionals that do not share a specific interest in EI and should be carried out directly within mental health services.

DISCLOSURE

The authors declare no conflict of interest.

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