EIPN
EARLY INTERVENTION IN PSYCHOSIS NETWORK

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

**Issue 02, December 2018**

## In this issue



# WELCOME

Welcome to Issue 02 of the Early Intervention in Psychosis Network's newsletter. A huge thank you to all that contributed this time around, we are amazed at the wonderful things happening in early intervention in psychosis teams.

It has been a busy and slightly difficult part of the year for the EIPN team as we've decided to freeze membership to our quality improvement and accreditation network until 2020/21. This decision was not taken lightly, but we know how EIP teams are having to rigorously audit themselves and thought it may be best to wait until the audit process is complete to begin promoting what we offer as a network in terms of improving quality.

Despite the above, we will still continue to run our annual EIPN forum which will be taking place on 24 July 2019, as well as publishing two newsletters a year. We have also recently introduced a discussion forum for people who work and are in involved in EIP to share good practice and network with each other. We are hoping this grows significantly in the coming months and it will be an excellent platform to ask questions and share policies and procedures as we already know there is some wonderful work taking place across the country. Keep a look out for information on page 7 on how to join the discussion forum in this edition.

We would like to wish you all a merry Christmas and a happy new year. Thank you for all of your hard work and support over the past year. We look forward to seeing you in 2019!


**EIPN Team**

**Follow us on Twitter @ccqi_ @rcpsych**
**And use the #eipn for up-to-date information**

## The difference a year makes

*"A year ago, we were struggling through every day, not knowing how to react to the many outbursts and difficult behaviour, feeling very alone with no one to answer our questions. Every moment was a challenge."*

I am the mother of a very determined 28-year-old man who suffers with psychosis. He hasn't always done so – going back a few years he successfully completed college and university and had enjoyed a year of travelling. It was when he came back from his travels that we began to notice a change in his behaviour. We didn't understand these changes so suggested he sought help, but he was adamant that it was not him that needed help.

At this time, he struggled to settle down and was unable to hold down a job. His relationship with his girlfriend sadly broke down, and he came back home to live with me.

His behaviour started to change even more last year, and things got worse as his symptoms escalated. His personality changed from easy-going and witty to anxious, accusing, and paranoid. We were treading on eggshells and felt there was no-one who would understand or be able to help us.

We took him to our GP who tried as hard as he could to get him to agree to a mental health assessment, but he would not listen. He did however accept that there was something wrong and after much of his own research decided that he had ADHD, so allowed an assessment to be carried out resulting in an ADHD diagnosis.

At this stage, he was self-medicating with vitamins bought from the internet. He also tried various anti-depressants and ADHD medication prescribed to him, but each time blamed his medication for the symptoms he was experiencing.

Life became extremely hard for the whole family and we were desperate to get help for him but without his agreement there was nothing we could do. One day he got in his car and drove for hundreds of miles, eventually phoning us as we had no idea where he was or how he had got there. We picked him up, went to the GP, and got referred to A&E where he met with a psychiatrist.

Even though he was in a very confused state we were told that he had to go home, and a crisis team would see him in the next few days. When the crisis team did turn up, he refused to engage with them and told them to leave. During the conversation with the crisis team he presented with his usual symptoms: thought-block, inappropriate laughter and involuntary jerking movements.

As the months went by his symptoms worsened. He was no longer able to reason, and was aggressive and extremely anxious. We finally had to call the police and demand an assessment. I knew the signs and had a strong suspicion of what was going on by now, as a late family member had suffered with a similar mental health problem. Our son was hospitalised, given medication and was then connected with South Gloucestershire Early Intervention Team.

It's now one year on and we are in a different place to where we were this time last year. During this year, he started to recover and has made some great steps forward including:

- Living independently;
- Joining a football group with other service users;
- Joining a music group;
- Made new friends;
- Cognitive Behavioural Therapy (CBT);
- Started practising yoga;
- Got his driving licence back.

Things are not perfect and it's still a rocky road. A few months ago, he decided to come off his medication and soon became prodromal which has resulted in similar behaviour to last year. However now there is support and plans are in place to help us manage. Life no longer feels so hopeless and I know that with the extra support he has a future.

We too have support from the early intervention team who have helped us connect with other carers whose story is very similar to ours. I hope this helps explain from a carer's perspective how difficult life is before support is given especially when the person that needs it the most is refusing it.

I would like to thank all the people involved in early intervention for the support they give – their help is crucial and also really appreciated.

**EIPN Family and Friends Representative**

# SAVE THE DATE

## EIPN 4th Annual Forum

**July 24th, 2019**

**Royal College of Psychiatrists, 21 Prescot Street, London, E1 8BB**

**Only two places per EIP service will be available**

***Avon and Wiltshire Mental Health Partnership Trust***

# Prescribing in First Episode Psychosis

As part of providing NICE concordant Early Intervention (EI) treatment in First Episode Psychosis (FEP), the appropriate and effective use of medications is critical. Patients' experience of medication in the first stages of treatment can have a lasting impact on future attitudes towards medication, compliance and outcome, as well as interactions and engagement with mental health professionals. This is particularly true for antipsychotic naïve patients who have never been prescribed antipsychotic medication before. Prescribing for FEP is therefore a crucial time to optimise medical treatments and maximise positive outcomes for the patient, which will lead to enhanced engagement and adherence to treatment.

There are currently no Trust-wide guidelines for FEP prescribing in Avon and Wiltshire Mental Health Partnership Trust (AWP). We believe this to be the case in most other mental health Trusts across the country. In discussions with teams across and within the local early intervention networks, it became apparent that practice around prescribing varied greatly. The Bath and North East Somerset (BaNES) EI locality set up a working group to audit prescribing in FEP across AWP using national best practice standards derived from NICE guidance (CG 178), the Maudsley guidelines 12th Ed, as well as the 2016 Early Intervention Pathway produced by the South London & Maudsley NHS Trust Psychosis Clinical Academic Group.

The audit was completed in February 2018. It found that second generation antipsychotics were primarily used, however, there was a need to improve patient choice in prescribing decisions. Treatment for some patients was found to be initiated by non-secondary care specialists or by GPs without consultation with secondary care. Medication was often not given an adequate trial and reviews of medication were found to need improvement. The audit also found that Clozapine was under-prescribed when clinically indicated.

A prescribing protocol was subsequently developed using the most recent research and established national guidelines. It is proposed that this work forms the basis for the development of an AWP prescribing protocol for FEP.

Key points of the protocol include:

- A period of antipsychotic free initial assessment (up to 7 days) with baseline investigations: If possible delay antipsychotic medication for at least two days until the diagnosis of psychosis is confirmed and organic causes are excluded. Benzodiazepines may be used during this period, and beyond this time alongside antipsychotics if needed.

- Antipsychotic medication for the treatment of FEP should be commenced by a specialist in secondary care, or in primary care only in consultation with an EI consultant psychiatrist. For inpatients, where possible an EI consultant should be involved in prescribing decisions.

- The patient should be included in the choice of antipsychotic medication and there should be documentation of this in the patient's notes.

- A second generation antipsychotic should be used as first line treatment:

  Guidelines do not state in what order second generation antipsychotics should be tried. A systematic review and meta-analysis of efficacy and safety of individual second generation versus first generation antipsychotics, in FEP, revealed that Olanzapine, Amisulpride and, less so, Risperidone and Quetiapine, showed superior efficacy, greater treatment persistence, and less extra pyramidal side effects. However, weight increase with Olanzapine, Risperidone and Clozapine and metabolic changes with Olanzapine were greater.

  Murray *et al* suggest that Olanzapine shouldn't be used as a first-line treatment because of the concerns that Olanzapine's adverse metabolic effects will be particularly burdensome to young people experiencing a FEP. Nevertheless, the designation of Olanzapine as a second-line treatment for FEP may be controversial because of its relatively good efficacy and because close monitoring and management of adverse metabolic effects may mitigate long-term risks.

  Aripiprazole is a weight sparing antipsychotic and therefore potentially a good initial choice. Recently it has been discussed that prolonged prescription of

antipsychotics sometimes induces changes in dopamine receptors, causing super-sensitivity, which could diminish the effectiveness of antipsychotic medication over time. Dopamine partial agonists may be less likely to do this.

- Antipsychotic treatment should start at a low dose and be slowly titrated upwards within the dose range given in the British National Formulary. Patients should be treated with the lowest effective dosage of antipsychotic medication to minimize adverse effects. The use of combinations of antipsychotics is not supported by evidence and is associated with more adverse effects. This is particularly important in the care of individuals with FEP, who are particularly vulnerable to medication side-effects. Up to 40% of those whose psychosis remits after a first episode should be able to achieve a good outcome in the long term either with no antipsychotic medication or with a very low dose.

- Following information sharing and including patient choice of antipsychotic, medication must be reviewed and documented in the notes: Record the rationale for changing or stopping medication, and the effects of such changes and monitor side effects of treatment.

- If two individual antipsychotics do not provide adequate benefit, evidence strongly supports, and guidelines recommend, using Clozapine rather than combinations of antipsychotics. For approximately one third of individuals treated for psychosis or schizophrenia, antipsychotic medications will have little or no therapeutic benefit. Clozapine remains the sole medication approved for treatment -resistant schizophrenia, and studies have demonstrated its superior efficacy in reducing psychotic symptoms. The use of Clozapine for treatment-resistant schizophrenia is underutilized, nationally and internationally and better understanding of the barriers to prescribing Clozapine is necessary given the implications for a patient's quality of life and hospital admission rates. In the UK, one study revealed that the mean time to first trial of Clozapine was 6.7 years and the mean number of antipsychotics prescribed before Clozapine trial was 4.85. Having a younger age at onset, lack of employment, a lower Global Assessment of Functioning disability score, and a higher Positive and Negative Syndrome Scale total score at baseline were factors associated with Clozapine use.

Following approval and implementation of these guidelines, information and training will be provided to all prescribers. Following this, we plan to re-audit in 2019.

*Please contact the EIPN team who will put you in contact with the authors if you require a summary of the proposed AWP prescribing protocol for FEP.*

**Dr Liz Ewins (ST7 in GA&OA), Dr Lise Packlet (ST6 GA), Dr Richard Stanton (Consultant Psychiatrist), Elena Ely (Senior Practitioner/NMP)**

### Involving Service Users and Carers

Earlier this year, we went through a full recruitment process to recruit some service users and family and friend representatives for the EIPN who would inform and guide the work we do and be part of peer-review teams and take part in discussions with various stakeholders i.e. senior managers, frontline staff, service users/carers.

We received significant interest in the roles and we successfully recruited four service users and family and friends representatives!

Join our **email distribution list** to keep up-to-date with information relating to EIP and EIPN developments.

Email '**Join**' to:
**eipn@rcpsych.ac.uk**

***Mersey Care NHS Foundation Trust***

## *Our* Recovery Journey Through EIS Event

The Early Intervention Service (EIS) in Merseyside covers Sefton and Liverpool with a caseload of over 800 service users.

When debating how best to offer information and advice to new service users it was decided to host an event helped by current and past service users describing their recovery journey through EIS.

Myself and a support worker (Mark Bell) approached four service users, two who have been discharged and two who do voluntary work at the Trust's recovery college and they were all immediately keen to participate. Within two months we had met together as a group four times, planned their individual speeches, bartered with a local college for the use of a room in return for delivering a mental health session to staff members, and arranged the very important tea, coffee and biscuits (the organisational skills of a support worker should never go unaccounted for!).

As is the way with EIS staff, we had no idea of numbers...Will anyone attend? Luckily we had a turn out of about 40 people. Not bad for a first time event and the room only held that many phew!

The event was amazing. I have to say, it was something magical. I was left feeling like a proud parent watching their children graduate. Verbal feedback was positive, and a second event was promised.


*Event 1, Tracey, Tom, Kerris, Mikey, Mark and Ben*

Sadly my side kick had been accepted into a band 4 post elsewhere (that dratted recovery college) so I had to find fresh blood to help me plan event number 2. I decided to join forces with colleagues in Sefton and the four of us (Clare, Diane, Brian and I) came up with a game plan. We found a new group of four service users, again two current and two newly discharged who were all willing to participate. This time the venue was harder to arrange and we finally secured a room at a different college 10 days before deadline!! It came free with no strings attached and home made biscuits to boot so we certainly didn't complain.

These four service users were a different group of people. But they bonded together quickly and over the course of meeting together for four sessions beforehand were able to use ideas from each other and us to develop their speeches. The event went as well as the first time, and the number of attendees was over 50 this time. Location is difficult for us as we cover a large geographical area, so getting people to travel to venues can often be difficult.

This event was interesting for me as two of the participants from the first time came to watch and I was keen to see what their feedback was having been on both sides. One of those service users (Ben Harris) is now employed by Mersey Care following successfully gaining a part time post with the Trust between the two events. He is also still open to EIS and we are very proud of all he has achieved. Ben was able to feedback:

*'Sharing the story of my recovery was liberating and rewarding; I felt valued and respected and it helped me make sense of my recovery and will hopefully help others. It empowered me to own and convey my lived experience, in effect turn a negative into a positive. It also gave me the opportunity to celebrate and thank those involved in my care'*.

After watching the second event he added:

*'Watching peers express their journeys as a now Mersey Care staff member, was inspiring, moving and reinforced the fact one can overcome, live and prosper with a mental health condition'*.

The theme of both events encompasses the phrase 'no one should be defined by their mental or physical health'. We are planning the next event to be held in February 2019, and I have already had five names passed to me of people keen to take part and tell their story to others.


*Event 2, Jeanette, Ben, Diane, Jude, Brian, Clare, Rob and Tracey*

**Tracey Garner, Cognitive Behavioural Therapist, Early Intervention Service in Merseyside**

# Knowledgehub

Join our new discussion forum designed to help you network and share best practice. The discussion forum is a good mechanism that allows you to:

- Have access to experienced and knowledgeable professionals from a range of disciplines in EIP;
- Share best practice and good quality improvement initiatives;
- Seek advice and network with other members;
- Share policies and procedures;
- Keep up to date with upcoming events and conferences.

Knowledge Hub is an online platform that allows you to be a part of the EIPN discussion forum and it is free to join sign up.

Once you have joined Knowledge Hub, you can request to join the EIPN Discussion Forum. ***Please note, you will not be able to request to join unless you have created an account with Knowledge Hub.***

**All requests to join the forum will be confirmed by the EIPN team.**

**What can I do on Knowledge Hub?**

- **Forum** - create a discussion thread for a particular query or question;
- **Library** - find and upload key documents for everyone else to see;
- **Blogs** - read blogs written by other members about EIP of if you fancy it, write your own;
- **Events** - keep up to date about upcoming events;
- **Members** - connect with other members of the group.

Email eipn@rcpsych.ac.uk if you have any queries about Knowledge Hub,

## *Central and North West London NHS Foundation Trust*

# *A day in the life of an EIS Peer Support Worker*

Having had a similar experience of mental ill health to the patients I work with here at Harrow & Hillingdon Early Intervention Service, I use this experience as a driving force behind every encounter I have. It is a great privilege to be in this role and do something I truly love every working day. My lived experience offers an added dimension to the team and an additional approach to patient engagement. Before the clock strikes nine I approach the Pembroke Centre in the hope that I can offer additional perspectives to staff and at least one opportunity to allow a patient to feel supported, heard and understood from a place of mutual understanding.

I arrive at work in the morning looking forward to a) the cup of tea I am about to drink, and b) to the 'zoning meeting' where we discuss our patients who are in the 'red' zone (patients of greatest concern). This allows us to start the day with all staff coming together to discuss any updates and potential plans for these patients. On Wednesdays, multi-disciplinary team working is truly celebrated when a large range of disciplines come together for an MDT to present updates, information and thoughts on how best to support our patients. As a peer support worker I hope to always view things from the patient's perspective and respond accordingly. I also have opportunity to identify any patients that may benefit from working with myself; either because they would like to speak to someone who 'has been in their shoes' or who may benefit from being exposed to a literal representation of the fact that recovery is not only possible, but very much achievable.

After morning meetings I may have an appointment with a patient to discuss any social, personal or financial concerns they may be having. I might support a patient with their confidence to use public transport or in going to the supermarket and offering advice on making healthier, more well-informed choices. I have great confidence that through engagement with our service, such as with the groups that are available, the employment service and individual CBT sessions (amongst other things), a patient's confidence can grow and flourish.

It's 12pm and I have peer supervision: I meet monthly with Fiona, a senior peer support worker who inspires me to reach my fullest potential as a peer. Fiona supervises all the work that I do, supports me with any difficulties I face or any questions I have, and guides me towards resolving these difficulties and answering these questions in creative ways. I also have clinical supervision with my manager which allows me to access support and guidance in relation to any clinical issues or concerns I have with the patients I work with. It also provides the opportunity for reflective practice; drawing upon what has gone well and what can be improved upon over the past month.

It is early afternoon and I may be on my way to a joint home visit where it is felt my input might be helpful. It may be to visit a patient who has recently decided to stop medication against medical advice. I would view this as an opportunity to enter a gentle discussion about why this decision was made and to listen and empathise with the difficulties the patient faces in this respect. If appropriate I might offer my own experience of stopping medication and the repercussions it had in my life and how I might have done things (if anything) differently. I often visualise how it may have been beneficial to meet with a peer support worker early on in my recovery journey when issues such as medication compliance arose. This visualisation helps me to identify what patients I work with might need from me as a peer.

I will return from the home visit whilst reflecting upon the meeting with my colleague. I will also communicate any thoughts or concerns I have as well as any insights from a peer perspective. While it's all still fresh in my mind I come back to the office and am greeted by 'JADE'; CNWL's client database where details of all patient interactions during that day require documentation. Then I tie up any loose ends, let my diary know of what it needs to remind me of in future and end the day looking forward to the interactions that tomorrow will bring.

**Sophie Levi, Peer Support Worker, Harrow and Hillingdon Early Intervention Service**

***Hertfordshire Partnership University NHS Foundation Trust***

## Evidence-Based Practice Group

Since early 2018 we have been running an Evidence-Based Practice Group which is open to all staff within the two early intervention in psychosis teams in Hertfordshire. The group was set up to create a protected time for staff to keep abreast of the latest developments and research within early intervention in psychosis.

The group runs monthly for one hour at a central location. Different staff members take turns at choosing a research article for discussion which is sent out in advance. Our local trust library has supported us by obtaining copies of the articles when needed. During the session a volunteer gives an overview of the article and discussion is generated based on a set of reflective reading questions. As well as thinking about the content of the research and its quality, we also discuss any new learning and how this might influence our practice, including generating action points. To date we have covered a wide range of topics including CBTp, family intervention, cannabis and psychosis, peer workers and experiences of recovery. Occasionally we chose videos or programmes to watch instead of reading an article. One month we watched the film 'Brain on Fire' which is closely linked to a research study we are involved in and produced some interesting discussion!

The group has had good attendance from a wide range of professional groups within the teams and there has been some positive feedback from attendees, including:

"it gives me some time to reflect and think about our work"

"an opportunity to link theory and practice"

"very interesting and engaging"

"thought provoking"

"allows me to take a step back from day to day work"

"a team that reflects together stays together!"

**Mary Ellen Khoo, Community Mental Health Nurse, PATH West, PATH – Psychosis: Prevention, Assessment and Treatment in Hertfordshire**


Our first edition of Standards for Early Intervention in Psychosis Services provide a comprehensive guide to best practice in EIP and they encompass the self-assessment standards.

They also include areas such as:
- Assessment, care and treatment;
- Staff training, supervision and support;
- Ethos of EIP teams;
- Policies and procedures.

You can use these to make improvements within your own EIP service.

**Grab your free copy from our website:**
**www.rcpsych.ac.uk/eipn**

# IEPA: International First Episode Vocational Recovery group (iFEVR) and International Physical Health in Youth Stream (iphYs) Joint Conference

This event offered the latest in early intervention research and implementation with the International First Episode Vocational Recovery group (iFEVR) and International Physical Health in Youth Stream (iphYs) joint conference.

'Promoting Recovery of Young People Experiencing Mental Illness: New Frontiers' was timed to fall after IEPA 11, but it was by no means an afterthought. Both sessions were packed with a program as varied as the disciplines and nationalities represented in the audience.

Robert Walker, from the Massachusetts Department of Health, first welcomed everyone to his city, and praised both groups for their concern with treating the whole person, and 'putting people back together again'.

iFEVR took over the morning session, with Jo Smith chairing, tackling vocational recovery. We heard from Miles Rinaldi and Cristian Mena about the implementation of the individual placement and support (IPS) program of vocational recovery in two very different contexts – the UK and Chile. Both involved starting small and working their way up. In the UK, vocational recovery is now part of government health policy and guidelines for early intervention services. In Chile, Programa de intervención Temprana en Psicosis.is still in the early stages but they are progressing, with the help of focus group input from users of the service.

Andrew Chanen then outlined his group's preparation for INVEST, the first RCT of IPS for people with borderline personality disorder (BPD), the first trial of IPS outside of psychosis in youth mental health. Young people with BPD are at a higher risk of unemployment up to 20 years later, and the highest community cost of BPD is the indirect cost of unemployment (not hospitalisation, as many may think). Yet the 'soft bigotry of low expectations' means there's almost no focus on functional recovery in BPD, and no evidence-based interventions for helping young people with BPD get back into to work or education. This may be about to change, and we await the results from INVEST.

Jennifer Humensky talked about the experience of vocational recovery in OnTrackNY, where a specialist-supported education and employment worker has improved initial rates of school and work participation and increased subsequent engagement with other parts of the service.

Gina Chinnery spoke about introducing a new peer worker role into the early intervention service at Orygen. This role works with IPS workers and draws on their lived experience of managing their own careers to support young people. Orgyen is exploring ways to make this available to more young people by trialling vocational support in the moderated online social therapy (MOST) platform.

A series of 'bolts from the blue' followed, where various iFEVR members presented two-slide presentations of innovations and inspiration.

- We recieved encouragement from David Erickson that IPS helps even when baseline employment is high.
- Jonathan Delman asked us to consider aspects of vocational recovery that IPS might not cover, such as adult needs and providing support for self-employment and entrepreneurship.
- Jennifer Humensky found that the continuity of IPS provision is as important as how long it's provided for.
- Abigail Wright presented evidence that we might need to look at metacognitive as well as cognitive impairment effects on employment.
- Amy Wilson brought in the perspective of supported education in veterans and showed how a flexible model of care can take support to where it's needed, and how vocational support can be a valuable engagement tool.
- Joseph Ventura shared promising results about the enhancing effect of exercise on cognitive training for improving role functioning.

Reflecting the collaborative nature of the conference, the next two sessions invited audience input, relating to key issues for iFEVR. Using sli.do technology, Eoin Killackey polled the audience in real time about the priorities for the next Meaningful Lives statement, which is now in its tenth year and due for an update. The results of the poll will be considered as the next Meaningful Lives statement is developed.

Eoin also looked back to reflect on the group's achievements. iFEVR has evolved into an international network that people all over can draw on for research and implementation support. Its biennial meetings are a 'focus for energy and effort'.

More about what was discussed, along with questions and answers from the audience, will be posted on the iFEVR blog, so keep an eye out.

Following an appropriately healthy lunch, iphYs set the agenda. Chaired by Phil Ward, the afternoon also began with some reflection. Jackie Curtis and David Shiers, founding chairs of iphYs, discussed the past, present and future of iphYs – eight years since it started, and five years since the HeAL declaration. They reflected that HeAL really was about raising expectations of young people receiving early intervention services about their physical health, and in that regard, it has provided standards and goals that are now available in seven different languages.

Highlights from the afternoon included:

- Gail Daumit's overview of the CHAMPION trial, which is testing the impact of a practical healthy-lifestyle intervention in mental health outreach programs.
- Nev Jones showing the actual priorities of young people with regard to their physical health as not always aligning with what researchers and clinicians prioritise. In particular, reproductive health (including genetic risk and ability to parent), weight and appearance, and the risks of taking antipsychotic medication are areas of concern, and areas where young people want more information.
- An update from Phil Ward and Scott Teasdale on the Keeping the Body in Mind program in Sydney, including new domains of intervention, such as tobacco smoking and oral health.
- Katherine Boydell taking us into the wonderful world of body mapping and how it can help young people understand and express their experiences of physical and mental health. A guided process of tracing a person's body on silkscreen and then filling in the outline with images, body mapping can also be used to teach the wider community about young people's experiences. You can see more of Katherine's work here.

More 'bolts from blue' included;

- Saana Eskelinen on the Health Hut integrated care service in Finland.
- Lauren Brooke on how sport can aid recovery for FEP, and not just because it involves physical activity.
- Laura Kernan from the local InSHAPE lifestyle intervention designed for severe mental illness, who shared promising results by improved fitness and weight.
- Debasis Das told his story of improving physical health assessment and monitoring in a busy, multi-ethnic NHS service in England, using the quality improvement requirements of the UK health system.
- Amal Abdel-Baki and Ahmed Jerome Romain showed how they not only motivated young people to get active but also motivated mental health professionals who think that physical activity is a 'lifestyle choice' that they may have thought themselves as too busy to try to implement.
- Abigail Lane drew our attention to obstructive sleep apnoea in early psychosis and its negative effect on physical health.
- Carmen Paz Castañeda and Brian O'Donoghue spoke of the challenges for physical health promotion in Latin America.
- Brian O'Donoghue finished with preliminary data on the physical health trajectories of young people in the clozapine service in Orygen, which specifically aims to manage the physical health effects of clozapine.

The conference ended once again with a discussion of the future, with iphYs facing similar issues of where to next, agreeing that implementation and knowledge translation is the key. At the end of a day showcasing innovations from around the world, the mood was optimistic and enthusiastic for the future of both groups, with great enthusiasm for the next meeting in 2020 in Rio.

*The original blog can be found on the IEPA website.*

**IEPA, Australia**

*North East London NHS Foundation Trust*

# Routine assessment of trauma within Early Intervention in Psychosis Services

**Background**
There is growing evidence that individuals with psychotic disorders have higher levels of trauma exposure than the general population and are more likely to experience adverse functioning. NICE guidance specifies that routine assessment of trauma history in those presenting with a first episode of psychosis is a key priority. Currently little is known about current practice within local services.

The aim of this audit was to firstly, assess the proportion of service users who had received an assessment of trauma history for all caseloads within North East London Foundation Trust (NELFT) Early Intervention in Psychosis (EIP) services. This included the four boroughs of Redbridge, Waltham Forest, Barking & Dagenham and Havering. Secondly, where a trauma assessment had been carried out, to determine whether the assessment was validated (i.e. using a standardised questionnaire) or whether it was an informal conversation, when it was carried out (i.e. within three months of acceptance) and which professional conducted it.

**Methodology**
Clinical notes on RIO of all individuals who were on the EIP caseload in all four boroughs between June 2014 and June 2017 were extracted. An automated text search was conducted by NELFT IT services, searching for particular terms associated with traumatic events and or PTSD. The terms were based on the Trauma and Life Events Checklist (TALE; Carr, Hardy, and Fornells-Ambrojo, 2018) which has been specifically designed for people with psychosis, and included: trauma, PTSD, TALE, TSQ (Trauma Screening Questionnaire; Walters, Bisson, and Shepherd, 2007), PCL (PTSD Checklist; Blevins et al., 2015), nightmare, flashback, re-experience, abus*, beat, violence, bullying, discriminate, racial/racist, war, refugee, assault, rape, accident, torture, witness, force, coerce*.

Terms were cross-referenced by clinicians and examined to ensure it was a true 'hit' (e.g. it was a true reference to that term, it referred to the client and not a relative / friend and that the client was not the perpetrator of the trauma term). If it was a true 'hit', information was collected regarding the date, assessor and type of trauma assessment (e.g., informal discussion or validated assessment).

**Summary of findings**
Trauma is not being routinely assessed within NELFT EIP services using validated measures. Where assessments are carried out, the majority are informal (across boroughs: mean=64.3 SD=25.5) and are carried out by medical doctors and care co-ordinators. All validated assessments (mean=3.5 SD=2.6) were carried out by psychologists. The majority of assessments were conducted within three months of acceptance onto the teams. Across the boroughs, trauma was identified in 39% of clients and PTSD symptoms were identified in 8.5% of clients.

**Discussion**
This audit is important in examining whether EIP services are working to NICE recommended guidelines and routinely assessing client trauma histories. The figures presented here are less than those reported in a previous study which used a validated measure and found that over three-quarters of 100 EIP patients reported exposure to childhood trauma (Duhig et al., 2015). Research suggests that individuals are not likely to volunteer information about trauma events which is where formal assessments can be useful in beginning a dialogue (Lippert, Cross, Jones and Walsh, 2009). A lack of use of standardised measures could mean an underreporting of trauma events. It is also unknown how many informal conversations are leading to assessments and treatment of PTSD.

Validated questionnaires are only being completed by psychologists. Given that initial contact with clients tends to be with care co-ordinators it would be useful to examine their views on completing formal measures and potential barriers to this. Potential barriers outlined in previous research include staff not feeling comfortable asking about trauma, being worried about re-traumatising clients and or current formal questionnaires being too lengthy to complete routinely (Walters, Hogg, and Gillmore, 2016 ). Collating views from care co-ordinators would be important moving forward.

**Recommendations**
1. Identify barriers to routine trauma assessment, particularly in relation to using validated measures.

2. Possible strategies to overcome implementation barriers could include:

- Training for staff to raises awareness on the links between psychosis and trauma, trauma assessment and PTSD, as well as on specific measures may be advantageous.
- A brief standardised trauma screening measure may be helpful for care-coordinators to complete to ensure trauma is assessed but that it is not burdensome.
- Ongoing support and or supervision could be helpful to assist care coordinators.
- Inclusion of a validated trauma and PTSD measure in the electronic system

*Please contact the EIP team for a full list of references for the above article.*

**Farah Khalid, Clinical Psychologist, Madiha Shaikh, Clinical Psychologist, Simone Farrelly, Senior Clinical Psychologist, Miriam Fornells-Ambrojo, Professional and Strategic Lead for Psychological Services for First Episode Psychosis, Redbridge Early Intervention in Psychosis Service**

## Advisory Group/ Accreditation Committee Recruitment

We are currently recruiting for members to join our Accreditation Committee and Advisory Group.

We are looking for people from a range of professional backgrounds in early intervention in psychosis services including, psychiatry, nursing, psychology, occupational therapy and care coordinators.

If you would like to apply to become a member of the Accreditation Committee and Advisory Group, please email the EIPN team on eipn@rcpsych.ac.uk to request an application pack.

The deadline is **7 January 2019**.

## List of members of the Early Intervention in Psychosis Network:

- Sheffield Early Intervention Team
- Wakefield Early Intervention in Psychosis Team
- Shropshire, Telford and Wrekin Early Intervention Service
- Bangor EIP/FEP Team
- Powys South EIP
- Cwm Taf EIP/FEP Service

# Useful links

**Care Quality Commission**
www.cqc.org.uk

**IRIS Network**
www.iris-initiative.org.uk

**National Clinical Audit of Psychosis**
www.rcpsych.ac.uk/ncap

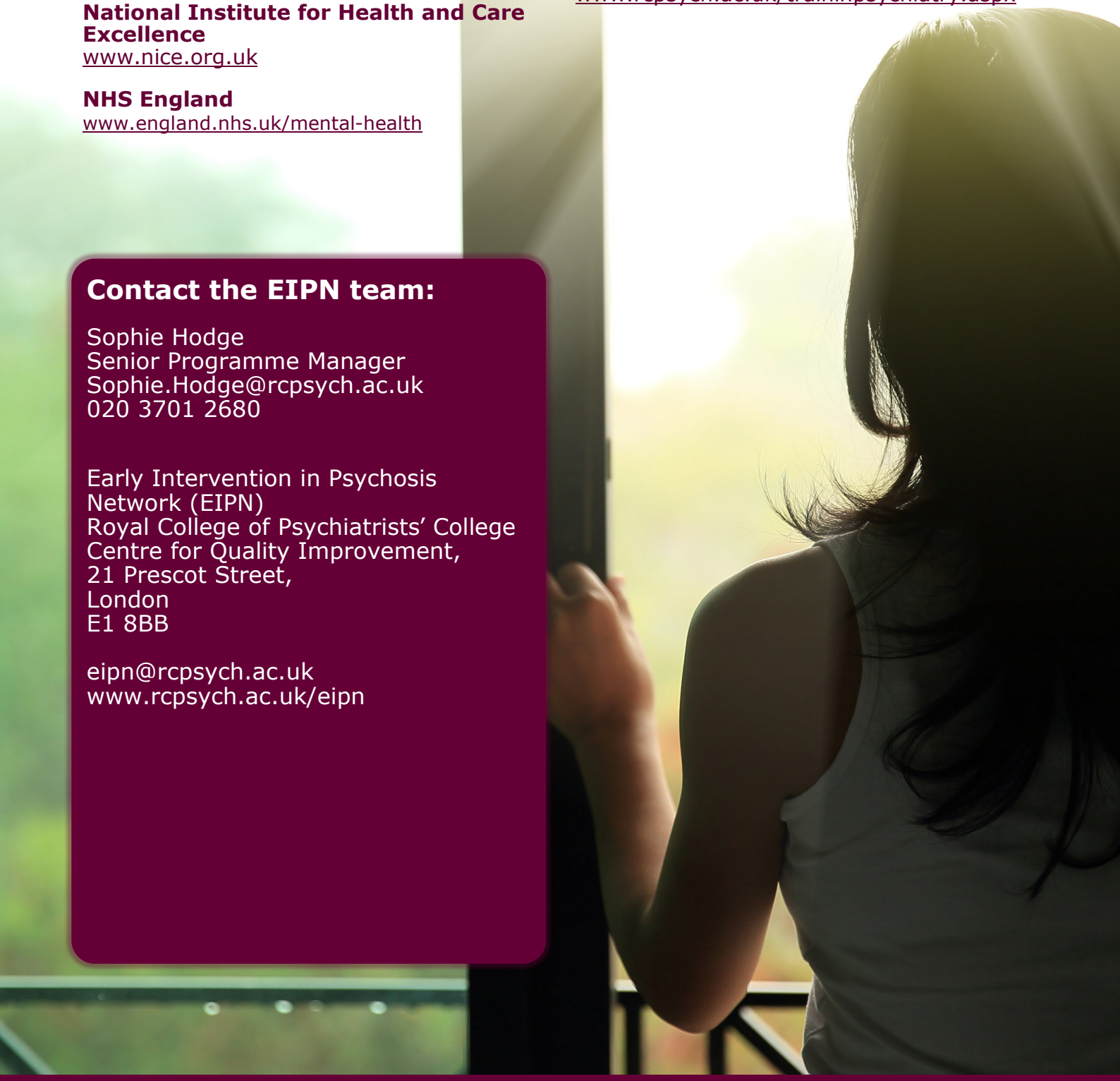
**National Institute for Health and Care Excellence**
www.nice.org.uk

**NHS England**
www.england.nhs.uk/mental-health

**Psychosis Research Unit**
www.psychosisresearch.com

**Royal College of Psychiatrists' College Centre for Quality Improvement**
www.rcpsych.ac.uk/quality.aspx

**Royal College of Psychiatrists' Training**
www.rcpsych.ac.uk/traininpsychiatry.aspx



## Contact the EIPN team:

Sophie Hodge
Senior Programme Manager
Sophie.Hodge@rcpsych.ac.uk
020 3701 2680

Early Intervention in Psychosis Network (EIPN)
Royal College of Psychiatrists' College Centre for Quality Improvement,
21 Prescot Street,
London
E1 8BB

eipn@rcpsych.ac.uk
www.rcpsych.ac.uk/eipn

The Royal College of Psychiatrists is a charity registered in England and Wales (228636) and in Scotland (SCO33869)
© 2018 The Royal College of Psychiatrists.

**Editor: Anita Chandra**