EIPN
EARLY INTERVENTION IN PSYCHOSIS NETWORK
CCQI
RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Issue 01, September 2018

In this issue

WELCOME

Welcome to the 1st edition of the Early Intervention in Psychosis Network's newsletter. A huge thank you to all that contributed; we are delighted to have received so many articles on a range of topics specific to early intervention in psychosis.

Its been a busy year for the EIPN team with the second EIPN self-assessment and developments within the project regarding our quality improvement and accreditation network. We would like to take the opportunity to thank all the early intervention in psychosis teams for their hard work in completing our self-assessment and engaging in this process.

We've just finished the year on a high with our 3rd Annual Forum which was extremely well attended. The programme for the day focused on key themes from the results of the self-assessment as well good practice workshops on areas such as creative therapies and effective ways EIP teams can manage their services in relation to transfers and caseloads. We hope you enjoyed the day and were able to take away lots of thoughts and ideas to develop your services with.

Earlier this year, we also published our first edition of Standards for Early Intervention in Psychosis Services. We've been hard at work developing a range of membership options to suit every teams needs and to provide bespoke quality improvement support and advice. Keep a look out for these membership types in this edition.

We are looking forward to rolling out the developments to our review process and hope you enjoy our new approach to quality improvement.

The EIPN Team

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

North East London NHS Foundation Trust

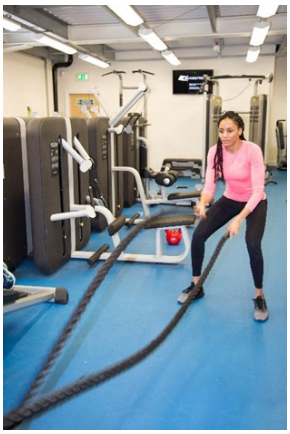
YMCA Fitness Groups

Waltham Forest EIP has been running an extensive exercise programme in collaboration with the local YMCA. The YMCA is a longstanding provider of housing and support for young people and so it was a natural fit that when they refurbished their gym in 2015 that we would look to make use of these facilities.

At that time there was a lot of money available through the Olympic Legacy funds to encourage participation in sport. We used this to develop an exercise group and this has continued to date, although now run through charitable funds.

We run two groups. One is a gym/weights group and the other is a spin and circuits group. We have a core group of regular attenders but there is a lot of change in attendance according to where people are in their recovery. As both groups have staff members who participate, we minimise the possible barriers to participation.

The instructor Simeon Clarke has worked in the fitness industry for some years and has a lot of experience in working across the interface with mental health services. He has a unique ability to focus on particular needs of one member while continuing to facilitate the group. One of the difficulties people commonly experience is the lack of ability to change the task or exercise in keeping with the group and Simeon does a lot to counteract this.



In return, NELFT and EIP have run several groups a year to improve both awareness of mental health issues and to think about how this can be factored into group participation more generally. We also use it for reception staff to improve their competence in dealing with challenging situations and improving their understanding of particular obstacles or barriers for people with mental health problems.

The spin group has become a very popular part of our team's running and undoubtedly continued participation of staff is one of the factors which helps with the health and wellbeing of our staff. For our service users, the focus has moved towards fitness rather than physical health and this is a much more natural focus for most.

Dr Peter Carter, Consultant Psychiatrist, Waltham Forest Early Intervention in Psychosis

SAVE THE DATE

24th July 2019

EIPN 4th Annual Forum

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

South of England

EPIC Minds E-Resource

People with concerns that might suggest an emerging or early stage of psychosis and their families increasingly search for information online before they seek help. And while the internet has a vast amount of information, the reliability of that information is often very variable. In June 2017, a group of service users, carers and clinicians set up a task and finish group to improve the basic information available about early psychosis across all EIP teams in the South of England.

The website also features short videos of individuals who were generous enough to share their stories, so that other people know that help is available, and recovery is possible. Aside from online materials, they also designed an A5 welcome pack, credit card sized 'Myth Buster', t-shirts, mugs and pop-up banners. An additional aim was to produce materials to reaffirm the value of the people working in EIP and attract new people into the workforce.

You can view the resources here: www.epicminds.co.uk

The new EPIC Minds animation features a script written by people with a lived experience of psychosis and their families.

EPIC Minds EIP animation on YouTube

Its aim is to demystify psychosis and treatments available via early intervention in psychosis teams. A previous animation video on 'What is Psychosis' has now **had over 100,000 views in the last year**.

Working within early intervention in psychosis is not easy. It requires a range of specialist assessment and treatment skills, as well as an optimistic mindset that, with the right treatment and support, people can and do recover. We put a call out to staff to share what it's like working in these teams, and the above video captures some of their thoughts on their roles.

South of England and Dawn Hyde, Carer and Families Participation Lead for the South EIP Programme

What is the Early Intervention in Psychosis Network (EIPN)?

We're a quality improvement and accreditation project that works with early intervention in psychosis (EIP) services all around the UK. The views, ideas, skills and experience of people who have used EIP services are vital for our quality improvement work.

We work at an individual team level as services are configured differently across the UK and Ireland.

Our standards of best practice form the framework by which we assess the quality of care and service provided by EIP teams and share.

To find out more about the us and how to join, visit our website at: **www.rcpsych.ac.uk/eipn**

Or contact a member of the team:
Email: eipn@rcpsych.ac.uk

Berkshire Healthcare NHS Foundation Trust

Health and Well-Being Pilot

Background
It is well documented that psychotic disorders are linked with significant long term physical health conditions and reduced life expectancy of 15-20 years below the general population. Cardiovascular disease, weight gain and obesity and diabetes are the greatest contributors to this reduction in life expectancy.

What we did
In partnership with Oxford AHSN, the South EIP Programme (Time4Recovery) and Livefit, Berkshire's EIP Service have developed a pilot intervention aimed at reducing health inequalities experienced by clients with a focus on improving diet, increasing physical activity and promoting recovery through social inclusion and engagement. The pilot was led by Brian McMahon (Mental Health Nurse and EIP Care Co-ordinator) and Camilla Sowerby (EIP Pharmacist) who both oversaw the development and implementation of the pilot and recently showcased this at the Royal College of Psychiatrists International Congress in Edinburgh.

A total of 10 participants with a body mass index (BMI) of >25 were included in the initial pilot which was implemented across two localities within the Berkshire EIP service. Each participant was identified as being in the contemplation or preparation stage of change prior to inclusion and was then allocated to their own qualified personal trainer (PT).

Early findings (within 3 months of the pilot)
Over the course of 12 weeks each participant engaged in initial one-to-one sessions with their personal trainer, before gradually progressing towards group sessions led by a trainer and involving other participants within the pilot.

Not only did participants increase their physical activity as part of the pilot, they also received specialist dietary advice and habit coaching from the Livefit team. This was delivered via the Livefit social media app that also aimed to stimulate conversation and communication between participants. Participants were encouraged to share images of prepared meals and to provide commitment scores based on their dedication to their individual health and wellbeing plans.

We presented our poster presentation at the 8th Annual College of Mental Health Pharmacy Conference.

What we learnt
Although not all results have been collected we are certainly excited by some of the early data. 80% of participants recorded an improvement in baseline data in resting heart rate and blood pressure. While 60% recorded a reduction in BMI and waist circumference.

Mean engagement was recorded at 79% which is greater than other leading interventions in this area such as the 'Healthy Body, Healthy Mind' pilot in Brisbane, Australia. Overall engagement improved as group PT sessions commenced this also coincided with an improvement in physical health data which indicates the effectiveness and increased efficacy of group led interventions.

The use of the social media app also increased as the pilot progressed with a number of participants accessing this and communicating with each other on a daily basis.

Feedback we received

"Thank you for an inspiring, fascinating and fun conference! Excellent speakers and great enthusiasm all round!"

"#CMHP16 has been fantastic – thanks to CMHP for organising! Great to meet lots of people for the first time & catch up with old friends!"

"Great opening session [Brett Hill Memorial Lecture] – brilliant insight into service user involvement in research and patient care."

Brian McMahon, EIP Care Coordinator (RMN) and Camilla Sowerby, EIP Pharmacist, Berkshire EIP Service

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

Birmingham and Solihull Mental Health NHS Foundation Trust

The Drop-in Service: Good Practice in Solihull Early Intervention Service

Solihull Early Intervention Team (EIT) have developed a drop-in service available to all service users and families/carers and provides a space to build social connections, access support and information within a local youth centre. The drop-in enables service users to meet the EIT team in an accessible, informal way to offer medical, social and psychological interventions. The drop-in also offers numerous psycho-education groups on psychosis, managing emotions, acupuncture as well as an art psychotherapy group and social groups (i.e. playing football, gardening, making music). It allows service users to access a range of physical health checks, sexual health advice, weight management and smoking cessation which is so important given the risk of such problems in this population. We have engaged with guest speakers talking about their recovery and recently filmed for a BBC documentary on understanding psychosis! At the heart of the drop-in is a compassionate service to service users and carers and enables them to work towards personal recovery.

The goals of the drop-in service are:

- **Improve engagement with service users, education on physical and mental health and reduce stigma**: the group interventions and social activities ran at the drop-in service aim to reduce stigma, provide education on both mental and physical health and normalisation of psychosis and to help young people work towards recovery.
- **Improving social inclusion:** It allows a space for young people to feel comfortable, meet others with similar experiences and improve their sense of social inclusion and acceptance. Some of the young people have additional needs impacting on their communication and social interactions, such as autistic spectrum disorder, and the drop-in also aims to provide a structured timetable of activities to suit the needs of all those who attend.
- **Improving therapeutic relationships, increasing contact and reducing missed appointments:** The drop-in service aims to improve therapeutic relationships and reduce the number of appointments that were not attended. It allows the team to have better contact with our young people and carers.

One of the psycho-education group ran at drop in

Service users and carers/families have expressed their satisfaction with the drop-in service and it helped them to understand psychosis, get help with both their physical and mental health and meet others going through similar experiences. A challenge was encouraging new service users to attend, so we have produced a short film, photographs of drop-in and leaflets to help introduce them to this service. Service users felt that the drop-in service had helped them to be more sociable, meet other people and helped them get involved in new and interesting activities. They felt it was a space to relax and get to know professionals and other service users.

Some of our young people playing one of the computer games at drop in

We also offer a number of internal peer support roles in which service users (as well as ex-service users) can have a voluntary role at the drop-in service and help run many of the interventions. We have made important connections with other partners and

organisations including services providing smoking cessation, weight management and sexual health advice that are also available at drop-in. We have also made important links with the Prince's Trust, SIAS (Solihull drug and alcohol services) and Solihull Young Carers who have attended our drop-in service to meet service users and families. Some of our service users are often initially reluctant to attend such services, especially independently, therefore having them available at drop-in allows them to meet informally and find out more about these services in a comfortable, safe environment.

Our chill out space down at drop in

One service user stated:

"Drop-in makes Early Intervention. It wouldn't be the same without it! It has made things alive for me, meeting people, being sociable again and finding out more information from the team."

Dr Donna Haskayne, Clinical Psychologist, Solihull Early Intervention Service

Read about our membership options

NEW

Consultancy

If you want some focused advice from an expert

Developmental

If you want to improve your service and work towards accreditation, but would like some time & support to achieve this

NEW

Accreditation

If your team wants support and a seal of approval from an independent body about the quality of your service

Avon and Wiltshire Partnership NHS Trust

Recovery Through Sport

In June this year, South Gloucestershire Early Intervention Team were happy to announce a partnership with Bristol Rovers Community Trust to support a brand new weekly social football group with the goal of improving people's physical and mental well-being through sport.

The project has already boasted encouraging participation numbers in the opening two weeks, with a positive response to the overall sessions. In mid-June, the group welcomed former Crystal Palace and West Brom 1st team coach Ben Garner to the session, to chat about this career and how he recovered from his own personal setbacks.

Project co-ordinators Jacob Kelly, Mental Health Support Worker and Robert Broomhead, Mental Health Nurse, have spent hours of their own time planning and developing this group. They have developed a working relationship with Bristol Rovers Football club to negotiate funding to cover the costs of running the group and to provide the expensive equipment required to facilitate the group.

Jacob said "We decided to set up a project that works for people who may struggle with their mental health or people who need more support socially. We wanted to organise a group where everyone would feel welcome and since the project has been set up, we've had some amazing feedback. Our participants have felt really good about themselves for taking part and through completing well-being scales with the attendees we've seen the group has really improved their mental and physical well-being"

Michael who is a Community Psychiatric Nurse working for the Bristol Community Rehabilitation Service said "I am working with a service user who has generally not been attending any activities and spends most of his life isolating himself in his flat. He has an interest in football however, and has begun to attend the football group on a Thursday. I have been very impressed with the supportive manner in which the football group is run and I have admired the supportive non-judgemental approach of the people running this group. The on-going direct benefits for the service user of attending this group are:

a) increased feelings of self-worth;
b) something to look forward to every week;
c) making friends and enjoying the camaraderie (increase in social inclusion and social contact);
d) a feeling of doing something that he has interest in and increased exercise;
e) increase in overall well-being including a reduction in anxiety and depression meaning the chances of further hospital admissions are very much reduced.

Overall, I think of this group as a marvellous community resource for people with social inclusion difficulties that helps promote activity and associated increase in general motivation along with the chance to have positive healthy human contact with other people. As a result of this group the service user has expressed an interest in finding other groups to join. This is a major transformation in his recovery. I hope the Recovery Football Group will continue in the foreseeable future."

The group is open to everyone over 18, male or female, from those who've never played football to the more experienced. The project is part of the South Gloucestershire Well-being College and was created by staff from South Gloucestershire AWP NHS service.

You can view a short video created by Bristol Rovers Community Trust here: https://youtu.be/lXUJ_i0M5Ec.

Jacob Kelly, Mental Health Support Worker, South Gloucestershire Early Intervention in Psychosis Team

South London and Maudsley NHS Foundation Trust

"Why am I hearing voices? Google it!" - Using Digital Technologies to Overcome Barriers to Accessing Psychosis at Risk Services

For the last 18 years, the OASIS team has been working to identify people who are at high risk of psychosis and to engage these people in interventions that can reduce the chances of them developing psychosis by up to 50% (Van der Gaag et al., 2016; 2012).

But, we have a problem. Although we have spent two decades trying to identify those likely to develop psychosis, we seem to be missing most of those who at risk. In fact, our recent audit of the Lambeth Early Onset (LEO) team showed that although 72% of LEO clients had prodromal symptoms before developing psychosis, OASIS had only provided care to 5% of the LEO caseload!

In trying to understand this discrepancy we thought about the barriers to accessing care that our clients face, barriers that are particularly problematic for people from Black, Asian and Minority Ethnic (BAME) backgrounds. For example, a study by Healthwatch Lambeth found that only 50% of people from a BAME background would speak to their GP about a mental health problem (2015). Given that most of OASIS' referrals come from GPs this poses a major problem. We took to the streets to explore this further; we spoke to local BAME people in barber shops and nail salons in Lambeth who told us they associated SLaM with the Maudsley Hospital and being sectioned, not with a place to access effective, early care. Importantly, they wouldn't think about contacting a SLaM service if they started to experience a mental health problem.

To remedy this issue, we have worked hard to outreach to people in our local communities, rather than garnering referrals solely through traditional routes like GPs. We present at local churches and mosques, we put flyers up in shops and we work with third sector organisations like youth centres. Yet despite this effort, last year only 9% of our referrals were self-referrals. It seemed that our community engagement approach just wasn't working. So, we decided to try something new.

We noticed that many of our clients described searching online when they first noticed early symptoms of psychosis. Unfortunately, only 17% of those we asked described finding the information they found helpful, whereas 50% found it unhelpful or very unhelpful. Given that the information people find online affects whether they seek help (Birnbaum, 2015) this was particularly concerning for our service. As one of our service users described it: *"when I first realised something wasn't quite right with me I took to the internet obviously, and it told me I had bipolar, schizophrenia and a personality disorder!! …and when I did come across [the SLaM website], it scared me!".* It seemed there was little de-stigmatising information available online about early psychosis and what did exist wasn't leading people towards OASIS.

To resolve this problem, we decided to work in collaboration with our service users to design and build our own website for young people with early symptoms of psychosis. We wanted our website to provide good quality, non-stigmatising information about unusual experiences and to provide a route for hard to reach groups to access OASIS via electronic self-referral.

Nearly a year later and we have made great progress. By using Quality Improvement methodology, we have been able to share our vision with vital SLaM teams who have allowed us to take risks that would otherwise have been impossible; SLaM's communications, digital services and information governance teams have all supported us to make our idea a reality. We have been awarded a grant from the Cicely Northcote Trust to fund the website development and a working group of OASIS staff, service users and students have developed initial plans for the website's content, design and domain name; all informed by service user feedback. We have even employed a web developer who is currently designing the website, made to the specifications of our service users.

We hope to launch the website by the end of the year for staff, service users and carers to use. Importantly we will be continually evaluating the success of the website; using Google Analytics and our service users' feedback to monitor how people are using the site, allowing us to edit it to ensure it remains relevant to those who need it most. As one of our service users, Larrissa, says:

"We have built this website for others like ourselves! The team have truly stuck to their word and fully included us! WE HOPE YOU ALL LOVE IT AS MUCH AS WE DO!".

Lauren Colgan, Senior Clinical Psychologist and Larrissa Henderson, Service User, OASIS Lambeth

Abertawe Bro Morgannwg University Health Board (ABMU)

Eco-Therapy

Eco-therapy is a type of therapeutic treatment which involves outdoor activities in nature. It has been shown to improve the mental health of young people in our service, as well as improving their levels of physical activity, social inclusion and confidence.

Our Early Interventions in Psychosis (EIP) team for the Abertawe Bro Morgannwg University Health board (ABMU) is working together with the Down to Earth Project to trial eco therapy for some of our service users. This is a new experience for both the Down to Earth Project And our EIP team.

The Down to Earth Project is a not for profit organisation based in the Gower Peninsula - an area of outstanding national beauty just a short drive from Swansea city. The Down to Earth Project work with people of all ages and abilities primarily focusing on people that are difficult to engage with or at risk.

In our practice, we have found that our service users have wanted to participate in work, educational or social activities, but have lacked the confidence or motivation to do so. We were looking for a service that could provide a "stepping stone" in helping these young people work towards their goals without overwhelming them and putting them in intense situations which may contribute to a further decline in confidence, mental health and functioning.

On a weekly basis, two members of our team provide an allocated number of service users transport to the sessions as a means of helping overcome a main barrier of engagement. Those members of the team actively participate in the activities alongside the service users, which has helped us to develop a therapeutic relationship in a non-clinical setting (as well as being good fun).

The Health board have assisted us in this endeavour by providing financial support and as such, we are able to provide lunch for the service users. To help promote autonomy the team and service users plan and buy ingredients with which they make their own meals using the kitchen facilities available at Down to Earth.

Our initial trial with Down to Earth consisted of 16 day sessions occurring on a weekly basis and we are currently in talks regarding the commencement of a new programme starting in September 2018. The activities in Down to Earth vary from woodwork to gardening, cooking, river and sea swimming and woodland management, with a focus on team work, education and empowerment. The activities aim to be fun and educational and through these activities the service users have obtained accreditations, which has given them an

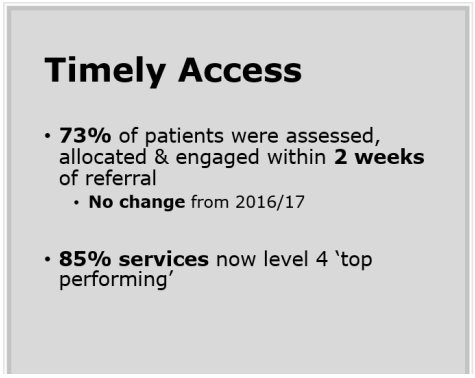
We found that those service users who attended the programme consistently improved in confidence and well-being.

"When I first went to the Down to Earth Project I was very shy and would get anxious around people that I didn't know. I feel that over the 16 weeks that I took part I have become more confident around people socially and members of staff have commented how I have improved. I really enjoyed the gardening, woodwork and cooking and would love to do something similar or another Down to Earth Course in the future to continue developing my confidence further." - EIP service user.

The initial eco-therapy programme provided by the Down to Earth Project was hugely successful, and our team and service users look forward to the next programme in September 2018!

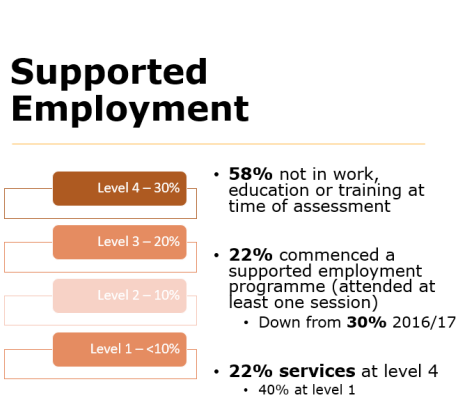
Bronya James, Early Interventions in Psychosis Practitioner, EIP ABMU Healthboard - Swansea

EIPN Update: 3rd Annual Forum "The Jewel in the Crown of Mental Health Reform"



We held our 3rd Annual Forum this year where we presented the results of the 2017/18 self-assessment, as well as showcasing innovations from EIP teams across the UK.

Presentations from the event can be found on our events page on: www.rcpsych.ac.uk/eipn



Central and North West London NHS Foundation Trust

First Episode Psychosis Carers: Reduce the suffering, develop the service, and disseminate the clinical findings: A new tri-beneficial practise-based evidence Service Delivery Model

First Episode Psychosis (FEP) carers typically experience shock, confusion and suffer from elevated rates of psychiatric and psychological disorders. Meeting the needs of these carers is recommended by both the NICE Guidelines for Psychosis (2014) and the Implementing Access and Waiting Time Standards in Early Intervention in Psychosis services (2016). To this end, under the leadership of the new Service Manager, Alastair Penman, an Integrated Psychiatry/Psychology/Service-User/ Academic-Practise-Based-Evidence service model has been trialled and developed for carers in the Harrow and Hillingdon early intervention in psychosis service. The model involves a three-fold integrated benefit:- clinical; service development; and academic. The work has so far produced improvements in local carer's mental health, and three international conference presentations and papers in Psychiatric journals. The service development initiative has been funded by a grant from the North London Clinical Research Network (NOCLOR) to Dr David Raune, team Clinical Psychologist.

Carers Psychological-Psychiatric Assessment

A new Carers Psychological-Psychiatric Assessment (CPPA) has been available to all new carers. 254 carers, of wide ethnic diversity and predominantly non UK-born and speaking English as a second language, completed the 90 minute CPPA.

At the individual clinical level the CPPA employs a 'Socratic-Intervention-Therapeutic' approach which encourages the new carers to think deeply through their caring experience using a structure of key illness beliefs, coping strategies, and emotional outcomes. It also seems to engage the carers more effectively. The results of the CPPA then informs MDT staff and Family Therapists to help families in a more sensitively tailored way.

At the service level, the CPPA results when collated, illuminate the psychiatric and psychological landscape of the local carer population, and have been used to make the case at board level for proportionate funding. Statistics based on the CPPA have been presented to the local carers in groups and this may have had a therapeutically normalising effect on their experiences.

Carers who provided written informed consent for their data to be published had their data analysed by Clinical Psychology Trainees (UCL/ Royal Holloway), MSc students (UCL/UoH) and medical students (Imperial). This data has so far been published in two articles: 'Burnout in early course psychosis caregivers: The role of illness beliefs and coping styles' (*Early Intervention in Psychiatry*, 2015) and 'Understanding the experience of burnout in first episode psychosis carers' (*Comprehensive Psychiatry*, 2018). Further recent findings have been presented at two international conferences. 'Key illness beliefs' was presented at the International Conference on Psychology and Psychiatry in Health (Paris, June 2018, Natasha Lyons); and 'Mothers versus fathers psychiatric and psychological needs' was presented at the British Association of Behavioural and Cognitive Psychotherapy, Glasgow July 2018, Caroline Floyd).

Cognitive Psychiatric-Psychological Group Intervention

The new psychoeducational intervention group was devised by and run by the team Clinical Psychologist (DR) and Consultant Psychiatrist (SR). The syllabus covers 'what is psychosis, what causes it, how to manage it, and how to manage as a carer'. 175 carers attended across several two-hour groups. An analysis of 147 carers in a three-session format showed improvement in a range of key illness beliefs, for example, a significant reduction in carers blaming themselves for the illness. The paper was published as 'Modifying illness beliefs in recent onset psychosis carers: Evaluating the impact of a cognitively focused brief group intervention in a routine service' (*Early Intervention in Psychiatry*, 2017). Currently, a new more economically efficient 'Single-Session cognitive psychoeducation for first episode psychosis carers' was trialled and then presented at the British Association of Behavioural and Cognitive Psychotherapy, Glasgow, July 2018, Natasha Lyons).

The new Practice-Based evidence service-delivery model simultaneously helps individual carers, results in local service improvements, and provides academic information to inform future development of services more widely to reduce suffering of the FEP carers.

Senior staff contributors to the programme: CNWL: Clinical Psychologist: Dr David Raune (Grant Holder/Programme Lead); Consultant Psychiatrists: Dr Shireen Rahim (Honorary Senior Lecturer, Imperial College School of Medicine) and Dr Saal Seneviratne (Group Psychoeducation); Dr Maria Dominguez and Dr Debra Keay (Child-Psychosis-Project); Dr Ruchit Patel (Depression-Anxiety). Psychosis Service-User Lead, Natasha Lyons. Hillingdon Borough Directors: Dr Mellisha Padayatchi (Consultant Psychiatrist) and Kim Cox; EI-Team Managers: Krishan Sahota, Chris Ugochukwu, Leanne Frizzel, Jonathan Souray; Service Manager: Alastair Penman; Academic-collaborators: UCL: Dr Jo Billings (Senior Lecturer in Clinical Psychology), Dr Carla Startin (Research Associate), Dr James Kirkbride (Reader in Epidemiology); UoH: Joerg Schulz (Head of Research Methods MSc); IOPPN: Dr Juliana Onwumere (Senior Lecturer in Clinical Psychology).

Funder: NOCLOR (Lynis Lewis, Service Director)

Harrow & Hillingdon Early Intervention in Psychosis Service

South West London & St George's Mental Health NHS Trust

Our Early Intervention Services

SWLSTG have five Early Intervention Service (EIS) teams, one for each of the five South West London Boroughs the Trust covers.

The services accept referrals for people aged 17 to 65 years, working collaboratively with the patient, their family and friends with the aim of minimising the impact of psychosis on their lives. Following an assessment of the patient's mental health needs, a plan of the care and support they will receive is drafted. Referrals are made via Community Mental Health Teams, Acute Mental Health Wards, Home Treatment Teams and Liaison Psychiatry Teams, as well as transfers from other Early Intervention Teams around the country.

The teams offer a range of interventions including education, access to psychology, Cognitive Behaviour Therapy (CBT), family work, medication management, physical health checks, stress management, relapse prevention (well-being), along with assistance with other needs such as daily living skills, further education, work, housing, drug misuse and helping patients and their family make sense of what has happened. These are tailored to the specific needs of the patient and their family.

The Trust's EIS teams participated in the self-assessments in 2016/17 and 2017/18 run by the Early Intervention in Psychosis Network (EIPN). Participation has led to improvements by all the teams, particularly in relation to timely access.

The teams work closely with CAMHS Services so that the transition at aged 17/18 is made easier. Patients below 17 years of age with a first episode psychosis who are considered to require mental health services are the responsibility of CAMHS however depending on individual need, discussion may occur with adult early intervention services regarding joint working. No EIS team takes on the care co-ordination role before the young person is 18 but teams can begin joint working from the age of 17 onwards to prepare for the transfer. At all times care needs are provided consistent with policies and guidelines regarding young peoples' services and EIS teams.

The teams regularly receive compliments from the families of patients transitioning from CAMHS to EIS, such as the one below:

"I am writing to express the utmost praise for my daughter's current treating team, the Wandsworth Early Intervention Service at Springfield Hospital. It was with trepidation we crossed the bridge into adult services earlier this year, just prior to (name's) 18th birthday. The team and in particular, (name), have always excelled in the services provided. The understanding, support and professionalism is beyond any previously experienced and the range of services and level of transparency is exemplary."

The EIP teams can refer patients for support with employment and attendance at college. The employment specialist discusses the patient's vocational goals works closely with the patient and their family to put their goals in to a plan of action. Support is also provided if the patient is already in employment or on a course but needs help with their situation.

Philip Twells, Senior Clinical Effectiveness Coordinator, South West London & St George's Mental Health NHS Trust

Devon Partnership NHS Trust

Open Dialogue, Medication and Functional Recovery in Psychosis

A new approach:
Open Dialogue is being presented as an alternative model for treating psychosis and now forms the basis of the mental health system in Lapland (Seikkula and Olson, 2003). The Open Dialogue approach appears to have significantly improved functional recovery with 73% in work or education at the five year follow up (Seikkula & Arnkil, 2006) far exceeding the 35% outlined above for EIP care. In general most people with severe mental illness say they would like to work (Secker et al, 2001), yet despite this, only a small proportion (estimates 5-15%) of all people with psychosis are employed (Marwaha et al, 2004). The reasons for this are often complex and involve confidence, interrupted skills acquisition due to the onset of illness but also include side effects of antipsychotic medications. The sedation that these cause make it difficult for people to feel energised and motivated. There are longer term problems associated with to cognitive decline (Ho et al, 2011; McGlashan; 2006 and Harrow, 2007; Vita, and De Peri, 2007).

Is medication the long-term solution?
It is clear that Antipsychotic medication has a positive impact when treating acute psychotic symptoms and when used in preventing relapse (Geddes, J. 2002), But there is doubt about the long-term efficacy of these treatments and the associated impact on physical health and life expectancy (Stip, E. 2002). There appears to be no definitive guidance on the duration of maintenance therapy for people suffering psychosis.

What is clear is that those with psychosis have a reduced life expectance of 15-20 years (Rethink, 2014). Contributing factors are a combination of high rates of suicide mainly within the first five years, and high rates of physical illness, in particular premature cardiovascular disease (Parks et al, 2006). The on-going impact of long -term medication use should not be ignored in relation to this issue. There is a clear link between antipsychotic use and metabolic syndrome (Chang et al, 2011; Morgan, 2003; Saha, 2007). The NHS has a clear strategy aimed at improving patients physical health and we must do everything possible to reduce morbidity associated with preventable physical health conditions.

One aspect of the Open Dialogue approach that seems to have been overlooked in its success is its limited use of antipsychotic medication.

Five-Year Outcomes for First-Episode Psychotic Crises in Western Lapland Treated with Open Dialogue: Diagnosed with Schizophrenia (N=30) and Other Psychotic Disorders (N=45).

Antipsychotic Use	Never Exposed: 67% Used During Study Period: 33% On-going at Five Years: 20%
Psychotic Symptoms	No Relapses During Study Period: 67% Asymptomatic at Five Years: 79%
Functional Outcomes	Working or in school: 73% Looking for a job: 7% Disability: 20%

Long term outcome studies:
The World Health Organisation Ten Country Study on first contact schizophrenia results (Jablensky et al, 1992).

	Benign course leading to full remission	Worst Outcome Group	Never Hospitalised	Taking neuroleptics throughout Follow up
Developed Countries	37%	42%	8%	61%
Developing Countries	63%	16%	55%	16%

When comparing the above two tables there is a striking similarity between recovery rates for those people least exposed to antipsychotic medications when considering longer term functional recovery rates. Similar results have been noted in other studies when exposure to antipsychotic medications have been limited to acute episodes. The Soteria House project (Mathews et al, 1979) developed a successful psychosocial treatment provided by non-professionals and used minimal antipsychotic medication with 42% never being exposed to antipsychotic medication and another 39% only using them on a temporary basis.

The Vermont Longitudinal study (Harding, 1987; HMcGuire, 2000) found that 34% of people, twenty years after discharge from hospital, with a diagnosis of psychosis, were fully recovered and working. Harding suggested the one thing they had in common was that they had all stopped medication a long time ago. The World Health Organization cross-cultural studies started in 1969 and continued to 1997, these studies tried to track the outcomes for psychosis and they concluded that being in a developed country was a strong predictor of poor outcome because those in developing countries had rates of complete remission of 53% with another 73% in employment. These studies concluded that patients not regularly maintained on antipsychotic medication faired far better (Jablensky et al, 1992; Hopper & Wanderling, 2000).

The Open Dialogue study reported a significant drop in hospital bed days. This reduced by two thirds from 110 days to 33 days during the course of the study (P.164 Seikkula & Arnkil, 2006). This represent a significant saving. Are there lesson for EIP and prescribing practices here?

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

James O'Donoghue, Team Manager, Torbay, South and West Specialist Team for Early Psychosis

Why we do what we do

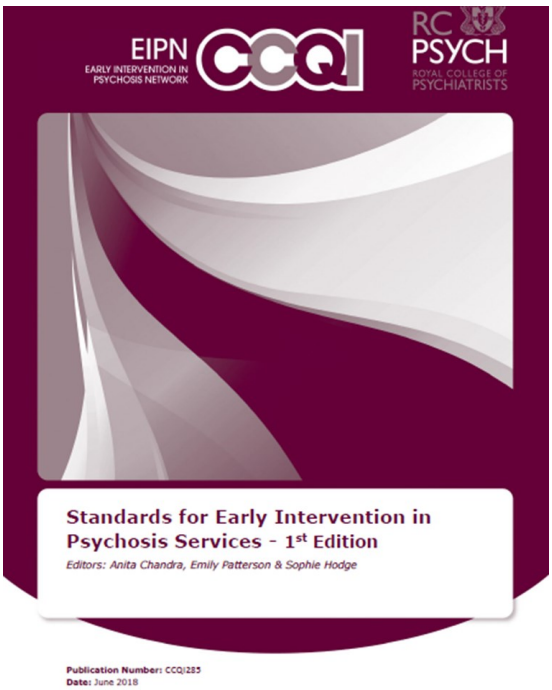
We believe everyone living their first episode of psychosis should:

- Have the best possible **care** and **treatments**

- Be able to access services **quickly**

- Be treated by people who have **hope** and believe in their **recovery**

- Work with people who go the extra mile to **engage** with them



We've just published our first edition of Standards for Early Intervention in Psychosis Services.

They are 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.

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

Surrey and Borders Partnership NHS Foundation Trust

Our Allotment Project- Gardening is Good for Physical and Mental Health!

We started work on our allotment in January 2018. When we first took ownership of the allotment it was very overgrown with uneven beds. We started with no tools or seeds and no actual funds to help with this. We decided that we would approach local businesses to request if it was possible for them to donate any items including tools or gardening materials that would help get us set up!

Fortunately… this turned out to be a great success and many companies happily gave us spades, roof felt for our shed roof which needed replacing, scaffolding boards to make beds, and our local garden centre in Surrey were very generous with hand tools and seeds. We even attended HMP Wandsworth who kindly donated refurbished tools to us, which they give to many community projects throughout the year. We have also helped finance the project by setting up a 'sausage sizzle' at our local hardware outlet, with client helping with the cooking and we made over £300 selling sausage sandwiches to the general public. The local community were so incredibly supportive and we were getting the EIP name out there and stamping out stigma!

The first half of this year, we developed the allotment and cleared the plot, deciding what seeds to plant in each bed, digging the trenches for the scaffolding boards to divide the beds and general maintenance to bring it to life! We initially starting the growing process by planting seeds in pots, kept in trays around the EIP office, many of our team members took the seedlings home to foster them while they grew (we only have so many window sills) and until they were ready to plant.

Our allotment plot, before and after

Soon after, we set up an allotment group for our EIP clients. Our clients took great pride in planting and planning the allotment, turning up each week to plant, weed and water daily when the weather was boiling hot and the ground was dry. The commitment is phenomenal. Some clients even donated plants from their home to grow on the plot and each week they would rush to the site and see what had grown and if there was anything to harvest.

Our allotment shed

So far we have we have donated several different crops to our clients and have given rhubarb to the York Road Homeless project. Our crops so far include corn on the cob, courgettes, marrow, tomatoes, rhubarb, potatoes and chillies. This has been a great source of excitement for our clients and we also have created a folder of recipes of the produce we have grown so that clients can choose which recipe they would to try when they take the produce home. The rhubarb crumble really went down well at York Road Project!

Flowers

We are now planning a BBQ at the allotment at the end of August to celebrate the amazing work with our clients and we will also use it as an opportunity for new clients to visit with their care coordinators to enable them to have a taster of what the allotment is like and to take home some produce. The benefits of having an allotment are vast. Feedback from clients has highlighted many things, including how the social aspect of coming to the allotment has helped increase confidence and decrease anxiety as many of our clients struggle with meeting new people in a social setting and at the allotment the find they are talking to other clients without realising while they dig or plant or water the plants. Other client feedback has shown that it is good for physical health as gardening is a great way to exercise and being out in fresh air with nature is such a mood booster. One client has said "the experience of the community allotment is very beneficial to me. I would recommend this!"

The clients have really helped this project get underway and because of them and their input, it is going from strength to strength. We have people in their teens to people in their 60's attend. We have also truly put our stamp on the allotment plot by planting some flowers which spell out 'EIIP'- a service which all are proud of, in an environment which is so very rewarding in so many ways!

Our fundraising event

Our produce

Sarah Aylott, Support Worker, Kate Allen, Service Manager, Early Intervention Team in West Surrey and North East Hampshire

Coventry and Warwickshire Partnership NHS Trust

Adapting to Our Patients: The Home Visit Physical Health Screen

The Clinical Problem
Many mental health clinics have problems with non-attendance by patients. Our audit work conducted across 2017 and 2018 demonstrated that the attendance rate for those offered a physical health screening appointment with our mental health team in the previous year was 63% (sample size 94 EIT patients). Here the did not attend (DNA) rate was 21%, with 9% postponing and 4% not attending with a reason given and a further 2% declining the assessment.

Other data from mental health research has shown a similar problem, with various samples giving significant DNA rates. For example the rate of missed appointments was 36% in initial work by Sims et al (2012) which was later reduced by text message reminders to 26-27% (Sims et al, 2012). Another analysis which included nine studies of various mental health clinic settings by Hawker (2007) found that DNA rates varied between 11 and 36%, dropping in each study after an opt in system was introduced, with the exception of one study where the rates remained unchanged (Hawker, 2007).

What is the Physical Health Screening Check?
These assessments allow us to keep up to date with each individual's current medical co-morbidities and medications as well as monitoring their psychiatric medication and providing general health promotion advice. This is of high importance and was recognised in the government review 'No Health without Mental Health' which set an objective that more patients with mental health problems will have good physical health (HM Government, 2011). The content of these checks includes elements from the Royal College of Psychiatrists (Psychiatrists, 2009) and consists of taking a medical, family and medication history as well as screening for smoking, substance misuse and completing blood tests, an electrocardiogram (ECG) and a blood pressure measurement among other assessments.

These physical health screening checks have many benefits, including keeping our team up to date with any action the GP is taking or any new physical health diagnoses. Further benefits include medication monitoring and early preventative work, for example encouraging patients to stop smoking, giving diet and exercise advice and encouraging attendance at screening appointments. The aim of this is to address problems early and help reduce ongoing detrimental effects on mental and physical health. For example, some of the most important outcomes in the last year have included a new diagnosis of diabetes, ECG changes and vitamin deficiencies. Therefore our team felt it was important to maximise the clinics effectiveness and accessibility.

What did we do?
As a team we considered options for improving the attendance rate for our physical health screening programme and alongside using reminder letters and increasing the number of sites the clinics were conducted at, a physical health home visit clinic was developed. This method would further help us to assess the physical health of those patients on our caseload who were unable to attend the clinic due to limitations in their physical or mental health.

However, there are always issues to overcome when making changes to clinic structure and some of the key issues we faced included equipment needs, chaperone requirements, blood test processing, travel time and staffing requirements. New equipment was therefore ordered including more blood testing equipment and a portable ECG machine to make the testing more mobile. Care coordinators were vital in helping patients to feel comfortable and acting as chaperone. Due to staff time commitments this was initially set up to run once per month only and blood tests were dropped at the pathology laboratory at the end of each clinic. Ongoing consideration of how to improve these factors further continues.

Did it help?
Following this process being completed the clinic was set up once per month and three clinics have been conducted so far, a total of 10 patients have been offered this form of physical health screening check and the home visit clinics have a current attendance rate of 100%. This has therefore given us early evidence that this method is likely to be effective in increasing screening attendance. Overall it will be a method the team continue to utilise and develop in the future and may be of benefit to other teams with similar concerns.

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

Dr Karen Romain (CT2), Dr Keri Thompson (CT1), Dr Richard Onyon (Consultant), Early Intervention Team South Warwickshire

Lancashire Care NHS Foundation Trust

Family Intervention: A Brief Discussion

It may be somewhat surprising to the reader to be informed that a therapeutic modality acknowledged universally as a successful intervention in reducing psychotic relapse and carer distress, has not been successfully embedded into common practice within mental health care (Claxton, Onwumere, & Fornells-Ambrojo, 2017; Garety et al., 2008; Yesufu-Udechuku et al., 2015). This is despite national guidelines published, (NCCMH., 2010) reassuring consumers that the intervention is not only desirable but also is of economic interest under the guise of good practice (Glynn, 2012; F. Lobban et al., 2013). Never the less, over 50 years has elapsed since two influential theories, Double Bind (Bateson, Jackson, & Haley, 1956; Gibney, 2006) and Expresses Emotions (Leff & Vaughn, 1985) were proposed, which acknowledged the influence of maladaptive family interactions that may predict a negative impact on the recovery of people experiencing psychosis (Barrowclough & Tarrier, 1998; Koutra et al., 2015). Here, it must be averred that psychosis is classed as a significant mental health issue worldwide characterised by high levels of unpredictability, personal and interpersonal difficulties that impact on the family home-life, environment and atmosphere (Grice et al., 2009; Onwumere, Bebbington, & Kuipers, 2011). Indeed, Shpigner (2013) identifies the salient fact that most families have not had time to prepare for the non-normative events of psychosis and have little experience of coping with the situation they find themselves in (Shpigner, Possick, & Buchbinder, 2013).

Overtime expressed emotion (EE) has become more predominant, with researched theory driving the development of various forms of family interventions (McFarlane, 2016; Pharoah, Mari, & Rathbone, 2010). Many of these FI models have, adapted and integrated CBT principals within their theoretical foundation (Barraclough & Tarrier, 1997; Bradshaw, 2002; Fiona Lobban & Barrowclough, 2016). However, Brief Family Therapy (BFT) (G Fadden, 1998; Faloon, 2003) (G. Fadden & Heelis, 2011) is widely championed as the therapy of choice as it, ostensibly, promotes family resilience based on behavioural management alone (NICE, 2015a). However, BFT, due to the consideration that family work cannot occur without the service users presence, does not formally offer individualised interventions to carers and overlooks the potential need of carers for privacy to express themselves away from the service user (NICE, 2015c). This is a potential fallacy, as published articles and textbooks often refer to the absence of the service user from family therapy interventions meetings (F Lobban & Barrowclough, 2009). Conversely the model developed by Barraclough and Tarrier (1997), is CBT orientated and includes the flexibility to work with the family, as a group or with individual carers.

Despite this published evidence and development of FI interventions,(Caqueo-Urizar, Rus-Calafell, & Urzua, 2015; Eassom, Giacco, & Dirik, 2014) it has been needful for NICE Guidelines in 2016 to include FI within their Quality Standard 80 in an effort to remedy the inconsistency in family interventions offered to carers (NICE, 2015b, 2015c). This awareness, that misinterpretation of communication within a family can lead to psychotic relapse, has led to multiple seminal studies including trials and systematic reviews during the last half a century (Bird et al., 2010; McFarlane, 2016). In response to this criticism of inconsistency, Eassoms' (2014) research describes many cited barriers to the instigation of family therapy within mental health services, such as inadequate referral pathways, high caseloads, and surprisingly lack of family engagement; although this reluctance (Yesufu-Udechuku et al., 2015) may be due to the associated stigma, linked with the early premise, that mothers were to blame for psychotic presentations in their offspring (Faloon, 2003; Leff & Vaughn, 1985). Additionally, Easson argues that internal changes need to occur within the culture of mental health services to facilitate the translation of FI research into practice and consistency of approach within teams. Whilst it is easy to declare that it is the in-place culture and deficits in team acceptance of the need for FI is the problem, other researchers (Gracio, Goncalves-Pereira, & Leff, 2016) have considered that there is little known about the active and effective ingredients that fall under the banner of FI: such as psychoeducation, therapeutic relationship, reframing attributions, and suggest further research is required to identify these efficacious variables; (Claxton et al., 2017; Sadath, Muralidhar, & Varambally, 2015).

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

Miv Riley, Senior Care Co-ordinator, Lancashire Early Intervention Service—North

Hertfordshire Partnership NHS Foundation Trust

The PATH Service: Current rewards and challenges of a shared case management approach

Launched in June 2017, the Psychosis Prevention, Assessment and Treatment in Hertfordshire (PATH) service works with approximately 450 service users across the county, and this number is expected to rise exponentially over the next three years. Due to significant challenges in recruiting registered mental health professionals, the service has implemented a 'mini-team' caseload model to address the demands on case management and the challenge of providing specialised care.

Recently presented at the annual EIPN meeting, the 'mini-team' model comprises of a Band 6 registered mental health practitioner, a Band 5 associate practitioner (AP) and a Band 4 support, time and recovery worker (STAR worker). The AP role is a new post, designed for individuals with a psychology degree who help to provide psychological interventions under supervision, alongside assisting in care-coordination. The mini-team is designed to deliver care to 35 service users instead of the recommended 15 per care coordinator. The Band 6 care coordinator is an accountable practitioner responsible for organising the overall care of service users, and provides direct supervision for the Band 5 and 4 practitioners. A competency framework and training programme has been developed by PATH to support the mini-teams in their professional development. Overarching clinical leadership is provided by a lead psychiatrist, nurse consultant and lead psychologist who support the mini-teams in clinical interventions and consultancy. An operational team across the county also functions to support the efficiency and effective running of the service.

One of the PATH Associate Practitioners, shares her experience of the rewards and challenges of working in a mini-team:

"Sharing a caseload with two other colleagues is helpful in providing the intensive support required for EIP clients. For example, we recently conducted interim daily visits to a service user whom we were particularly concerned about, but who did not yet meet the 'crisis' threshold. I believe the mini-team model allows us to engage with clients from an increasingly flexible and assertive approach; as opposed to traditional one person care coordination.

Within our mini-team we are able to draw on each other's strengths which is important in providing better opportunities for service users. In reference to one client, the STAR worker has been able to provide practical support such as encouraging access to community resources, our nurse has provided the medication monitoring, and I have delivered a psychologically informed intervention. Three professionals working directly around one client seems to provide more accessible care. We are also able to provide support for families and carers, which we hope is valuable for those supporting a loved one experiencing a first episode of psychosis.

Receiving weekly supervision from a psychologist has been both invaluable to my development as a practitioner, and in formulating our client's presentations both systemically and individually. Being able to provide prompt access to psychologically informed interventions has been rewarding. For instance, I recently worked with somebody who was isolated and could not leave their bedroom due to hallucinations. After a care-plan consisting of medication and a programme of graded-exposure; they have grown in confidence and are looking to get a job.

Like all jobs, the AP role is not without its challenges. Managing the boundaries of starting a piece of psychological work with someone and the transition between ending a piece of care coordination can prove problematic. Sometimes the clients want help with their basic needs such as benefits or medication and you have to direct them to someone else in the team which can be confusing or frustrating for the client.

For me, the Associate Practitioner role is embedded well within the mini-team and represents a dynamic and challenging post. I am very lucky to have a mini-team who I work well with and it is a great help that we all work with the same clients and carers so we understand the idiosyncrasies particular to working with each client. I hope that the service users and families share the same view of the mini-team approach and I look forward to what new things the PATH service can bring."

Although PATH is not yet fully staffed, we hope the service will continue to grow in its committed workforce and will persist in its endeavour to provide specialist care, empower service users, and reduce the duration of untreated psychosis.

We are privileged to be part of so many people's lives and stand alongside them in their journey towards recovery.

Charlotte Gould, Associate Practitioner, Dr Zohra Taousi, Lead Consultant Psychiatrist and Hildah Jiah, Lead Nurse Consultant, PATH Service

What we did in 2017

Last year we were invited to work with five teams in England;

First, we **collected** more detailed information about their teams;

We visited them for a day to help them reflect on practice, by discussing the information and self-assessment results:
- Conducted by a trained team of peers;
- Help us understand local context;
- Highlight areas of achievement and areas for improvement;
- Work together to generate solutions to problems

We provided them with a report, summarising our findings
Action planning

Lancashire Care NHS Foundation Trust

A day in the role of an EISp care coordinator

Brief Background
I have been a senior care coordinator within the LCFT Early Intervention Service (psychosis) for over eight years. All coordinators in the EIS service, use PSI in a CBT informed approach to interventions when working with service users.

Engaging in the recovery process with service users, the face-to -ace work is most rewarding, as it is this collaborative therapeutic work that helps them return to work, education or employment or just be the best they can be for themselves. However, I cannot get away from the mundanities of the care coordinator role for instance, duty role, attending meetings, completing mandatory training, making entries on the electronic care plan system, i.e.: writing care plans, answering/sending emails, updating risk assessments, updating health and social needs, and other such data entries. Not my favourite part of the role, but necessary as part of the care offered.

08:00-4.30pm Monday 20 August 2018
The team I work for is classed as semi –agile, this means that we each have a laptop and can work from where there is an LCFT access point/ desk, or even from home. I am fortunate in that I live about 10 minutes from the EIS office base and generally set up my laptop at home for 07:45am. On this particular day I have two visits and one assessment to complete and will be traveling between St Anne's, Blackpool and Fleetwood. I also have it noted in my diary to make two cold calls on service users who had not been available for booked appointments in the previous week.

08:00am
At approximately 8:00am, I start work by reviewing and replying to emails and writing up any visits or activities that I undertook the previous day into service user records. Making any required phone calls also.

09:30am
Every weekday morning at 9:30am, EIS staff remotely access the morning team meeting. The aim of the team meeting is to discuss referrals received the day before into the service, the suitability for assessment, allocating the assessment to an available care coordinator, providing feedback from completed assessments and information sharing around any service users that had specific needs from the previous day.

The meeting can take from half an hour to 1.5 hours depending on the complexities of discussions.

I ensure the duty worker is aware that my appointments diary is up to date before I start community-based visits.

10:45am (Psychosis Group) Appointment 1: St Anne's: (approx. 1 hour)
This service user has been under my care coordination for a few months. We had already completed early warning signs, a family tree and a timeline of his illness as he recalled it. Together we review this work and wonder how we can move forward, eventually agreeing on the development of a pictorial mood diary as he could use his artistic skills and found it easier to draw feelings than speak about them at this time. We agreed to come back to this at our next meeting.

12:00pm (ARMS Group) Appointment 2 Blackpool (approx. 75 mins as it included a post meeting normalisation discussion with the service user)
The service user had been in full employment and have been off work now for a few months and his employers HR advisor had asked for a meeting a well-being meeting. This is more of a supportive activity for the services user, who had experienced high levels stress and depression due to pressures at home. The employer was reassured that their employee was moving forward in his recovery and the potential of a phased return to work in next few months whilst remaining supported by EIS.

Brief lunch break
Parked, looking at the Lake District coastline…. (20mins approx.)

14:00pm Assessment in Fleetwood (approx. 1.5 hours)
The CAALMs assessment took 1.5 hours to complete. I wrote an objective overview of the assessment, attached it to a secure email for the duty worker to feedback into the next morning meeting as I would be off.

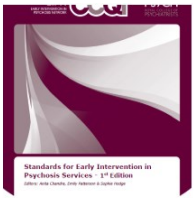
15:35pm
On the way back from Fleetwood, I called on two service users who did not attend their booked appointments. One did not answer the door, phone or text messages so I left a note in the letterbox. I will follow up with a further appointment letter. The second service user was in. She had attended a meeting with the social services and was unhappy with the pressure

she felt she was under. At 17.00pm, at the end of this appointment I phoned in safe to the EIS office to let them know I was going home and had completed my work shift.

Mileage for the day was recorded as 34.5. and no speeding ticket.

Miv Riley, Senior Care Co-ordinator, Lancashire Early Intervention Service—North

Benefits of EIPN membership



Individualised reports

Peer support & learning from service users

Bespoke quality improvement advice

Benchmarking with other EIP teams

Free places at our future annual conferences & special interest days

Opportunity to visit other services in our network

Mersey Care NHS Foundation Trust

Implementing Family Pathways in an Early Psychosis Service

The five year forward view has tasked EIP services with reducing barriers to treatment in psychosis and ensuring that all people with psychosis, and their families, are able to access evidence based treatments. Working with families of people with psychosis has a strong evidence base. Family interventions (FI), focussing on assessment of need, information sharing, stress management and goal setting, have been shown to reduce relapse, reduce hospital admission and symptom severity, improve social functioning plus improve family coping, through reduction of stressful patterns of communicating and coping within families (NICE 2014). Guidance suggests 10 sessions delivered over 3-12 months.

Despite a long history of efficacy there are acknowledged challenges in implementation and delivery of these interventions with less than 16% of families accessing. Service barriers to implementation are recognised as a lack of organisational or management support for implementation; a lack of caseload adjustment following staff training; poor access to supervision; staff confidence in working with families and preferred biological models of psychosis. Family and service user barriers are also recognised through negative attitudes of families towards FI; FI not being delivered in equal partnership or with cultural sensitivity, or service users being too medicated to take part (Fitzsimons, 2018).

We work in an Early Intervention in Psychosis service in Merseyside, which includes inner city Liverpool, with high levels of deprivation and ethnic diversity, with a total three year caseload of 800. Within our local service our own experience of failed implementation mirrored this evidence base. Practitioners undertaking training struggled to integrate into workload due to high caseloads, and there was a lack of consistent supervision. There could also be confusion within the team around where the psychoeducation and support of a care coordinator ended and FI began.

As the service thought about working with families, the importance of a "think family" approach, looking at family and social networks' needs across the care pathway was recognised. The spectrum of need was considered ranging from information sharing and practical support, to group based interventions, through FI, with some families benefiting from more systemic family therapy.

With additional investment from commissioners, we looked at models for developing an effective family service. We were inspired by the work of Burbach and Stanbridge (1998, 2006) in Somerset who adapted a systemic approach to FI and through this managed to implement training and family work throughout the Trust. The service was also further interested in other, less evidence based but still well recognised ways of working with families including multiple family group and open dialogue approaches (Asen, 2002, Seikkula 2006).

It was felt most helpful to develop a post for a family therapist who would be able to take a family and systemic approach across the service, supporting practitioners to "think family", building on already established relative's education groups, supporting training, implementation and supervision of family interventions, and delivering family therapy to families with more complex needs. A senior Family Therapist post, Band 8a, was decided upon due to the level of strategic work and supervision required.

Implementing Family Pathways in an Early Psychosis Service – from the point of view of a Family Therapist in post

Starting the role

Fresh from completing the supervisor's course, I wanted to clarify the implicative and contextual forces (Cronen, 1992) that I would be faced with within the first few months of the new post. This involved taking the time to understand the variable experiences of FI across the staff group and meeting with my immediate line manager and Dr Stevens, to hear more about their hopes for the development of FI over the coming months. Within four or five weeks I had become aware of what was expected of me and the attitudes of the staff group I'd be directly working with towards this. I noticed a broad sense that the topic of FI had become a nuisance of sorts and one dominant narrative of 'we do it already' was loud and clear from Care Coordinators. Taking that narrative at face value, I began strategising how my role could introduce something new, novel and exciting to the pre-existing understanding of FI.

Successes

I like to think we have had instant success in implementing family work across the large patch we cover. Simply put, we can now offer an

increasing range of family work to our service users and all staff can access systemic consultations about their cases.

Any family work can be live and retrospectively supervised and we now have a clearly mapped out referral process. We have developed and delivered in house training and we hope that, by Spring 2019, 100% of our care co-ordinators, and perhaps Psychologists, are trained to deliver FI. Our service has begun connecting with other services that are also embedding Family Intervention and increasing the presence of Family Therapy in their teams. No doubt the introduction of a National Forum for Family and Systemic Therapy in EIS, set up by my former colleague Paula Kennedy, will help teams to synthesise and collaborate their efforts.

Hurdles

However, barriers still remain and I have been challenged by the pressure to take abstract concepts and fit them into a mould of clearly defined operational paradigms. I believe too much rigidity risks losing the beauty and art of any therapeutic endeavour so I have been conflicted when trying to build a framework around understanding the 'what' and the 'how' of systemic work within EIS. I have developed referral frameworks and hosted introductory workshops in understanding family work in addition to using consultations and supervision to help staff work with the uncertainty and unpredictability of families. Embracing uncertainty is thought to create more dialogue between staff and families and according to Anderson and Goolishan (1992), it reduces the opportunity of misunderstanding.

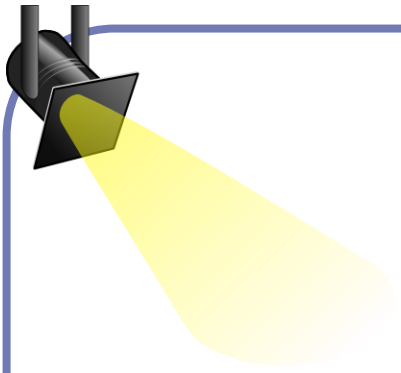
However, despite offering training and supervision, staff remain faced with high caseloads, increasing time pressures and extra administrative duties. A new Electronic Patient Record system and a Trust wide push for mandatory training compliance has seemingly lessened the priority of, or perhaps space for, staff to embrace new practices.

Future

Lastly, we are piloting the introduction of Family Interventions within the first 10 weeks of a new Service User (FEP) journey in EIS. This is creating a shift towards earlier involvement and support for families in the care of their relative. In addition to this, despite losing some family therapy capacity, we are just ready to go live with a weekly Family Therapy Clinic and we hope to give in vivo development opportunities to staff across the service. The future's bright.

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

David Kenny, Family Therapist and Dr John Stevens, Consultant Psychiatrist and Family Therapist, Liverpool and Sefton Early Intervention Services



EIP Spotlight Audit 2018/19

The National Clinical Audit of Psychosis (NCAP) will be carrying out an EIP spotlight audit in 2018/19.

This will replace the existing self-assessment that has been carried out by the Early Intervention in Psychosis Network (EIPN).

For further information about the audit, please visit the NCAP website on: www.rcpsych.ac.uk/ncap.

NCAP
NATIONAL CLINICAL AUDIT OF PSYCHOSIS

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

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

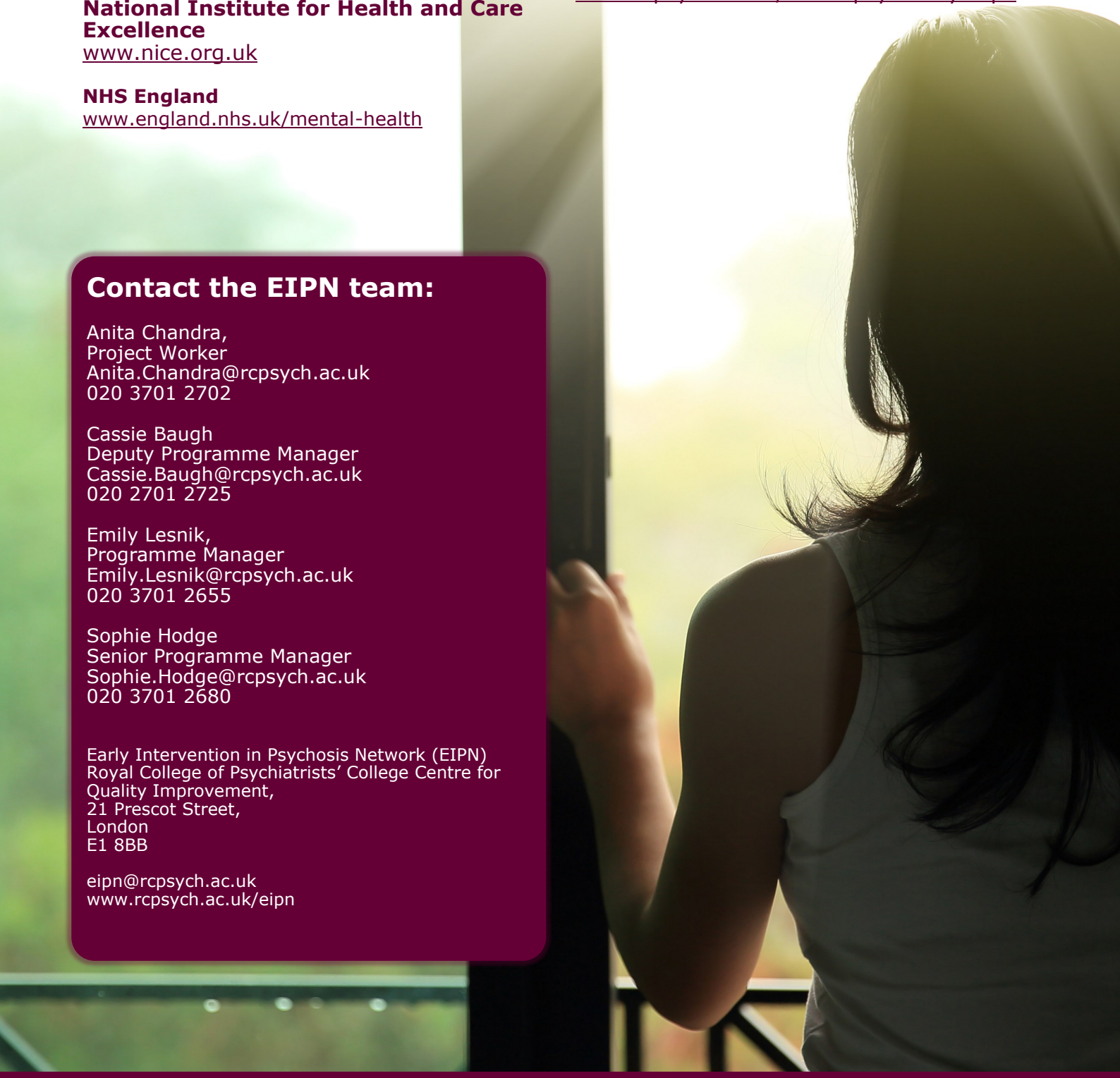
National Institute for Health and Care Excellence
www.nice.org.uk

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



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