Psychosis Care Pathway and Narrative
### Routine Referral

**Screen**
- Referral received
- Tel. triage using screening checklist to:
  - determine urgency
  - consider medication, social, psychological and physical health needs

**Assessment**
- First face to face contact within 7 days
- Medication screen within 3 days of referral if on prescribed medication

**MDT Discussion**
- Within 7 days of assessment
- Earlier medical review if concerns
- Discharge/signpost if psychosis pathway not appropriate

**Care Plan/CPA**
- Allocation of a care coordinator and care plan within 14 days of referral
- Formulation by medic within 21 days of assessment

**Delivery of Care**
- Engagement from first contact (incl. assertive):
  - As indicated:
    - Social care
    - Medication
    - Psychological interventions
    - Physical health
    - Substance misuse
    - Carers support

**Review of Care Plan**
- If deterioration in mental health/crisis/relapse:
  - Identify any deterioration early and fast track
  - Consider acute care pathway
  - MDT discussion (CPA if criteria met) to review medication, social, psychological and physical health needs; update care plan
  - Consider advance statements
  - Patient and carer views
  - Communication with GP
  - WRAP/Recovery College
  - Review outcome measures incl. PROM

**Review as Required by Personal Plan**
- **Weekly face to face:** if first episode
- **Weekly:** if medication changes, changing mental state, current risks, carer concerns, specific interventions
- **Weekly/biweekly:** if difficulties engaging in services
- **Every 4 weeks:** consider Clozapine if no response to antipsychotic medication. If mental state is settled, consider increasing review to 3 monthly then 6 monthly
- **Annual review:** (if not indicated sooner) of Care Plan/CPA (incl. items listed in Care Plan / CPA box above). Completion of outcome measures

**Discharge**
- Plan with patient/service user, carers and GP if over 6-12 months:
  - Stable and functioning well
  - No medication or stable medication
  - Not detained
  - Acute care pathway not needed
- Complete crisis and contingency plans
- Comprehensive communication with primary care, patient and carer
Crisis and Acute Care

**Screen**
- Referral received
  - determine urgency
  - consider medication, social, psychological, and physical health needs

**Holistic Assessment**
- Centred around views of patient and carer (review assessment if one already present)
  - engagement
  - medication, social, psychological, and physical health needs
  - patient and carer views
  - outcome measures incl. PROM

**MDT Discussion**
- Involving medical, nursing, and social care staff as minimum to agree:
  - provisional formulation /diagnosis
  - priorities for care planning

**Care Plan/CPA**
- Update care plan
  - Risk management plan
  - Physical health
  - Safeguarding (adult/child)
  - Social issues
  - Family issues
  - Medication Management plan
  - Carers support
  - Consider psychological interventions
  - Commence discharge planning

**Delivery of Care**
- Assertively engage if needed
  - Begin/adjust medication, (crisis management), social care unless contra-indicated
  - Initiate psychological interventions (see stepped pathway)

**Review**
- MDT discussion (CPA if criteria met) to review mental state, medication, social, psychological & physical health needs; update care plan
  - Advanced statement
  - WRAP, vocational needs
  - Review outcome measures incl. PROM
  - Worsening mental state:
    - monitor risk
    - monitor changes
    - monitor compliance
    - monitor self care
  - Review care plan
  - Review psychological interventions (see stepped pathway)

**Transfer to Community Team**
- MDT discussion
  - Review needs and plan care including crisis plan
  - Comprehensive communication with community team, primary care, patient and carer

**Screen**
- Within 4 hours

**Assessment**
- Urgent – Face to face within 24 hours
  - MHA assessment if needed
  - Medication review within 48 hours of referral

**MDT Discussion**
- Within 24 hours of assessment

**Care Plan/CPA**
- Within 24 hours of assessment, consider medication
  - Formulation with medic within 72 hours of assessment

**Delivery of Care**
- Commence within 24-48 hours of assessment
  - Medication review within this time frame
  - Allocation of a care coordinator within 14 days

**Review as per Personal Crisis Plan**
- In crisis: daily or twice daily if needed for medication compliance, interventions, review of risk and mental state and need for inpatient care, etc.
  - Review of frequency via MDT. Discuss response to treatment
  - Discharge CPA (if inpatient) within 7 days of assessment
  - 7 day follow up after discharge from acute pathway
Contributions and Acknowledgements

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Introduction

TRIumPH (Treatment and Recovery In PsycHosis) is a care pathway for people with psychosis that aims to promote good clinical practice. The pathway details the services that people experiencing psychosis can expect during different phases of their care. The pathway is informed by the success of other pathways (e.g., stroke and cardiovascular), current evidence base and by best practice guidelines. It aligns itself to the NICE Guideline for Schizophrenia (2014), the National Audit of Schizophrenia (NAS)\(^1\), NICE Quality Standards (2015)\(^2\) and to the Access and Waiting Time Standards for Mental Health Services (2015/16)\(^3\).

The NICE Quality Standards (2015) and Mental Health Access and Waiting Times Standards (2015/16) state that:

- Adults with first episode psychosis will be treated with a NICE approved care package within 2 weeks of referral. This is measured by allocation of a care coordinator in a service which provides the range of NICE approved treatments.
- Adults with psychosis or schizophrenia are offered cognitive behavioural therapy for psychosis.
- Family members of adults with psychosis or schizophrenia are offered family intervention.
- Adults with psychosis or schizophrenia that have not responded adequately to treatment with at least 2 antipsychotic drugs are offered Clozapine.
- Adults with psychosis or schizophrenia who wish to find or return to work are offered supported employment programmes.
- Adults with psychosis or schizophrenia have specific comprehensive physical health assessments.
- Adults with psychosis or schizophrenia are offered combined healthy eating and physical activity programmes, and help to stop smoking.
- Carers of adults with psychosis or schizophrenia are offered carer-focused education and support programmes.

The pathway is underpinned by ten Principles of Care which define the overall approach, treatments, and standards. A key expectation of this pathway is that it supports timely delivery of evidence-based interventions by appropriately trained and supervised staff. Care is shaped by the monitoring of treatment outcomes using clinician and patient/service user completed outcome measures.

This pathway document covers aspects of care from assessment, through to treatment delivery, training and provision of clinical supervision, to discharge from secondary care services. The pathway operates for all people experiencing psychosis who are involved with Southern Health NHS Foundation Trust (SHFT), regardless of the care team providing the service; see diagram below.

Psychosis in the elderly is complex. There are multiple co-morbidities and the psychopathology is not necessarily the same as in adults. The general principles of this pathway will apply to functional psychosis although necessary adaptations will be required to ensure that person-centred care can be provided to this group.
References

1. The National Audit of Schizophrenia (NAS) (2014) has been consulted in creating this pathway. The NAS focuses, in the main, on the prescribing of medication. Psychological Therapy is noted as an intervention to be offered where the “illness” is treatment resistant; this does not align to the NICE Guideline Update (2014). Currently the NAS shows that the majority of patient/service users were offered no psychological therapy even in the case of standard treatment ‘resistance’. Given this, and the need to ensure the pathway draws on all possible evidence base or recommended treatment options for psychosis, the pathway aligns itself to the NICE Guideline (2014) rather than the NAS.


Principles of Care

This psychosis pathway is supported by the ten principles of care. These principles underpin the approach that all people experiencing psychosis can expect from the care provided by SHFT.

**Principle 1:** People who experience psychosis can expect care which is underpinned by up-to-date bio-psycho-social understandings of the development and maintenance of psychosis and recovery. Respect will be given to people who wish to explore alternative frameworks for understanding their experiences (alternative to illness model).

**Principle 2:** People who experience psychosis can expect care to be directed towards recovery and delivered in an atmosphere of optimism and hope.

**Principle 3:** People who experience psychosis will be supported to maximise the amount of control they have in their lives at every point in the pathway.

**Principle 4:** Treatments offered for the experience of psychosis will be evidence-based and align to best practice guidelines such as the NICE Guideline for Schizophrenia (2014). People experiencing psychosis can expect such interventions to be delivered by appropriately trained and clinically supervised staff, and that psychosocial outcomes from any treatment will be appropriately measured to ensure recovery and progress is transparent to both the patient/service user and staff.

**Principle 5:** People on the psychosis pathway will have the same right to be consulted and informed about any issue in the same way as patient/service users on any other pathway. This includes being consulted about service developments, being given the chance to express opinions about services and having access to information.

**Principle 6:** Across all phases of the episode of psychosis and across all care teams, care packages will include a combination of psychopharmacological, psychological, and psychosocial interventions to create an optimal treatment environment. Psychological strategies will be supported by care staff with equal weighting with psychopharmacology so as to support recovery and not undermine it by creating a unilateral dependency on medication as a means of alleviating distress.

**Principle 7:** Care packages offered will be ‘holistic’; taking into account all domains of the person’s life which are impacted on by the experience of psychosis and provide advice about appropriate support.

**Principle 8:** People experiencing psychosis will be treated with respect at all times, and their dignity and safety will be protected by care staff during the times when they may become overwhelmed by their experience.

**Principle 9:** Psychosis is personally meaningful to each person who experiences it, although this is not always obvious to others. As such the content and origin of thoughts, worries and fears, and the behaviours they drive will be given due regard and not dismissed as meaningless.

**Principle 10:** Stigma has a significant impact on recovery from psychosis. People experiencing psychosis can expect to be treated in a de-stigmatising environment which will be driven by the behaviours of staff, expressions of understandings by staff, and adherence to these Principles of Care. Early detection can reduce the duration of untreated psychosis so people should receive treatments and support as soon as they need them.
Psychosis Care Pathway and Narrative

Care of the Individual

Person with possible psychosis

Engagement

Ask questions to identify if the person may have psychosis. Seek information from primary and secondary sources

Additional considerations (including substance misuse, anxiety, depression, trauma, learning difficulties or disability)
Cluster 16-Dual diagnosis with substance misuse

Cluster 10 if first episode of psychosis

Holistic assessment and formulation of needs

Risk assessment and management

Collaborative care planning

Treatment and therapy options

Monitoring of progress and review

Transitions and endings
WRAP

Ongoing recurrent psychosis 11,12,13

Psychotic crisis 14

Cluster 17: assertive engagement
Early Detection

Identify if the person may have psychosis

Use information from the mental health assessment including the mental health examination and from other people, especially family to make a decision which may take a few weeks or even months to confirm.

What does ‘psychosis’ mean?

‘Psychosis’ is a psychiatric term, and describes experiences, such as hearing or seeing things or holding unusual beliefs, which other people don’t experience or share. For many people, these experiences can be highly distressing and disruptive, interfering with everyday life, conversations, relationships, and finding or keeping a job.

Identification of psychosis can include the use of diagnostic criteria and validated measures to conceptualise the information the service receives. For example, ICD-10 or DSM V criteria.

Screen

A ‘checklist for psychosis’ tool is available for referrers to provide guidance as to whether someone may be developing a psychosis and involves allocating points to presenting symptoms or issues, such as:

- Family concerns, use of alcohol, street drugs, isolation.
- Sleep difficulties, depressed mood, poor concentration, tension or nervousness, restlessness.
- Feeling, hearing or seeing things other people cannot or feeling people are watching them.
- Ideas of reference, odd beliefs, inappropriate mood, odd behaviour or appearance, family history of psychosis.
- Psychosis needs to be the core of the problem.
# Checklist for Psychosis

<table>
<thead>
<tr>
<th>Patient/service user name</th>
<th>DoB</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The family is concerned</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Excess use of alcohol</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Use of street drugs</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Arguing with family and friends</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Spending more time alone</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Sub total</strong></td>
<td></td>
</tr>
</tbody>
</table>

| Sleep difficulties |     |
| Poor appetite      |     |
| Depressed mood     |     |
| Poor concentration |     |
| Restlessness       |     |
| Tension or nervousness |     |
| Loss of pleasure from things |     |
| **Sub total** |     |

| Feeling people are watching you* |     |
| Feeling, hearing or seeing things other people cannot* |     |
| **Sub total** |     |

| Ideas of reference* |     |
| Odd beliefs*        |     |
| Odd manner of thinking or speech |     |
| Inappropriate mood  |     |
| Odd behaviour or appearance |     |
| Family history of psychosis in parents/siblings/grandparents |     |
| **Sub total** |     |

Refer if total \( \geq 20 \) or

*if any item with an asterisk is endorsed
Holistic Assessment

Engagement

Engagement is the process of getting to know the patient/service user, their strengths and weaknesses and aspirations. It is something that begins at first contact and is ongoing throughout the patient/service user’s involvement with services.

Assessment

A person with a possible psychosis entering the service will have a comprehensive assessment which will help to identify with the patient/service user how the service can best meet their needs.

The assessment aims to:

- Aid the formulation and/or understanding of the patient/service user’s difficulties.
- Inform the treatment plan, e.g. suggest a specific treatment is indicated, or highlight treatments that are contraindicated or not likely to be helpful.
- Consider whether a clear diagnosis of psychosis would be helpful and/or alter the treatment currently being offered.
- Help the patient/service user’s own understanding of their difficulties.

A multidisciplinary team approach is required, which may consist of a psychiatrist, clinical psychologist, nurse, social worker, occupational therapist, support time and recovery worker. Consent for the assessment should always be obtained from the patient/service user and an explanation given as to its purpose and possible outcomes.

The assessment is likely to consist of a combination of the following:

- A face to face clinical interview and mental state examination.
- Full history, taken both face to face and from the notes allowing sufficient time for this process, to include risk history and experiences of trauma and assessment of physical health.
- Information from family, carers and other relevant organisations (e.g. Police, A&E, primary care, social services and the voluntary sector) should also be included where possible.
- Psychometric assessment can be considered – e.g. WAIS III, WMS III, BADS, if memory, executive functioning or cognitive impairment is thought to be present.
- Advice, information and support from other relevant organisations (e.g. specialist teams, forensic team etc.) should be sought when required.
- Every effort should be made to engage the person in an assessment at this stage including being flexible about time, place and format of the assessment, remembering that people experiencing psychosis may be feeling frightened and vulnerable, not knowing who to trust.

The content of the assessment is likely to include:

- Identification of the problems the person is experiencing, any distress or difficulties as a result of these experiences, and what he or she would like to change.
- The person’s view of why this is happening and of their problems in general.
- The person’s life situation (accommodation, work and/or leisure activities, relationships with friends and relatives).
- Current medication and physical health status.
- Skills, abilities and areas of difficulties.
- Self-esteem.
- What help the person is receiving from other people and from services.
- What additional help he or she feels is needed.
- What has and what has not been helpful in the past.
- Views of the family/carer.

Different things will be relevant for different people so a whole person approach is needed, examining all the different factors that may be playing a role.

It is important to remember that many patients/service users will have experienced numerous assessments in various contexts so care needs to be taken to ensure that assessment is a respectful and collaborative process.

Scales may be used to measure aspects of experience such as voice hearing or dimensions of beliefs, also social and occupational functioning, anxiety, depression and quality of life. Such scales if used need to be reliable and valid.

**The following circumstances might indicate the need for an emergency or second opinion assessment at points after the initial assessment is complete:**

- High risk behaviours.
- Patient/service user is not benefiting from current intervention including pharmacological, psychological, social, vocational.
- There are significantly differing professional opinions regarding the presentation.
- There is no clear formulation of the patient/service user’s difficulties.

Many people with psychosis experience negative symptoms (emotional blunting, poverty of speech, lack of motivation, social withdrawal). Frequently they are not addressed with the same fervour as the more acute positive symptoms but they can be just as, if not more disabling. If recovery is to be effective then efforts need to be made to support the individual with these difficulties through psychosocial interventions and appropriate prescribing at all stages of the pathway. This could be through interventions as basic as supporting someone to get out of bed in the mornings, attending to their personal hygiene or engaging in structured activity.

**Risk assessment and management**

- **Risk assessment in people with psychosis should:**
  - Form part of a full assessment of the person’s needs and not be completed in isolation.
  - Identify and set out long-term and more immediate risks.
  - Clearly state what the risks are, and if they relate to self or others or relate to risk from others to the patient/service user.
  - Be agreed by the Multi-Disciplinary Team (MDT) where appropriate.
  - Assess general risk, as well as that associated with specific symptoms.
  - Be reviewed at agreed times, such as when there is a major change in the patient/service user’s circumstances, when increased risk is predicted, or when a crisis has arisen. Outside of these specified instances, a risk assessment should be collaboratively reviewed on a six monthly basis.

- **Agree explicitly the risks being assessed with the person and develop where possible a collaborative risk management plan that:**
  - Addresses both immediate and longer term risks.
  - Relates to the overall long-term treatment strategy.
  - Takes account of changes in personal relationships, including the therapeutic relationship.
All staff providing clinical interventions to people with psychosis should attend regular team-based risk reflective practice groups. These groups are facilitated by staff who have received training in the field of positive risk-taking.

**Useful Trust policies and NICE guidance**

- CP92 Risk Assessment and Management of Patients/Service Users
- NICE Guidelines – Schizophrenia (update)
- NICE pathways (Psychosis and schizophrenia overview)

**Formulation of needs**

Following completion of the assessment, an individual personalised understanding of difficulties should be developed, taking into account the patient/service user’s readiness to change. This may include:

- A problem list with associated goals identified by the patient/service user.
- A list of strengths, skills and coping assets.
- A description of the development of the patient/service user’s difficulties.
- Factors that maintain the current difficulties.
- Identifying potential triggers for crises.
- Potential unhelpful dynamics that may develop between the patient/service user and others (including the service).
- The outcome should be fed back to the patient/service user in a respectful and acceptable manner.
- Sufficient time for questions should be allowed and written information given whenever possible.
- With permission from the patient/service user, the outcome of the assessment should be shared with all relevant parties (i.e. those organisations who have regular contact with the patient/service user).

This understanding should lead to the development of an individualised action plan, outlining the focus and goals of intervention, or the rationale for no treatment if that is recommended. The action plan is likely to include referral for therapy and treatment options such as CBT, family work or vocational advice. Further specialist review will then take place, which can further inform understanding of the person’s current distress and difficulties and suggest ways of moving toward emotional well-being and recovery.
**Multi-Disciplinary Team (MDT) Discussion**

MDT discussions should involve at a minimum medical, nursing and social care views and aim to agree a working formulation and/or provisional diagnosis and risk assessment. To do this, the assessing clinician should have available:

- Patient/service user’s readiness to change.
- A problem list with associated goals identified by the patient/service user.
- A list of strengths, skills and coping assets.
- A description of the development of the patient/service user’s difficulties.
- Factors that maintain the current difficulties.
- Identifying potential triggers for crises.
- Potential unhelpful dynamics that may develop between the patient/service user and others (including the service).
- Risk issues and management
- Safeguarding issues
- Carer needs

The outcome should be discussed with the patient/service user in a respectful and acceptable manner. Sufficient time for questions should be allowed and written information given whenever possible. With permission from the patient/service user, the outcome of the assessment should be shared with all relevant parties including carers (i.e. those organisations who have regular contact with the patient/service user).

**Plan Care/CPA**

The aim is to plan next steps. This may or may not be a full care plan, but will set out clearly what will happen next based on patient/service user’s, carer’s and clinician’s views. The list is a series of prompts, i.e. elements to consider, and should be included in the care plan if appropriate. Priorities may change over time, depending on the level of engagement and stage of recovery.

**Collaborative care planning**

All steps should be taken to draw up a care plan in collaboration with the patient/service user, although it is acknowledged that there may be times when it is difficult to reach agreement about this.

- Care planning should reflect the level of engagement the service has with the patient/service user. Should there be minimal contact or rapport between the patient/service user and the service the care plan may prioritise engagement. At other points during the individual’s recovery, other interventions such as medication or talking therapies (low intensity or high intensity) may need to be prioritised; while at other phases it may be vocation.
- Physical health should be considered in the care plan.
- Carer/family views should be considered.
- It is essential that MDT working takes place. Where good working relationships and close collaboration within the team are fostered, treatment is more likely to be consistent and implemented according to the agreed plan.
- Where it becomes evident that professionals have differing opinions, it is essential that a meeting is held and agreement reached to provide a consistent approach to care delivery.
- It is important to involve and communicate with the patient/service user’s GP as part of the care planning process.
For a minority of patients/service users there will be circumstances in which it may be appropriate to involve and liaise with other agencies, such as out of hours services, the Police, Accident and Emergency Departments, non-statutory services including employment support agencies and social services, particularly in terms of children at risk (as per SHFT policy guidance for confidentiality and information sharing).

Wherever possible, with the agreement of the patient/service user, involvement of carers should be sought.

The care plan should include the patient/service user's short and long term goals and a crisis plan and be periodically re-evaluated through the CPA process, evolving over the course of the patient/service user's association with clinicians.

**Delivery of Care: Treatment and Therapy Options**

Psychosocial interventions for psychosis can be classified as evidence based practices or promising practices according to the extent to which efficacy is supported by meta-analyses, randomized controlled trials (RCTs) and best practice guidelines e.g. NICE (2014). The best evidenced therapies for people with psychosis are currently cognitive behaviour therapy (CBT) and family interventions for psychosis (FI). However the patient/service user may benefit from low intensity interventions like coping strategies or mindfulness. Any intervention should be person centred and needs led.

The National Audit of Schizophrenia (2014) sets out a clear set of standards for therapeutic interventions for people with schizophrenia. These include: care and crisis planning, psychological interventions, medical interventions and physical health interventions. Local initiatives also highlight the need for social/occupational interventions. The Trust has a proven record of innovation in psychosocial therapies and these provide opportunities to deliver person centered interventions. These interventions are listed as a set of minimum standards and are not intended to stifle innovation.

Practitioners should jointly agree interventions with patients/service users that are person centred and document the rationale for selected interventions.
See NAS (2014) for details of each of these therapeutic interventions.
Aspects of crisis planning and psychological and social/occupational interventions are described in this document for local context.
Psychosis Care Pathway and Narrative

Crisis Planning

The current Department of Health definition (2011) for urgent care is:

- Urgent and emergency care is the range of healthcare services available to people who need medical advice, diagnosis and/or treatment quickly and unexpectedly.
- People using services and their carers should expect 24/7, consistent and rigorous assessment of the urgency of their care need and an appropriate and prompt response to that need.

Crisis management plans

All patients/service users should have a crisis management plan, including:

- An assessment of any previous crises to which all those involved in the patient/service user’s care have an opportunity to contribute.
- A chronological history of risk including contextual details associated with episodes of crisis and high risk.
- A risk assessment including factors that are likely to increase and decrease risk as well as the factors that would indicate the benefits of taking a positive risk approach.
- A detailed plan which specifies as much as possible the strategies and course of action that would be beneficial at a time of crisis. This plan should be developed in collaboration with the patient/service user, and if appropriate, identified family/friends. It should be shared as widely as possible and include agreements on how the various professionals and team will conduct themselves at times of high risk (as per Trust policy guidance).
- This risk plan should be available on RiO.
- After each episode of risk, the plan is to be reviewed and updated accordingly so a clear Advanced Directive is available for the next crisis.

Crisis management strategies

- Crisis assessment
- Increased psychosocial support
- Priority medication review
- Support the patient/service user to implement their crisis management plan/advance directive
- Enhance the patient/service user’s coping strategies
- Positive risk management
- Enhance the family’s coping
- Offer family work
- Consider the acute pathway if appropriate
- Suicide prevention protocols
- Crisis debrief, collaborative updating of crisis management plan/advance directive/WRAP plan
- Graduated return to appropriate level of service involvement
Where a crisis has been triggered by deterioration in the patient’s mental state, then the long term medical management plan should be reviewed (see later). Medications can be used in the short term to help the patient/service user through a crisis. In these instances, it is usually the sedative and calming side effects of a medication that is being utilised rather than their therapeutic properties. The choice of medication used will depend on a variety of factors including:

- The estimated length of time that it is considered the medication will be needed.
- The current treatment the patient/service user is receiving.
- The addictive potential of any medication prescribed.
- The side effect profile of the medication being prescribed (both beneficial and unwanted ones).
- Evidence of previous response to the use of short term medication.

The types of medication used in a crisis situation include benzodiazepines and antipsychotics. Benzodiazepines used in a crisis are by definition intended for short term use only. If it becomes clear during the course of the crisis that a longer term approach is needed then the patient/service user’s medical management plan should be reviewed.

It is just as important when managing a crisis to support patients/service users to apply newly acquired coping skills, or if necessary to teach such skills. The whole care team will support the use of new/alternative coping strategies as a priority thereby facilitating increased self-efficacy and improving functioning.
Social Care

Vocation

Record in care plans current daily activities and occupational goals. Sometimes when people are very unwell or not keen to start on vocational work, the care coordinator or team member has to improve engagement and do preparatory work.

- Joint care planning is a good strategy and includes occupational short/long term goals, assessment of skill level (NICE guidelines, 2014), motivational interviewing and information gathering (including past education/past employment/work experience). The team should start partnership working with Job Centres, employment advisors and non statutory advisors to provide Individual Placement and Support (IPS; NICE, 2015). Work environment should also be considered including a graded return to work.

- Consider if there is a need for psychology and neuropsychological testing to assess skill level and suggestions for support or aids to create successful vocational experiences.

- Collaborative review of symptoms and the impact on work to create an action plan that supports and links with employers for adaptations/support.

- Skills based work either in a group or individually. More effective outcomes have been found with group work.

Pre-vocational work

- Pre-work skills questionnaire
- Creating a CV
- Social skills
- Interview skills
- Form filling/applications
- Writing personal statements
- Career choices
- IT skills
- Exhibition of projects – team working
- Problem solving
- Coping strategies

‘Work hardening’

- Adhere to a structured day
- Attendance at groups
- Self care and personal presentation
- Life skills (e.g. DIY, first aid, staying safe/drugs awareness, budgeting)
- Pre-work habit training adding to current routine

Social contact

Social contact is hugely important. Services can offer befriending schemes along with social groups, some of which may include physical activity, music, football or walking groups.

- Patients/service users should be directed to locally available social schemes.
WRAP

As a component of standard treatment, all patients/service users should be given the opportunity and support to complete a Wellness Recovery Action Plan (WRAP).

WRAP is promoted in SHFT as an essential element of patients/service users’ care, and is based on five key best practice principles:

- **Hope**: people who experience mental health difficulties get well, stay well and go on to meet their life dreams and goals.

- **Personal responsibility**: it’s up to you, with the assistance of others, to take action and do what needs to be done to keep yourself well.

- **Education**: learning all you can about what you are experiencing so you can make good decisions about all aspects of your life.

- **Self-advocacy**: effectively reaching out to others so that you can get what it is that you need, want and deserve to support your wellness and recovery.

- **Support**: while working towards your wellness is up to you, receiving support from others, and giving support to others, will help you feel better and enhance the quality of your life.

WRAP plans will be utilised by mental health care teams to inform treatment plans across all stages of the individual’s experience of psychosis. WRAP plans will be revisited following any crisis or major change in the person’s life. They are an important part of a post-crisis collaborative debrief informing the next phase of care.
Medication

Antipsychotic medication is offered to all patients/services users with psychosis and many patients/services users find it essential in helping them to achieve a recovery from their experiences and distress. There are a variety of different types of antipsychotic medication available and these can either be taken orally or administered via an injection on a monthly basis. They fall into two broad categories, namely first generation antipsychotics, e.g. Haloperidol, Zuclopenthixol, Flupentixol Sulpiride and second generation antipsychotics, e.g. Olanzapine, Risperidone, Quetiapine, Aripiprazole and Amisulpride. The choice of medication prescribed should be a collaborative decision between the patient/service user and their prescriber and the choice should be based on a variety of different factors, including:

1. The severity of symptoms
2. The preferred route of administration e.g. oral or intramuscular
3. The speed of onset of medication, e.g. a rapidly absorbed medication would be preferable for those in acute distress from their psychotic experiences
4. The side effect profile of the medication

Some medications have side effects which can be desirable, e.g. night sedation. However, medications can also have side effects which are undesirable, e.g. increased appetite, muscle stiffness or problems with sexual functioning.

The patient/service user should have the opportunity to ask as many questions as they desire about the available options and proposed medical management plan. They should also be provided with written information about the medication being prescribed. For patients/service users who do not know which questions to ask about their medication, there is a Trust leaflet (Your Medication, Your Choice) available which may be of help. If a patient/service user is too unwell to be able to make a decision about the choice of medication then the psychiatrist/nurse prescriber will prescribe in the best interests of that patient/service user.

Once a medication has been initiated, the patient/service user can expect to be regularly reviewed by their prescriber and the dose of medication adjusted in order to ensure that they receive the maximum benefit from their treatment whilst experiencing the minimum side effects possible. If for any reason the patient finds they cannot tolerate the medication, or that the medication is not helping sufficiently with their symptoms, then the treatment plan should be reviewed and an alternative antipsychotic trialled if it is felt appropriate. Usually, the right medication for the patient/service user is found on the first or second trial of treatment. Occasionally, a patient/service user may find that they are not getting the benefit from their medication they would have hoped for after two trials of treatment and in that instance treatment with Clozapine should be offered.

- Details about all of these medications can be found on the following websites:
  - [www.nhs.uk/medicine-guides/pages/default.aspx](http://www.nhs.uk/medicine-guides/pages/default.aspx)
  - [www.mind.org.uk/information-support/drugs-and-treatments/antipsychotics](http://www.mind.org.uk/information-support/drugs-and-treatments/antipsychotics)

In most instances, prescribing will be performed in concordance with NICE guidelines for schizophrenia. However, there will be instances where a patient has a particularly complex range and severity of symptoms that warrants prescribing outside these guidelines. If that is the case, then the individual will be informed of this and provided with reasons for the rationale behind it.

As well as using antipsychotic medications to treat the symptoms of psychosis, there will at times be recommendations made by the prescriber about the use of adjunctive agents. These may include antidepressants, anxiolytics or mood stabilising agents. Again, all prescribing decisions made by the treating prescriber will be made in full collaboration with the patient/service user.
The patient/service user’s prescriber will also make recommendations about how long they should remain on treatment. These recommendations will be based upon:

- The speed of onset and resolution of symptoms of psychosis
- The severity of symptoms and any associated risks
- The number of episodes of psychosis experienced by the patient
- The presence of any ongoing precipitating risk factors for further episodes of illness
- Tolerability

The usual recommendation following one episode of psychotic illness is that the patient/service user remains on treatment for two years in order to minimise the risk of further episodes of psychosis. If the individual has experienced two episodes of psychosis then it is likely that the prescriber may recommend treatment for up to five years. If the patient/service user has had three or more episodes of illness, then it is likely that the prescriber will recommend life long treatment with antipsychotic medication. It is therefore particularly important in these instances for the patient/service user to work closely with the prescriber in determining the right medication for them.

If at any point a patient/service user decides they would like a trial period off medication, then it is recommended that this decision is made in collaboration with the treating team. Where possible, prior to coming off antipsychotic medication, it would be wise to ensure that the patient/service user has had the necessary psycho-education in order to make an informed decision about this, and also has a WRAP (Wellness Recovery Action Plan) in place in order to ensure that the trial off medication is as successful as it can be. The decision to come off treatment should always be made taking into account the patient/service user’s current circumstances and in particular the potential impact that a further episode of psychosis would have on their current situation, e.g. if they have recently commenced employment or a college course or had a child, it may be wiser to wait to have a trial off treatment as a potential relapse in their psychotic illness at these times could be particularly devastating. There may also be times when a prescriber disagrees with a patient/service user’s decision to come off treatment. This could be due to the nature of their illness or the risks associated with any potential relapse. Even if the prescriber disagrees with the proposed plan, they will continue to support and work with the patient/service user during the period off medication as they will potentially be particularly vulnerable.

A patient taking long term antipsychotic medication should have their physical health monitored on a regular basis as this medication can in the long term cause problems with the regulation of blood lipids and glucose levels. This yearly monitoring of their physical health is usually provided in primary care in liaison with secondary mental health services.

It is also recognised that many individuals with psychosis have issues with taking medication, for example:

a) They may not consider that they need it
b) They may want to deal with their problems without medication
c) They dislike the possible side effects
d) They forget to take it
e) They don’t find it effective

Developing collaboration around medication involves listening, discussion, exploration of concerns, exploration and negotiation around the type and dosage of medication. The best predictable outcome is quality of relationship between the patient and their prescriber.
Psychological Interventions: A Stepped Intensity Approach

The national IAPT programme (2014) highlights the need for more accessible, efficient care for people with psychosis. Stepped care approaches aim to improve access to psychological therapies by offering the least restrictive treatment option, yielding the greatest health gain. This approach has proved successful in increasing access to therapies in primary care, and is likely to prove beneficial in secondary and tertiary care settings.

Stepped intensity psychological therapies

Phase 1 interventions
- Psychological consultation to MDT
- Psychological assessment and formulation
- Psycho-education and guided self-help
  - Befriending
  - Peer support

Phase 2 interventions
- CBT informed group work
- Family and friends group work

Phase 3 interventions
- CBT for psychosis
- Family work for psychosis
- Evidence based interventions for co-morbid problems (e.g., anxiety and depression)

Phase 3 interventions: These are the interventions for which there is significant evidence, as recommended by NICE (2014) – formal CBT for psychosis, and Family Intervention for psychosis.

Phase 2 interventions: These have been found to be valuable locally, or are being developed locally, as less intensive versions of the formal CBT and Family Interventions for psychosis. Phase 2 interventions may be important in facilitating access to psychological therapies for people new to these approaches.

Phase 1 interventions: The literature indicates a modest but growing evidence base for the following:

i) Psycho-education & self-management – With the aim of improving the person’s understanding of their mental health needs, treatment options and self-management skills. This is likely to improve functioning, reduce risk of relapse and improve medication concordance (Gellatly et al, 2007 – meta-analysis; Xia, Merinder & Belgamwar, 2011 – Cochrane review). The current NICE guideline expects that services offer psycho-education to friends and family of all people with psychosis (NICE, 2014).
ii) **Peer support** – To provide credible support from someone who has also experienced psychosis, and personal advice about living with psychosis and recovery (NICE, 2014). There is some evidence that peer support may improve mental health, coping skills and quality of life (Davidson et al. 1999).

iii) **Befriending** – Involves the facilitation of longer-term friendships for social and emotional support. Befriending may be effective in reducing relapse and hospitalisation rates (Buckley, Pettit & Adams, 2007 – Cochrane review). This intervention may also reduce depression (Mead et al, 2010 – meta-analysis) and implicitly challenge delusional beliefs (Samarasekera et al, 2007).

**Cognitive Behaviour Therapy (CBT)**

CBT is an individualised psychological intervention that encourages people to take an active role in treatment. CBT for Psychosis (CBT-P) aims to help a person understand his or her experience of psychosis in terms of its impact on thoughts, feelings, physical sensations and behaviour and to develop ways of reducing distress and disturbance associated with these difficulties. Through a better personal understanding of voice hearing or paranoia for example, the person is likely to be able to manage their experiences more effectively and engage more actively in their own recovery.

**Family work**

Family work should be offered to all families of people with psychosis who live with or are in close contact with the patient/service user. Family work should be offered regularly, especially when the patient/service user and/or family are experiencing difficulty.

**Essential components of family work:**

- Include the patient/service user if possible/practical.
- Take account of the relationship between the main carer and the person with psychosis.
- Have a specific supportive, educational or treatment function and include negotiated problem solving or crisis management work.
- Consist of at least 10 intervention sessions following the engagement and assessment sessions.
- Should take place at a time and location the family feels comfortable with.
Psychosis Care Pathway and Narrative

Physical Health

Life expectancy for adults with psychosis or schizophrenia is between 15 and 20 years less than for people in the general population. This may be because people with psychosis or schizophrenia often have physical health problems, including cardiovascular and metabolic disorders, such as type 2 diabetes, that can be exacerbated by the use of antipsychotics. Comprehensively assessing physical health will enable health and social care practitioners to offer physical health interventions if necessary.

GPs, community health services and mental health services need to ensure that protocols are in place to carry out comprehensive physical health assessments in adults with psychosis or schizophrenia, and share the results (under shared care arrangements) when the service user is in the care of primary and secondary services.

Adults with psychosis or schizophrenia should have a regular health check (at least once a year) that includes taking weight, waist, pulse and blood pressure measurements and blood tests. This checks for problems such as weight gain, diabetes, and heart, lung and breathing problems that are common in adults with psychosis or schizophrenia and often related to treatment. The results should be shared between their GP surgery and mental health team.

Psychosis and schizophrenia in adults (2014) NICE guideline CG178, recommendations 1.5.3.2 and 1.5.3.3

Comprehensive physical health assessments

Comprehensive physical health assessments for adults with psychosis or schizophrenia should focus on physical health problems common in people with psychosis and schizophrenia by monitoring the following:

- weight (plotted on a chart) – weekly for the first 6 weeks, then at 12 weeks, at 1 year and then annually
- waist circumference annually (plotted on a chart)
- pulse and blood pressure at 12 weeks, at 1 year and then annually
- fasting blood glucose, HbA1c and blood lipid levels at 12 weeks, at 1 year and then annually
- overall physical health.

Interventions should be offered in line with NICE guidelines on lipid modification, preventing type 2 diabetes, obesity, hypertension, prevention of cardiovascular disease and physical activity. (Adapted from Psychosis and schizophrenia in adults (NICE guideline CG178) recommendations 1.1.3.2, 1.5.3.2 and 1.5.3.3).

The Lester tool is a recommended tool that helps guide the management of physical health: www.england.nhs.uk/2014/06/13/lester-tool

Shared care arrangements

Secondary care teams should assess the patient/service user's physical health and the effects of antipsychotic medication for at least the first 12 months or until the person's condition has stabilised, whichever is longer. Thereafter, assessments may be transferred to primary care under shared care arrangements and should take place at least annually. Service users may no longer be under the care of shared care arrangements if they are discharged from secondary care services (Adapted from Psychosis and schizophrenia in adults (NICE guideline CG178) recommendation 1.3.6.5).
Substance Misuse Needs

These need to be identified and addressed at the first assessment. Identify all of the following:

- Particular substance(s) used
- Quantity, frequency and pattern of use
- Route of administration
- Duration of current level of use
- Consider safeguarding issues
- Involve carers

Where dependent use is identified, referral and joint working with the relevant team is required. Physical health monitoring relevant to need is essential.

For non dependent use, brief intervention and advice can be useful.

Resources:

- Drug misuse: opioid detoxification (NICE clinical guideline 52)
- Alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (NICE clinical guideline 115)
- [www.nice.org.uk/guidance/cg120](http://www.nice.org.uk/guidance/cg120)
- [www.nhs.uk/Change4Life/Pages/alcohol-health-harms.aspx](http://www.nhs.uk/Change4Life/Pages/alcohol-health-harms.aspx)

Carers support

Include the views of carers if possible at the first assessment. Offer a carer assessment of their own needs and discuss with them their strengths and views. If possible and with consent of patient/service user, involve them in the care planning process and address any identified needs. Advise carers about their statutory right to a formal carers’ assessment provided by social care services and explain how to access this.

**Give carers written and verbal information in an accessible format where there is permission (NICE, 2014):**

- Diagnosis and management of psychosis and schizophrenia
- Positive outcomes and recovery
- Types of support for carers
- Role of teams and services
- Getting help in a crisis

When providing information, offer the carer support if necessary. Offer a carer-focused education and support programme, which may be part of a family intervention for psychosis and schizophrenia, as early as possible to all carers. The intervention should:

- be available as needed
- have a positive message about recovery
**Review of Care Plan**

In order to ensure that mental health services are supporting a patient/service user to the best of their ability and that progress is being made, there will be regular meetings, the purpose of which will be to monitor an individual’s progress and review their care plan. This may or may not occur within a formal Care Programme Approach meeting. These reviews can occur anywhere between six and 12 months and there may be more informal reviews occurring at each point of contact with professionals. During these appointments, goals will be set and documented. These care plans will be reviewed on a regular basis in order to ensure that patient/service user’s needs are being met.

As part of these review meetings, formal outcome measures will be taken, for example **HoNOS** (Health of the Nation Outcome Scale) and **DIALOG** (if locally agreed) which allows services to track progress for patients/service users in a quantitative fashion.

**Acute pathway: inpatient/residential admission**

Residential/inpatient admission should only be considered when there are no safe alternatives and it should be brief, time limited and goal determined.

- The decision to admit a patient/service user must be made within the context of a joint assessment between acute team, care coordinator and psychiatrist or lead clinician.
- Where possible, admission should be informal and negotiated with the patient/service user.
- Those patients/service users under 18 will be looked after in line with the Trust’s policy on under 18s in inpatient care.
- Admission should be undertaken with care and dignity with the best interests of the patient/service user as paramount.
- Once the patient/service user arrives in hospital a plan of care must be formulated in collaboration with the patient/service user. This plan must include the goals identified at the point of assessment by those agreeing the person’s admission. This plan should also include when hospital admission may end earlier than planned if the goals of admission are met.
- During admission or at least during the period the person is under the Acute Care Team, a CPA should be convened where the risk and crisis plan can be updated. It is essential that all key professionals are in attendance at this meeting and that the patient/service user and their family/carers are actively involved.
- An estimated discharge date should be agreed and communicated to the patient/service user.
- Where a crisis and/or WRAP plan does not exist it is essential that one is developed in collaboration with the patient/service user prior to discharge and placed on RiO.
- Provide specific interventions e.g. CBT through integrated programmes.
- The option of patient/service user and family engaging in family work should be discussed and if possible this work started while the patient/service user is an inpatient.
- Where a patient/service user is already engaged in a community psychological therapy, a review of this will occur to determine if this should continue while an inpatient.
- Discharge plans should be discussed at the point of admission.
Suicide Prevention Tools

Linehan’s Suicide Crisis Protocol (Linehan, 1993):
1. Assess long-term and imminent risk of suicide or parasuicide
2. Focus on the present
3. Problem solve the current problem
4. Reduce high risk environmental factors
5. Reduce high risk behavioural factors
6. Commit to a plan of action
7. Troubleshoot the plan
8. Anticipate a recurrence of the crisis response
9. Re-assess suicide potential

More details on recovery:
www.emotionalwellbeing.southcentral.nhs.uk/component/content/article/2-getting-help/243-recovery

Discharge CPA meeting

Transitions and endings
Transitions and endings can often be difficult and may be experienced by the patient/service user as rejection or abandonment. Therefore a plan for transitions and endings should be clearly agreed. This should allow sufficient time for a gradual reduction of the frequency and intensity of support and treatment and an opportunity to discuss the patient/service user’s feelings.

Review
This is to reassess needs and review the care plan to ensure that it is meeting the patient/service user’s needs. A relapse prevention plan must be completed. The review should include re-rating outcome tools, such as PROM and HoNOS via clustering assessment.

Discharge
A plan of discharge should be agreed which includes clear written communication on management plans and how to access services in the future. Information on medication management (including when to titrate medication up and down), relapse signatures and a crisis plan should be communicated to primary care. Patients/service users should also be given information on who to contact for support. Carers should be included in this communication where permission is given.
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