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Reaching consensus on the principles of trauma-informed care in early intervention psychosis services: A Delphi study

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Abstract

Aim: The current study sought to conceptualize and reach consensus on the principles of trauma-informed care in early intervention psychosis services.

Methods: A three-phase Delphi method was employed in this study. Experts included researchers, service providers and Experts by Experience in the area of early intervention in psychosis. In the initial qualitative phase, an expert panel (n = 57) shared their views on the constituents of trauma-informed care in early intervention psychosis services. Thematic analysis led to the generation of statement items. The expert panel was asked to rate the extent to which each statement item was an essential principle of trauma-informed care, leading to consensus of endorsed principles.

Results: Qualitative analysis of the first phase data led to the identification of 185 distinct statements which were compiled into an online questionnaire for the panel to rate in Phase 2. The Phase 2 questionnaire was completed by 42 experts, with the endorsement of seven principles. In Phase 3, the panel were invited to re-rate 24 statements. This phase was completed by 39 panel members, with the acceptance of a further nine principles. Consensus was achieved resulting in the endorsement of 16 essential principles of trauma-informed care.

Conclusions: The study offers novel understanding of the conceptualisation of trauma-informed care in early intervention services and suggests principles which are widely agreed by experts in the field. The recommendations may inform the adoption of consistently delivered trauma-informed care in early interventions in psychosis and facilitate the evaluation and development of services.

KEYWORDS
Delphi technique, early intervention, psychosis, trauma-informed

1 | INTRODUCTION

Research findings point to a significant and predictive relationship between childhood trauma and psychosis risk (Traulesen et al., 2015; Varese et al., 2012). Childhood trauma has been found to be a causal factor for command hallucinations and voice hearing (Dorahy et al., 2009; Read et al., 2005), and associated with increased severity of hallucinations and delusions (Bailey et al., 2018). High prevalence of childhood trauma has been reported among those experiencing first episode psychosis (Bendall et al., 2012; Conus et al., 2010), therefore the impact of trauma has been described as integral to understanding the development of psychosis (Toner et al., 2013).

Early intervention services (EIS) facilitate prompt access to high-quality care following first episode psychosis (MacDonald et al., 2018). EIS have demonstrated reductions in rates of relapse, suicide risk, hospital admissions, crisis contacts and led to improved outcomes in employment and education, social functioning and quality of life (Adamson et al., 2018). However, trauma and adversity have been found to predict poorer treatment outcomes in those accessing EIS (Jones et al., 2019), with individuals demonstrating a more severe clinical profile, lower remission rates and poor treatment compliance (Schäfer & Fisher, 2011).

The clinical implications of such findings have resulted in practitioners being called on to understand "the critical and primary role of trauma and fundamentally change their practice as a result" (Sweeney et al., 2016, p. 185). It has been recommended that secondary prevention of the effects of childhood trauma requires recognition of its occurrence and understanding of the behavioural strategies adopted by individuals to reduce the emotional impact of their experiences (Felitti et al., 1998). Trauma survivors could struggle to feel the safety and trust required for effective therapeutic relationships (Fallot & Harris, 2009) impacting their engagement with services (Mihelicova et al., 2018). This could delay access and uptake of important early interventions for those experiencing first episode psychosis. Practitioner training and more consistent assessment and treatment of trauma have been encouraged within EIS (Peach et al., 2020); however, limited guidance on how to address trauma in this setting has been noted (Walters et al., 2016).

The adoption of practices aligned with the principles of trauma-informed care (TIC) could be valuable in the development of a coordinated approach to working with trauma in EIS. Services integrating TIC are those where all members of an organization understand the impact of trauma, aiming to promote recovery through each interaction (Elliott et al., 2005) and to limit the potential for re-traumatisation (Johnstone & Boyle, 2018). A review of TIC demonstrated benefits for service users in reduced posttraumatic stress and general mental health symptoms, enhanced coping skills and greater treatment retention (Sweeney et al., 2016).

In the development of guidelines for organizations interested in adopting a trauma-informed model of service, five foundational principles of safety, trustworthiness, choice, collaboration and empowerment were proposed (Fallot & Harris, 2009). Studies in homelessness populations (Hopper et al., 2010) and working with women accessing human services (Elliott et al., 2005) have extended the principles of TIC to incorporate service-specific practices of: promoting recovery from trauma, emphasizing strengths and resilience and cultural competence. Furthermore, the Substance Abuse and Mental Health Services Administration (SAMHSA, 2014) in the United States, supported the inclusion of additional components of peer support and cultural, history and gender issues. Services have been encouraged to tailor the foundational principles to their specific context (Kezelman & Stavropoulos, 2012), yet a lack of consensus on what constitutes TIC within services for people with a psychotic illness has been acknowledged (Bloomfield et al., 2020).

Due to the high levels of childhood trauma experienced by those accessing early interventions for psychosis (Bendall et al., 2012),

studies have called for the adoption of a trauma-informed approach within these services (Coates et al., 2019). The integration of TIC in EIS could facilitate enhanced understanding of trauma, reduce re-traumatisation, and lead to positive outcomes for both service users and staff. To date, no consensus exists surrounding the principles of a trauma-informed approach within EIS. The current study aimed to address this gap, inviting experts in the field of early psychosis to comment and reach agreement on the principles of TIC in EIS using a Delphi approach. Findings aim to provide conceptualisation and more consistent understanding of TIC across EIS settings.

2 | METHODS

2.1 | Participants

Participants were recruited by contacting publishing authors in the area of early psychosis and through the International Early Psychosis Association (IEPA). Corresponding authors who had published in Early Interventions in Psychiatry with a focus on early intervention for psychosis, or who had published first-person accounts of the experience of psychosis in Schizophrenia Bulletin, between January 2017 and July 2019 were contacted. Participants were eligible for the study due to the high levels of trauma experienced by those accessing EIS and a burgeoning literature surrounding the need for the implementation of TIC within this setting. A personalized invitation containing a link to a study website was emailed to 119 corresponding authors and 34 EIS listed on the IEPA website with available email addresses. Participant information detailed the study rationale, including aims to recruit individuals with expertise in trauma and TIC. Snowball sampling resulted in the identification of further experts, including those co-authored on journal articles. A reminder email was sent 1 month after the initial invitation with a final reminder emailed 2 weeks prior to Phase 1 closing. The study website and a blog written for the IEPA by the first author were shared with international psychosis organizations via social media. Recruitment ran from May 2019 to October 2019. Registering participants were provided with an information sheet and a link to Phase 1 of the study. Informed consent was provided by ticking an electronic box before beginning Phase 1. The study was granted ethical approval by the Faculty Research Ethics Committee at Queen's University, Belfast.

2.2 | Design

The Delphi method structures a communication process, enabling a group of individuals to collectively deal with a complex issue (Linstone & Turoff, 1975). It involves the gathering of expert opinion and inviting an expert panel to independently rate statements to reach consensus on these views. Feedback is provided through a statistical summary of the group's ratings. The process results in statements for which there is considerable agreement among the panel (Langlands et al., 2008). Online methods facilitate opportunities for global experts to contribute to the process.

The current Delphi study was structured in three phases. In the first, an online panel of experts were asked: "What are the principles of TIC in early intervention psychosis services?" Panel members were encouraged to reflect on principles each regarded as best practice, including those they currently deliver or aspire to deliver, or those considered important in EIS. A first-phase qualitative round has been described as optimal as it provides an opportunity to expand current knowledge (Iqbal & Pipon-Young, 2009). Analysis of qualitative responses led to the generation of distinct statement items. In the second phase, the expert panel was asked to rate each of the items (from *Essential* to *Should not be included*). Responses were analysed to calculate the aggregated percentage rating of each item. Items were endorsed if they were rated *Essential* by over 80% of the panel. Items were re-rated if they were rated *Essential* by 70–79.9% of the panel. Those not meeting either of these criteria were rejected as they were not perceived to be essential principles by the panel. In the final phase, the panel re-rated a shorter list of statements to reach consensus on the essential principles of TIC in EIS.

3 | RESULTS

3.1 | Phase 1

3.1.1 | Expert panel

Phase 1 included a questionnaire to gather information about the participant, and a qualitative section asking each individual to share their views on the principles of TIC in EIS. In this Phase, 57 participants completed a demographic questionnaire to identify their age, gender, country of residence, experience in EIS and professional role (see Table 1). The expert panel were involved in EIS in various ways: through working in a service (n = 31, 54.4%), conducting research

(n = 19, 33.3%) or as a service user in the past (n = 7, 12.3%). Professional roles included: 20 (35.1%) clinical psychologists, 16 (28.1%) academic or clinical researchers, 8 (14%) psychiatrists, 5 (8.8%) nurses and 8 (14%) other professionals (Peer Counsellors, Experts by Experience, Peer Support Workers and Practice Leads). Most commonly, participants resided in the United Kingdom though there was worldwide representation. On average, the expert panel had over 10 years' experience in early interventions in psychosis.

3.1.2 | Qualitative data

In the qualitative section, participants shared views on the principles of TIC in EIS. All qualitative data were combined, and individual contributions were not identifiable. Thematic analysis was conducted using Braun and Clarke's (2006) six-step process. These included: familiarization with the data; generation of initial codes; searching the text for themes; reviewing themes; defining themes; and writing the report. To enhance support for outcomes derived from the thematic analysis, the report, anonymized data and preliminary statement items were circulated to authors (redacted for peer review) and an independent Expert by Experience. A total of 185 statement items were generated from the qualitative analysis. These were grouped into seven core themes (see Table 2) which provided structure for the Phase 2 questionnaire.

3.2 | Phase 2

In Phase 2, the panel was invited to assess the relevance of statement items arising from the qualitative analysis, rating how essential each item was as a principle of TIC in EIS. One participant requested to withdraw from the study following Phase 1, resulting in 56 participants invited to rate the Phase 2 items. A questionnaire was developed

TABLE 1 Participant demographics

		n	%
Gender	Female	34	59.6
	Male	23	40.4
Country of residence	United Kingdom	26	45.6
	Mainland Europe	9	15.8
	Ireland	5	8.8
	Australia	5	8.8
	United States	5	8.8
	Canada	2	3.5
	India	2	3.5
	Other[a]	3	5.2
	Mean (years)	SD	Range (years)
Age	40.75	9.49	25–66
Duration of service	10.40	7.59	1–30

[a]Other countries of residence included New Zealand (n = 1), Mexico (n = 1) and one individual currently travelling.

TABLE 2 Phase 1 themes and number of statement items in each theme

Theme	Number of items
Adopting individualized trauma-informed care in early intervention psychosis services	34
Trauma-informed principles of care in early intervention psychosis services	43
The wider role of a trauma-informed early intervention psychosis service	15
Beliefs and values of a trauma-informed early intervention psychosis service	35
The trauma-informed environment of the early intervention psychosis service	9
Knowledge of trauma-informed care among staff in the early intervention psychosis service	24
Supporting staff in a trauma-informed early intervention psychosis service	25

using an online survey platform (Qualtrics). Participants were asked to rate if each of the 185 statements were *Essential, Important, Unimportant* or *Should not be included* as a principle of TIC. A *don't know/depends* option was not included due to difficulties in the interpretation of such rated items (Morrison & Barratt, 2010). In addition, a glossary of terms was provided defining less familiar concepts (e.g., the "Double Empathy Problem" or "small 't' and large 'T' traumas") with definitions sourced from representative bodies; additional clarifying information is consistent with Delphi methodology (Jorm, 2015).

Of the maximum Phase 2 panel (*n* = 56), 42 individuals rated the 185 statement items. Some participants did not fully complete this phase (*n* = 15). Among those who did not complete, nine did not begin the questionnaire and six questionnaires were partially completed. Partial responses were excluded from analysis and members who did not complete this phase were excluded from subsequent phases. Responses to the Phase 2 statement items were analysed to determine expert consensus. Items receiving a rating of *Essential* by at least 80% of the panel were endorsed as principles. Seven items met these criteria in Phase 2. Items rated *Essential* by 70–79.9% of the panel would be re-rated in Phase 3. There were 24 items to be re-rated in the next phase. Items not meeting either of these criterion were rejected (*n* = 154) as they were not deemed to be essential principles by the expert panel.

3.3 | Phase 3

In Phase 3, the panel was invited to re-rate a reduced list of statements to reach agreement on the essential principles of TIC. Participation was requested from those who had completed Phase 2 (*n* = 42). Participants received a table outlining each of the 24 statement items to be re-rated, the group aggregated *Essential* percentage rating of each item and a personalized column showing how they rated items in the previous phase. In accordance with Delphi methodology, experts could consider their original response in the context of the group rating and had the opportunity to revise their view (Jorm, 2015). Participants received a copy of the essential items which had been endorsed in Phase 2 along with the group percentage rating. Out of a maximum panel of 42 members, 39 participants completed Phase 3 (92.9%). This was 68.4% of the original expert panel (*n* = 57). Based on the predefined criteria, a further nine statements were endorsed as principles in this phase. A total of 16 statement items were rated *Essential* by at least 80% of the panel. These constitute the recommended principles of TIC in EIS (see Table 3).

4 | DISCUSSION

Expert consensus was reached on 16 principles of TIC in EIS. This is the first study to our knowledge to provide consensus on the conceptualisation of trauma-informed practice in this setting. Outcomes show high agreement in the endorsement of the principles

TABLE 3 The principles of trauma-informed care in early intervention psychosis services

Statement item[a]	Group rating "essential" %	Phase endorsed
A trauma-informed early intervention psychosis service will work to protect the service user from ongoing abuse.	89.7	3
Staff within a trauma-informed early intervention psychosis service…		
are trained to understand the link between trauma and psychosis.	85.7	2
will be knowledgeable about trauma and its effects.	84.6	3
A trauma-informed early intervention psychosis service…		
seeks agreement and consent from the service user before beginning any intervention.	84.6	3
will build a trusting relationship with the service user.	84.6	3
will provide appropriate training on trauma-informed care for all staff.	84.6	3
will support staff in delivering safe assessment and treatments for the effects of trauma.	84.6	3
adopts a person-centred approach.	83.3	2
will maintain a safe environment for service users.	83.3	2
will have a calm, compassionate and supportive ethos.	82.1	3
is trustworthy.	82.1	3
will acknowledge the relevance of psychological therapies.	82.1	3
will be sensitive when discussing trauma.	81.0	2
is empathetic and non-judgemental.	81.0	2
will provide supervision to staff.	81.0	2
will provide regular supervision to practitioners who are working directly with trauma.	81.0	2

[a]Sentence stems are represented in italics with the statement item completing this stem.

which extend on foundational concepts of TIC including providing safety, increasing choice and empowerment and reducing re-traumatisation (Elliott et al., 2005; Fallot & Harris, 2009; Hopper et al., 2010; Johnstone & Boyle, 2018).

The trauma-informed components of safety and trustworthiness were described in the essential principles of: protecting service users from ongoing abuse; consent seeking from service users prior to the introduction to interventions; development of trusting therapeutic relationships; sensitivity when discussing trauma; and values of being trustworthy, empathetic and non-judgemental. The panel agreed strongly that those accessing EIS are protected from ongoing abuse. TIC encompasses the prioritization of emotional and physical safety

(Sweeney et al., 2016) with services encouraged to offer safety planning (Elliott et al., 2005) and to recognize common trauma reactions that individuals may adopt to cope with the emotional impact of ongoing abuse (Hopper et al., 2010). Among those accessing EIS, perceptions of safety and validation within the therapeutic relationship have been found to facilitate disclosure of significant trauma experiences (Jansen et al., 2018). Findings demonstrate the need for trauma-sensitive practices which promote service user choice and control in trauma disclosure (Tong et al., 2018) and may lead to the identification of appropriate trauma-focussed treatments (Schäfer & Fisher, 2011). TIC has been shown to enhance treatment retention (Mihelicova et al., 2018); therefore, with outcomes in EIS strongly linked with engagement (Jones et al., 2019) the adoption of more consistent TIC practices could increase opportunities for service users to avail of positive outcomes of EIS (Adamson et al., 2018).

Panel members agreed on the importance of trauma-informed training, knowledge and supervision for staff within EIS. The development of a trauma-informed culture has been suggested to be contingent on staff competence in understanding the impact of trauma on their clients (Muskett, 2013). Enhanced knowledge and increased confidence in the delivery of trauma assessment and treatment was shown among EIS staff who received trauma training (Walters et al., 2016). Training could support the adoption of more consistent childhood trauma assessment in EIS (Peach et al., 2020; Read et al., 2005). Experts highlighted the importance of regular supervision among staff, particularly those delivering trauma treatments. To reduce the impact of vicarious trauma and decrease burnout and staff turnover (Sweeney et al., 2016), additional resources to establish regular clinical supervision may be required (MacDonald et al., 2018). While the expert panel acknowledged the relevance of psychological therapies, the treatment of trauma among individuals with psychosis has been described as greatly under-researched (Bloomfield et al., 2020). Further work in this area is warranted to identify evidence-based therapies for the treatment of trauma among those experiencing psychotic illness.

Despite recognition for the value of TIC across mental health settings, the complexity surrounding its concept has been described as a barrier to its implementation (Sweeney et al., 2016). Findings from the current study address this issue by identifying and presenting the agreed constituents of TIC within the EIS context, providing organizational practices aligned with a trauma-informed approach. For the implementation of TIC within services, Fallot and Harris (2009) proposed steps towards establishing a trauma-informed organizational culture. First, in initial planning, the organization is encouraged to consider the importance of and commitment to TIC and to establish a representative and inclusive workgroup to lead and oversee the changes; second, a training event is held for staff and service users, to provide education on trauma-informed cultures and direction to the implementation of changes; third, a short-term follow-up is conducted using a self-assessment and planning protocol, with additional training provided to staff; finally, a longer-term follow-up is scheduled to review progress, identify barriers to implementation, and to maintain momentum on the change process (Fallot & Harris, 2009). Becoming

trauma-informed requires steady support from senior leaders, investment in staff training and as TIC is evolving, each organization will need to consider developing ways to discuss TIC (Menschner & Maul, 2016). The current study provides a crucial first step towards the implementation of TIC in EIS.

While the study demonstrated high agreement among experts on the endorsed principles of TIC in EIS, limitations were noted. First, the study was conducted in English-language which may have restricted participation from experts whose first language was not English. Second, while Experts by Experience contributed to findings, this sample was small in number and not all were retained throughout the Delphi phases. The inclusion of Experts by Experience would be recommended in the integration of the principles of TIC to EIS. Such approaches have been encouraged, particularly in the assessment and evaluation of the trauma-informed culture of the service (Fallot & Harris, 2009). Finally, while the agreed principles demonstrated practices aligned with TIC, it was observed that trauma-specific treatments were absent. However, it has been acknowledged that the implementation of a trauma-informed organizational culture should precede the adoption of trauma-informed clinical practices (Menschner & Maul, 2016). Further work would be required to identify evidenced-based and trauma-informed clinical treatments to support individuals who have experienced trauma who are accessing EIS.

Study outcomes provide the first consensus-achieved conceptualisation of trauma-informed practice within EIS. Expert agreement led to the identification of 16 essential principles of TIC and may facilitate the implementation of consistently delivered trauma-informed practice in this setting. The incorporation of these practices could result in positive benefits for those providing and accessing early psychosis care. The principles consolidate specialist knowledge and may act as a framework for the evaluation and enhancement of a trauma-informed EIS.

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