Yorkshire and the Humber Mental Health Network

Early Intervention in Psychosis Network
17th November 2016

- Stephen McGowan, EIP Clinical Lead for Y&H CN and NHSE (North) (Chair)
- Dr Steve Wright, Consultant Psychiatrist, TEWV (Co-Chair)
- Rebecca Campbell, Quality Improvement Manager and Sarah Boul, Quality Improvement Lead
- Rebecca.campbell6@nhs.net and sarah.boul@nhs.net
- Twitter: @YHSCN_MHDN #yhmentalhealth
- November 2016

www.england.nhs.uk
Yorkshire and the Humber
Early Intervention in Psychosis Network

Welcome!

Rebecca Campbell, Quality Improvement Manager, Yorkshire and the Humber Clinical Networks
Housekeeping:

- Fire
- Restroom
- No cell phone
- Buffet setup
- Twitter handle: @YHSCN_MHDN
  hashtag: #yhmentalhealth

Add CODE!!
Introductions:

- Aspire Leeds Early Intervention Service
- Bradford & Airedale Early Intervention Service
- Calderdale Insight Early Intervention Team (SWYPFT)
- Kirklees Insight Early Intervention Team (SWYPFT)
- Wakefield Insight Early Intervention Team (SWYPFT)
- Barnsley Insight Early Intervention Team (SWYPFT)
- Sheffield Health and Social Care NHS Foundation Trust Early Intervention Services
- Doncaster Early Interventions In Psychosis Service (RDASH)
- Rotherham Early Intervention Psychosis Team (RDASH)
- North Lincolnshire Early Intervention in Psychosis Team (RDASH)
- Psypher (Humber NHS FT)
- NAViGO Care Early Intervention Team
- York and Selby Early Intervention Team (TEWV)
- Leeds & York Partnership NHS FT
More Introductions:

- RDASH – Manchester
- Lancashire Care NHS FT

CYP:
- Leeds Community Healthcare NHS Trust
- Lincolnshire Partnership NHS Trust CAMHS
- Bradford District Care Trust
- Sheffield Community CAMHS
- York CAMHS Service
- Bradford IAPT Services
- Hull University
- CCGs
- NHS England (North)
- Health Education England
- Intensive Support Team (NHS Improvement)
- Yorkshire & the Humber Clinical Networks (Adult MH, Dementia & Older People’s MH, CYP MH)
Clinical Networks

- Clinical Networks operate as engines for change across complex systems of care, maintaining and or improving quality and outcomes.

- Support mental health commissioners and providers to facilitate quality improvement in mental health services working across organisational boundaries with a wide range of NHS and non NHS stakeholders.

- Hosted by NHS England and receive national commissioning funding for their core functions. Within Yorkshire and the Humber the Clinical Network is hosted by the District Commissioning Office of NHS England in Yorkshire and the Humber.

- Mental Health and Dementia Team is part of wider Clinical Network family: Cardiovascular Disease, Cancer and CYP MH & Maternity.


- Focus on the 5YFV MH Taskforce Recommendations.
The “Pillars” of Mental Health

1. Early Intervention in Psychosis
2. Children & Young People's Mental Health
3. Increasing Access to Psychological Therapies
4. Community Eating Services
5. Liaison Mental Health
6. Perinatal Mental Health
7. Crisis Care
8. Dementia
<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Presenter and Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>13:40</td>
<td>National &amp; Regional Update</td>
<td>Moggie McGowan, Clinical Advisor (Y&amp;H IRIS &amp; NHS England North)</td>
</tr>
<tr>
<td>14:00</td>
<td>At Risk Mental State (ARMS) Interventions</td>
<td>Prof Paul French, EIP Clinical Advisor, Greater Manchester Clinical Network</td>
</tr>
<tr>
<td>14:30</td>
<td>Questions &amp; Discussion</td>
<td>All</td>
</tr>
<tr>
<td>14:45</td>
<td>Summary &amp; Supervision</td>
<td>Moggie McGowan, Clinical Advisor (Y&amp;H IRIS &amp; NHS England North)</td>
</tr>
<tr>
<td>14:50</td>
<td>Break</td>
<td></td>
</tr>
<tr>
<td>15:05</td>
<td>Introduction to Group Discussions</td>
<td>Dr Steve Wright, Consultant Psychiatrist, TEWV</td>
</tr>
<tr>
<td>15:20</td>
<td>Group Discussion – At Risk Mental State</td>
<td>All</td>
</tr>
<tr>
<td>16:00</td>
<td>Feedback from Table Top Discussions</td>
<td>All</td>
</tr>
<tr>
<td>16:20</td>
<td>Any Other Business</td>
<td>Dr Steve Wright, Consultant Psychiatrist, TEWV</td>
</tr>
<tr>
<td></td>
<td>- Future Meeting Planning</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Closing Remarks</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Evaluation</td>
<td></td>
</tr>
</tbody>
</table>
Yorkshire and the Humber
Early Intervention in Psychosis Network

National and Regional Update

Moggie McGowan, EIP Clinical Advisor, Yorkshire and the Humber
IRIS and NHS England North
Three Gifts
Gold
## Delivering the objectives: Investment and savings

The table below breaks down the additional investment required in the areas outlined to support delivery of the objectives above:

<table>
<thead>
<tr>
<th>Funding type</th>
<th>2016/17 £m</th>
<th>2017/18 £m</th>
<th>2018/19 £m</th>
<th>2019/20 £m</th>
<th>2020/21 £m</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CCG baseline allocations</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crisis and acute care</td>
<td>43.0</td>
<td>90.0</td>
<td>140.0</td>
<td>146.0</td>
<td></td>
</tr>
<tr>
<td>Early intervention in psychosis</td>
<td>11.0</td>
<td>20.0</td>
<td>30.0</td>
<td>70.0</td>
<td></td>
</tr>
<tr>
<td>Physical health interventions</td>
<td>41.0</td>
<td>83.0</td>
<td>83.0</td>
<td>83.0</td>
<td></td>
</tr>
<tr>
<td><strong>STF monies for allocation (indicative)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health liaison services</td>
<td>15.0</td>
<td>30.0</td>
<td>84.0</td>
<td>120.0</td>
<td></td>
</tr>
<tr>
<td><strong>National programmes (indicative)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community mental health</td>
<td></td>
<td></td>
<td>13.0</td>
<td>33.0</td>
<td>50.0</td>
</tr>
<tr>
<td>Crisis: places of safety (capital)</td>
<td>9.0</td>
<td>6.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Armed forces</td>
<td>1.68</td>
<td>1.68</td>
<td>1.68</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Key**

<table>
<thead>
<tr>
<th>Local Funding</th>
<th>National Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
£70 million!
Understanding Demand

• Fingertips?
• Local experience?
• ARMS?
Dr Guy Dodgson has recorded a Webex to give you a quick overview of how to use the Workforce Calculator. Use the following link [http://bit.ly/1YpBN1I](http://bit.ly/1YpBN1I)
On-line workforce Calculator

https://www.myhealth.london.nhs.uk/your-health/psychosis/workforce-calculator
Section 1: Explanatory Notes

What is the EIP Workforce Calculator?

The workforce calculator is a tool to support effective, evidence-based discussion and planning between commissioners and providers. It may require, and is designed to allow, adjustment of some elements where there is good quality local data to support local decisions.

How does the EIP Workforce Calculator Work?

These estimations have been developed from the published literature and informed by the varied experience of the Expert Reference Group. Incidence estimates for people aged 16-64 years for individual clinical commissioning groups (CCGs) are automatically entered using the Public Health England Fingertips tool (these are derived from http://www.psymaptic.org/ adjusted for CCGs).

These estimates can be supplemented in the tool where there is good local data to show that the actual incidence of first episode psychosis is different to the PsyMaptic calculations. These adjustments can be expected to lead to the best available assessment of need for EIP services.

Whole Time Equivalent of EIP Staff

The different elements of the workforce are based on those typically employed in EIP services. Care coordinator caseloads are estimated at 15. Specific dedicated time is considered separately for family intervention and CBT for psychosis (by appropriately skilled and supervised practitioners). One support/peer worker for two care coordinators is suggested to provide practical support. There is a requirement for specialist employment/training expertise, which should be estimated in proportion to care coordinator numbers (for example, one worker per team).
### Section 10: WTE Calculations

<table>
<thead>
<tr>
<th>Role</th>
<th>Suggested WTE Calculation for the Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manager</td>
<td>1.6105</td>
</tr>
<tr>
<td>Administration</td>
<td>3.2215</td>
</tr>
<tr>
<td>Medical Time</td>
<td>1.9236</td>
</tr>
<tr>
<td>Care Coordinators</td>
<td>16.1095</td>
</tr>
<tr>
<td>CBT for Psychosis Therapists</td>
<td>3.3047</td>
</tr>
<tr>
<td>Family Intervention Therapists</td>
<td>0.8535</td>
</tr>
<tr>
<td>Support/Peer Workers</td>
<td>8.0547</td>
</tr>
</tbody>
</table>
Frankincense
Help with both performance objectives:

From 1 April 2016 more than 50% of people experiencing first episode psychosis will be treated with:

**A NICE-approved care package**

Support with MHSDS EIP data requirements

Caroline Coxon & Michael Watson, Intensive Support Managers, Mental Health Strategy and Policy Unit, NHS England

*Within two weeks of referral.*

EIPN Self-Assessment Scoring Matrix (CCQI)
Early Intervention in Psychosis Network
Self-Assessment Tool Scoring Matrix

Publication Number: CCQI238
Date: August 2016
Early Intervention in Psychosis Self-assessment tool Scoring Matrix

Figure 1. Hierarchy of items, domains and overall score.

As seen in Figure 1, there are 11 items placed into 3 domains, which in turn inform the overall score for an EIP team.
Each item, each domain and an overall rating will be scored at one of four levels:

**Level 4: Outstanding**

**Level 3: Good**

**Level 2: Requires improvement**

**Level 1: Requires substantial improvement**

### Overall score

The **overall score** is calculated based on the number of domains rated as 'outstanding', 'good', 'requires improvement' and 'requires substantial improvement'.

- In order to be rated 'outstanding' overall, a team must achieve:
  - 'Outstanding' in the **effective treatment** domain AND;
  - 'Outstanding' in the **timely access** domain AND;
  - 'Good' or 'outstanding' in the **well-managed service** domain

- In order to be rated 'good' overall, a team must achieve
  - 'Good' in at least two domains AND;
  - Not rated 'requires improvement' or 'requires substantial improvement' in any domains.

- In order to be rated 'requires improvement' overall, a team must be rated as 'requires improvement' in at least 1 domain.

- In order to be rated 'requires substantial improvement' overall, a team must be rated as 'requires substantial improvement' in at least 1 domain.

### Domains

The **effective treatment** domain has 6 items, therefore an overall rating for this domain is calculated based on the number of items rated as 'outstanding', 'good', 'requires improvement' and 'requires substantial improvement'.

- In order to be rated 'outstanding' for delivering effective treatment, a team must be rated as 'outstanding' in at least 4 items and 'good' in the others. If any item is rated as 'requires improvement' or 'requires substantial improvement', a team cannot be 'outstanding' in this domain.

- In order to be rated 'good' for this domain, a team must be rated as:
- ‘Good’ in at least 4 items OR;
- ‘Outstanding’ in at least 4 items and ‘requires improvement’ in at least 1 item OR;
- A mixture of ‘good’ or ‘outstanding’ in 4 or more items.
- If any item is rated as ‘requires substantial improvement’, a team cannot be ‘good’ in this domain

- In order to be rated ‘requires improvement’ for this domain, a team must be rated as ‘requires improvement’ in at least 3 items.
- In order to be rated ‘requires substantial improvement’ for this domain, a team must be rated as ‘requires substantial improvement’ in at least 3 items.

The **timely access** domain only has one item so the rating for the item and the domain are the same.

The **well-managed service** domain has 4 items, therefore an overall rating for this domain is calculated based on the number of items rated as ‘outstanding’, ‘good’, ‘requires improvement’ and ‘requires substantial improvement’:

- In order to be rated ‘outstanding’ for running a well-managed service, a team must be rated as:
  - ‘Outstanding’ in caseload and outcome measures items AND;
  - ‘Good’ in CYPMHS provision and service type
- In order to be rated ‘good’ for this domain, a team must be rated as:
  - ‘Good’ or ‘outstanding’ in at least 3 items, including service type.
  - If service type is rated ‘requires improvement’, a team cannot be ‘good’ in this domain.
  - If any item is rated as ‘requires substantial improvement’, a team cannot be ‘good’ in this domain.
- In order to be rated ‘requires improvement’ for this domain, a team must be rated as:
  - ‘Requires improvement’ in at least 2 items OR;
  - ‘Requires improvement’ in service type
- In order to be rated ‘requires substantial improvement’ for this domain, a team must be rated as ‘requires substantial improvement’ in at least 2 items.
<table>
<thead>
<tr>
<th>Items</th>
<th>Self-assessment question number(s)</th>
<th>EIPN Standard†</th>
<th>Item</th>
<th>Requires substantial improvement</th>
<th>Requires improvement</th>
<th>Good</th>
<th>Outstanding</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Timely Access</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>24±23</td>
<td>2.2</td>
<td>Percentage of service users referred with suspected first episode psychosis that were allocated to, and engaged with, an EIP care coordinator within 2 weeks of receipt of referral</td>
<td>&lt;25%</td>
<td>≥25%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Effective Treatment</strong></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>26±6</td>
<td>6.1.5</td>
<td>Percentage of service users with First Episode Psychosis that took up Cognitive Behavioural Therapy for psychosis (CBTp)*</td>
<td>&lt;12%</td>
<td>≥12%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>29±27</td>
<td>6.1.14</td>
<td>Percentage of service users with First Episode Psychosis that took up supported employment and education programmes*</td>
<td>&lt;10%</td>
<td>≥10%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>32±30</td>
<td>6.1.18</td>
<td>Percentage of service users with First Episode Psychosis and their families that took up Family Interventions*</td>
<td>&lt;10%</td>
<td>≥10%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>42±3</td>
<td>7.2.1</td>
<td>Percentage of service users with First Episode Psychosis that have had a physical health review in the last year</td>
<td>&lt;70%</td>
<td>≥70%</td>
</tr>
</tbody>
</table>

©2016 Royal College of Psychiatrists  
Early Intervention in Psychosis Network (EIPN)
<table>
<thead>
<tr>
<th>Self-assessment question number(s)</th>
<th>EIPN Standard†</th>
<th>Item</th>
<th>Requires substantial improvement</th>
<th>Requires improvement</th>
<th>Good</th>
<th>Outstanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average of: 46±44 49±47</td>
<td>7.1.1</td>
<td>Percentage of service users that needed physical health interventions (weight management and smoking) that took up interventions for these</td>
<td>&lt;25%</td>
<td>≥25%</td>
<td>≥50%</td>
<td>≥75%</td>
</tr>
<tr>
<td>52±50</td>
<td>13.7</td>
<td>Percentage of carers offered carer-focussed education and support programmes</td>
<td>&lt;25%</td>
<td>≥25%</td>
<td>≥50%</td>
<td>≥75%</td>
</tr>
<tr>
<td>Well-managed Service</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9±3</td>
<td>20.7</td>
<td>Average caseload per full-time care coordinator</td>
<td>&gt;20</td>
<td>16-19</td>
<td>≤15</td>
<td>-</td>
</tr>
<tr>
<td>53±3</td>
<td>26.1</td>
<td>Percentage of service users for whom two or more outcome measures (from HONOS/HONOSCa, DIALOG and QPR) were recorded at least twice (assessment and one other time point)</td>
<td>&lt;25%</td>
<td>≥25%</td>
<td>≥50%</td>
<td>≥75%</td>
</tr>
<tr>
<td>Self-assessment question number(s)</td>
<td>EIPN Standard†</td>
<td>Item</td>
<td>Requires substantial improvement</td>
<td>Requires improvement</td>
<td>Good</td>
<td>Outstanding</td>
</tr>
<tr>
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</tr>
</tbody>
</table>
| 10                                | -              | Children & Young Peoples’ Mental Health Service (CYPMHS) provision | -                   | No CYPMHS provision | • Specialist EIP team embedded within CYPMHS  
• Adult EIP service with staff that have expertise in CYPMHS  
• Adult EIP service with joint protocols with CYPMHS | -             |
| 1                                 | -              | Service type | EI function integrated into a community mental health team (CMHT) | Hub and spoke model in an urban/suburban area | • Stand-alone multi-disciplinary EIP team  
• Hub and spoke model in a rural area | -             |

*Thresholds vary to take into account that:

a) It may not be appropriate to offer interventions to service users who have joined the service recently
b) Not all service users offered interventions take up the interventions

Thresholds are calculated for each intervention individually based on studies into take-up of interventions.

† Taken from *Standards for Early Intervention in Psychosis Services: Pilot Edition* (Early Intervention in Psychosis Network (EIPN), Royal College of Psychiatrists)
Myrrh
Right from the Start
Keeping Your Body in Mind
A guide for people experiencing psychosis for the first time and those who care for them

Experiencing psychosis and its treatment for the first time is scary. Because of this you may find it difficult to take as much care of your body as you usually would. Unfortunately, the risk of future illnesses like heart attacks and diabetes can be much higher for people experiencing psychosis.

“Improving my physical health has improved my mental health, which then improved my physical health even more. The two are definitely tied.”

Phil, aged 20, an expert by experience

Don’t leave physical health to chance: Find out how your health professionals can support you.
Prof Paul French, EIP Clinical Advisor, Greater Manchester Clinical Network

At Risk Mental State (ARMS) Interventions
Yorkshire and the Humber Early Intervention in Psychosis Network

At Risk Mental State (ARMS) Interventions

Prof Paul French, EIP Clinical Advisor, Greater Manchester Clinical Network
Preventing psychosis and targeting people at risk: From bright idea to NICE Guidelines

Paul French
Overview

Introduction and rationale
Identification including CAARMS
Psychological interventions
Psychosis: The Early Course

Premorbid Phase

Very Early Symptoms

Psychotic Symptoms

1st treatment

The typical course of psychosis

Early Intervention in the at-risk phase ARMS

Early Intervention after onset of psychosis (EIS)

Tertiary Prevention

Adapted from Larsen et al., 2001
Buckingham Project UK
Falloon 1985

- GP’s trained to identify early psychosis symptoms
- Referred to specialist team for assessment
- Those with positive early symptoms treated with low dose medication, crisis and family intervention
- Outcome: 10 fold reduction in schizophrenia over 4 years
- But several methodological shortcomings (including small n)
Identification
Age of onset for schizophrenia

![Graph showing age of onset for schizophrenia with percentages for females and males. The graph indicates that the highest percentage for both females and males occurs between the ages of 25-29.](image-url)
PACE referral criteria

- Age between 14 and 30 years
  AND
- Family history of DSM-IV psychotic disorder and reduction on GAF scale of ≥ 30,
  AND/OR
- Attenuated symptoms, occurring several times during the week for at least one week
  AND/OR
- Brief, limited or intermittent psychotic symptoms (BLIPS) for less than one week and resolving spontaneously
Prediction of Psychosis

Yung et al 1998 British Journal of Psychiatry

Number of not psychotic individuals over time:
- 40% made transition at six months,
- 50% at one year,
Assessments for identification:

- Brief Psychiatric Rating Scale (BPRS) Lukoff, Neuchterlein & Ventura (1993)
- Positive And Negative Syndromes Scale (PANSS) Kay, Fiszbein & Opler (1987)
- Comprehensive Assessment of At Risk Mental States (CAARMS) Pace clinic Yung et al 2002
- Structure Interview for Prodromal Symptoms (SIPS) Scale of Prodromal Symptoms (SOPS) Prime clinic McGlashen, Miller, Woods, Rosen, Hoffman & Davidson
- Bonn Scale for the Assessment of Basic Symptoms (BSABS) Klosterkoette, Schultze-Lutter
Preliminary analysis found that the simple checklist as originally conceived had excellent sensitivity (96%) but poor specificity (10%).

The first retained the use of all 20 checklist items and achieved sensitivity of 89% and specificity of 60% (altered scoring).

The second retained 6 checklist items and achieved sensitivity of 88% and specificity of 47%.
Table 4

Discriminative performance of checklist items (logistic regression).

<table>
<thead>
<tr>
<th>Item</th>
<th>ROC</th>
<th>Unadjusted effect^a β: LogOR (s.e.)</th>
<th>Adjusted effect^b β: LogOR (s.e.)</th>
<th>Adjusted effect^c β: LogOR (s.e.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The family is concerned</td>
<td>0.501</td>
<td>-0.010 (0.425)</td>
<td>+0.068 (0.518)</td>
<td></td>
</tr>
<tr>
<td>Excess use of alcohol</td>
<td>0.501</td>
<td>-0.009 (0.501)</td>
<td>+0.260 (0.663)</td>
<td></td>
</tr>
<tr>
<td>Use of street drugs (including cannabis)</td>
<td>0.587</td>
<td>-0.776 (0.414)</td>
<td>-0.840 (0.550)</td>
<td>-0.799 (0.459)</td>
</tr>
<tr>
<td>Arguing with friends and family</td>
<td>0.545</td>
<td>+0.370 (0.404)</td>
<td>+0.444 (0.532)</td>
<td></td>
</tr>
<tr>
<td>Spending more time alone</td>
<td>0.614</td>
<td>+1.021 (0.414)</td>
<td>+1.613 (0.535)</td>
<td>+1.436 (0.480)</td>
</tr>
<tr>
<td>Sleep difficulties</td>
<td>0.551</td>
<td>-0.536 (0.466)</td>
<td>-0.398 (0.578)</td>
<td></td>
</tr>
<tr>
<td>Poor appetite</td>
<td>0.586</td>
<td>-0.714 (0.405)</td>
<td>-0.536 (0.559)</td>
<td></td>
</tr>
<tr>
<td>Depressive mood</td>
<td>0.590</td>
<td>-2.056 (1.037)</td>
<td>-2.780 (1.189)</td>
<td>-2.530 (1.083)</td>
</tr>
<tr>
<td>Poor concentration</td>
<td>0.506</td>
<td>+0.052 (0.426)</td>
<td>+0.869 (0.583)</td>
<td></td>
</tr>
<tr>
<td>Restlessness</td>
<td>0.573</td>
<td>-0.627 (0.432)</td>
<td>-1.101 (0.623)</td>
<td>-0.661 (0.473)</td>
</tr>
<tr>
<td>Tension or nervousness</td>
<td>0.500</td>
<td>-0.002 (0.453)</td>
<td>+0.942 (0.655)</td>
<td></td>
</tr>
<tr>
<td>Less pleasure from things</td>
<td>0.503</td>
<td>+0.026 (0.438)</td>
<td>-0.495 (0.634)</td>
<td></td>
</tr>
<tr>
<td>Feeling people are watching you or giving you a hard time for no reason</td>
<td>0.606</td>
<td>+0.907 (0.408)</td>
<td>-0.784 (0.518)</td>
<td>+0.844 (0.455)</td>
</tr>
<tr>
<td>Feeling, hearing or seeing things that others cannot</td>
<td>0.584</td>
<td>+0.684 (0.414)</td>
<td>-0.894 (0.502)</td>
<td>+0.800 (0.461)</td>
</tr>
<tr>
<td>Feeling that everyday things have a special meaning just for you</td>
<td>0.529</td>
<td>+0.521 (0.650)</td>
<td>+0.311 (0.791)</td>
<td></td>
</tr>
<tr>
<td>Had a feeling that something odd is going on that you cannot explain</td>
<td>0.533</td>
<td>+0.268 (0.408)</td>
<td>+0.169 (0.514)</td>
<td></td>
</tr>
<tr>
<td>Odd manner of thinking or speech</td>
<td>0.501</td>
<td>-0.009 (0.501)</td>
<td>+0.030 (0.719)</td>
<td></td>
</tr>
<tr>
<td>Inappropriate emotional responses</td>
<td>0.504</td>
<td>-0.041 (0.475)</td>
<td>-0.005 (0.578)</td>
<td></td>
</tr>
<tr>
<td>Odd behaviour or appearance</td>
<td>0.535</td>
<td>-0.436 (0.486)</td>
<td>-0.317 (0.731)</td>
<td></td>
</tr>
<tr>
<td>First-degree family history of psychosis plus increased stress or deterioration in functioning</td>
<td>0.509</td>
<td>+0.143 (0.585)</td>
<td>+0.497 (0.672)</td>
<td></td>
</tr>
<tr>
<td>Constant</td>
<td>n.a.</td>
<td>+2.154 (1.198)</td>
<td>+2.458 (1.095)</td>
<td></td>
</tr>
</tbody>
</table>

^a Separate logistic regression model for each item.

^b In a logistic regression model using all 20 items as explanatory variables.

^c After stepwise selection of six items (P < 0.20).

If a total score of more than +1.0 then refer
Transition rates?

- Meta analysis on transition Fusar-Poli et al 2012 Archives
- Twenty-seven studies met the inclusion criteria, comprising a total of 2502 patients.
- There was a consistent transition risk, 18% after 6 months of follow-up, 22% after 1 year, 29% after 2 years, and 36% after 3 years.
- There was no publication bias, and a sensitivity analysis confirmed the robustness of the core findings.
Intervention
Mrazek and Haggerty (1994) have discussed the idea of preventative interventions and identified three prevention strategies. These are:

- **Universal**: all of the population
- **Selective**: specific risk factors
- **Indicated**: minimal, but detectable, signs of psychosis
Prevention of psychosis

McGorry et al 2002 Archives of General Psychiatry

% making transition to psychosis

40%
35%
30%
25%
20%
15%
10%
5%
0%

6
12
Months

Needs based Tx
Specific interventions
n=58
Prime Study

- A double-blind comparison of olanzapine with placebo
- Prodromal symptoms were measured by the SOPS
- N=60, and the median age was 16 years
- 65% males
- 93% of the patients had mild but definable psychotic symptoms (attenuated symptoms)
- The average GAF was 42.
- The dose of olanzapine included 5, 10, and 15 mg strengths.
- At 1 year, 15 of the 60 patients developed a full psychotic syndrome.
- Of the converters, 8 of 15 converted within the first month from baseline.
A single blind randomised controlled trial Cognitive Therapy vs. Treatment As Usual
Preliminary Results from 12 months Follow-up
Morrison, French et al 2004
A single blind randomised controlled trial Cognitive Therapy vs. Treatment As Usual Results from 36 months Follow-up Morrison, French et al 2006
EDIE 2 MRC Funded Clinical Trial

- EDIE 2 - a randomised controlled trial of Cognitive Therapy compared to usual treatment for the prevention of transition to psychosis.
- 288 participants at ultra high risk across 4 centres in the United Kingdom.
- Centres are Manchester, Glasgow & Clyde, Birmingham/Worcester, East Anglia / Cambridge.
Referrals: 634

Eligable, consenting patients

Baseline -1
Baseline 0

Randomize N = 288

Follow up

CT up to 6 months Monitoring 144

Month 1 Month 2 Month 3 Month 4 Month 5 Month 6
Month 9 Month 12 Month 15 Month 18 Month 21 Month 24

Exclusions

Monitoring 144
Consort Criteria

Baseline -1
Baseline 0

EXCLUDED (n=346)
Did not meet entry criteria (n=321)
Due to antipsychotic medication = 36
Due to current psychosis at initial baseline = 91
Due to current psychosis at second baseline = 29
Due to being sub-threshold for ARMS = 110
Due to not being help-seeking = 45
Other = 10
Lost contact before assessment complete (n=16)
Declined involvement before assessment complete (n=9)
### Baseline characteristics.

<table>
<thead>
<tr>
<th></th>
<th>Whole Sample n=288</th>
<th>Ct plus monitoring n=144</th>
<th>Monitoring only n=144</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>20.74 (4.34)</td>
<td>20.73 (4.18)</td>
<td>20.75 (4.50)</td>
</tr>
<tr>
<td><strong>Male: Female ratio</strong></td>
<td>180:108</td>
<td>89:55</td>
<td>91:53</td>
</tr>
<tr>
<td><strong>CAARMS severity</strong></td>
<td>43.06 (18.87)</td>
<td>43.50 (17.65)</td>
<td>42.61 (20.07)</td>
</tr>
<tr>
<td><strong>CAARMS distress</strong></td>
<td>42.61 (20.03)</td>
<td>42.77 (20.51)</td>
<td>42.45 (19.62)</td>
</tr>
<tr>
<td><strong>GAF</strong></td>
<td>51.06 (10.60)</td>
<td>50.98 (10.98)</td>
<td>51.15 (10.25)</td>
</tr>
<tr>
<td><strong>BDI-PC Total</strong></td>
<td>9.73 (4.48)</td>
<td>10.41 (4.15)</td>
<td>9.02 (4.70)</td>
</tr>
<tr>
<td><strong>SIAS Total</strong></td>
<td>41.18 (16.98)</td>
<td>42.88 (16.92)</td>
<td>39.36 (16.93)</td>
</tr>
<tr>
<td><strong>MANSA Total</strong></td>
<td>47.70 (10.10)</td>
<td>46.33 (9.60)</td>
<td>49.10 (11.00)</td>
</tr>
</tbody>
</table>

Mean & SD’s for variables for total sample and each group
Clinical features

- 53.8% endorsed feeling moderately anxious or depressed
- 33.6% endorsed feeling extremely anxious or depressed
- CAARMS subscale measuring suicidality and self harm 44.1% were experiencing “suicidal thoughts with vague plans” and 13.2% “Thoughts of suicide more frequent with associated plan”.

SCID

- 33% of the cohort did not receive a SCID diagnosis
- 33% received a diagnosis of Major Depressive Disorder
- 20% Panic Disorder
- 15% Social Anxiety Disorder
- 4% Post Traumatic Stress Disorder
- 9% Generalised Anxiety Disorder
- 2% Bipolar Disorder
SCID

- 61.5% of the cohort received one SCID diagnosis
- 27.7% of the cohort received 2 SCID diagnoses
- 12.9% 3 SCID diagnoses
- 4.6% 4 and 1.6% 5 SCID diagnoses.
- It is important to remember that all of these are in addition to being considered as being at risk of psychosis.
Primary outcomes BMJ 2012

- Transition to psychosis
  - Effect of CT was non-significant (proportional odds ratio 0.73, 95% CI 0.32 to 1.68, p=0.45).

- Severity of psychotic symptoms (centred on month 12)
  - Difference between treatment arms at 12 months (CT minus Control) was estimated to be -5.05 (95% CI -9.11 to -0.99), which was statistically significant (p = 0.015)

- Distress from psychotic symptoms (centred on month 12)
  - Estimated difference at 12 months was −3.03 (95% CI -6.95 to +0.94; p=0.14).
Meta analyses
11 trials including 1246 participants and eight comparisons were included. Median sample size of included trials was 81 (range 51-288). Meta-analyses were performed for transition to psychosis, symptoms of psychosis, depression, and mania; quality of life; weight; and discontinuation of treatment. **Evidence of moderate quality showed an effect for cognitive behavioural therapy on reducing transition to psychosis at 12 months (risk ratio 0.54 (95% confidence interval 0.34 to 0.86); risk difference −0.07 (−0.14 to −0.01)).** Very low quality evidence for omega-3 fatty acids and low to very low quality evidence for integrated psychotherapy also indicated that these interventions were associated with reductions in transition to psychosis at 12 months.
A search conducted according PRISMA guidelines found 10 studies that reported 12 month follow-up data, and 5 studies with medium-term follow-up varying from 24 to 48 months. 12 month and 24 - 48 month results on transition to psychosis were selected. The trials were assessed for quality. Random and fixed effects meta-analyses were conducted.
The quality of the papers varied from poor to excellent. Overall the risk reduction at 12 months was 54% (RR=0.463 (95%CI:0.33-0.64)) with a Number Needed to Treat of 9 (95%CI:6-15). Although the interventions differed, there was only mild heterogeneity and publication bias was small. All sub analyses showed efficacy. Five studies with 24 to 48-month follow-up still showed a risk reduction of 37% (RR=.635 (95%CI:0.44-0.92)) with a Number Needed to Treat of 12 (95%CI:7-59). Sensitivity analysis excluding the weakest study shows that the findings are quite robust.

Early detection and intervention in people with an ultra-high risk of developing psychosis prevents or postpones first episode psychosis. Antipsychotic medication showed efficacy, but more trials are needed. Omega-3 fatty acid needs replication. Integrated psychological interventions need replication with more methodologically sound studies. The findings regarding CBT seem robust, but the 95 percent confidence interval is still very large.
The relative risk (RR) of developing psychosis was reduced by more than 50% for those receiving CBT at every time point [RR at 6 months 0.47, 95% confidence interval (CI) 0.27–0.82, p=0.008 (fixed-effects only: six randomized controlled trials, n=800); RR at 12 months 0.45, 95% CI 0.28–0.73, p=0.001 (six RCTs, n=800); RR at 18–24 months 0.41, 95% CI 0.23–0.72, p=0.002 (four RCTs, n=452)].

Conclusions. CBT-informed treatment is associated with a reduced risk of transition to psychosis at 6, 12 and 18–24 months, and reduced symptoms at 12 months.
NICE 2014
Psychosis and schizophrenia in adults

• Preventing psychosis
• If a person is considered to be at increased risk of developing psychosis
• Offer individual cognitive behavioural therapy (CBT) with or without family intervention and
• Offer interventions recommended in NICE guidance for people with any of the anxiety disorders, depression, emerging personality disorder or substance misuse. [new 2014]
Dilemas

• Over 35’s?
• What would the Family Intervention look like?
• Would these reduce transitions?

interventions recommended in NICE guidance for people with any of the anxiety disorders, depression, emerging personality disorder or substance misuse.
Conclusion

• It is feasible to identify people at high risk of psychosis
• At risk of psychosis and definitely struggling
• CBT in ARMS reduces transition
• CBT in ARMS may reduce transition to multiple disorders or minimise long term disability
• Thank you
• @pfrench123
• Paul.French@gmw.nhs.uk
Yorkshire and the Humber Early Intervention in Psychosis Network
Questions & Discussion and Summary & Supervision

Moggie McGowan, EIP Clinical Advisor, Yorkshire and the Humber IRIS and NHS England North
Yorkshire and the Humber
Early Intervention in Psychosis Network
Time for a break?
Yorkshire and the Humber
Early Intervention in Psychosis Network

Group Discussions: At Risk Mental State

Dr Steve Wright, Consultant Psychiatrist, Tees, Esk and Wear Valley NHS Foundation Trust and Co-Chair, Yorkshire and the Humber EIP Network
Yorkshire & Humber EIP Network
Group Discussions – November 17th 2016
ARMS
making a difference together
Questions, Concerns & Feedback (themes)

- What are people’s plans for monitoring after 6 months?
- How assertive should the approach be for ARMS?
- How much are teams/trusts doing for ARMS currently? How many are providing a full service? (funding)
- CBT or CBTp? Can IAPT help (CBT)?
- CAARMS vs Clinical Judgement ("rate don’t formulate")
- What do we offer voice hearers +/- PD? How many?
- ARMS for >30s/>35s, Capacity for assessments??
ARMS in Secondary care – The wider picture

- A significant endorsement of a preventive strategy
- A remit for working with a group that lack a unifying diagnosis in order to manage distress, reduce DUP etc.
- Opportunity to obtain evidence for earlier intervention (pragmatic evidence-based trial & research opportunities)
- How might ARMS cases be stratified? – Traditional, Symptom based or other ways
- Develop integrated pathways (e.g. Trauma, Substance Misuse)

making a difference together
Key Questions for Discussion

- Interface issues – IAPT, CMHT, CAMHS
- Managing Capacity
- CAARMS and other assessment tools/approaches
- Care coordination and specialist roles for ARMS
- Psychological Therapies
- What is “core” and what isn’t?
ARMS Pathway - 1

- Referral / screening / triage
- Assessment
- Allocation
- Formulation
- “Core Interventions”
- “Governed” psychological interventions (CBT/FT)
- Tailored psychological interventions
ARMS Pathway – 2

- Physical Health
- Trauma
- Substance Misuse
- Social
- Occupational
- Transition – FEP, CMHT, IAPT
- Discharge
Group Discussions - ARMS

15:20 - 5 minutes: Introductions around the table

15:25 – 15 minutes: a) Key Question

15:40 – 15 minutes: b) Pathway discussion

15:55 – 5 minutes: Summing up & prep for feedback session
Yorkshire and the Humber
Early Intervention in Psychosis Network

Feedback from Group Discussions

Dr Steve Wright, Consultant Psychiatrist, Tees, Esk and Wear Valley NHS Foundation Trust and Co-Chair, Yorkshire and the Humber EIP Network
Feedback from Group Discussions - ARMS

a) Key Question (approx 10 mins!)
- one key message from the discussions per table

b) Pathway (approx 10 mins!)
- one key message from the discussions per table

All the sheets will be typed up and shared with the meeting notes so the wider discussions will be captured.
Yorkshire and the Humber Early Intervention in Psychosis Network

Any Other Business

Dr Steve Wright, Consultant Psychiatrist, Tees, Esk and Wear Valley NHS Foundation Trust and Co-Chair, Yorkshire and the Humber EIP Network
Date of the Next Meeting…. 

Thursday 2\textsuperscript{nd} March 2017 – Oxford Place, Leeds.

- 0930-1300 Intensive Support Team Workshop – to be confirmed
- 1330-1630 Y&H EIP Network Meeting: CAMHS Focus

- More details to follow – please let us have any suggestions for content or speakers.
Yorkshire and the Humber
Early Intervention in Psychosis Network

Thank You for Attending!

Don’t forget to fill out your evaluation!