North East and Yorkshire and the Humber
Adult Mental Health Clinical Networks

Early Intervention in Psychosis Network

2 December 2020

NHS England and NHS Improvement

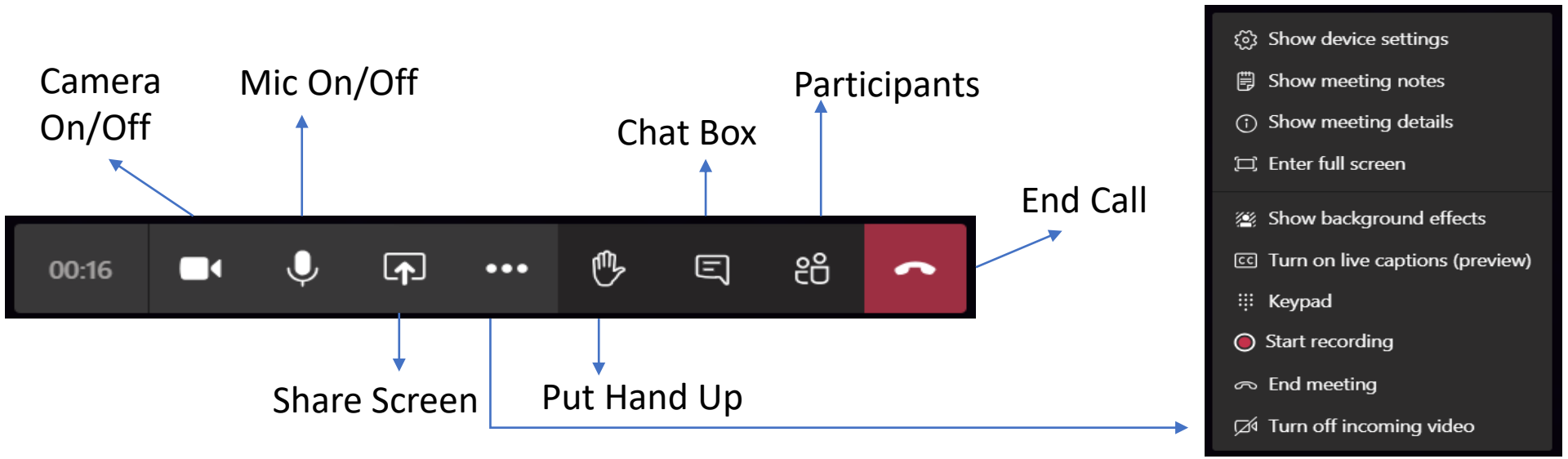
Housekeeping

Please remain on mute throughout the session, unless invited to speak – thank you.

You are welcome to use the video function, however this occasionally causes bandwidth problems so you may wish to turn it off.

Whilst we will have an open conversation, please *feel free to use the chat box function* to ask questions or make comments.

If you would like to speak please use the “Put Hand Up” function and the moderator will come to you in due course.



Today's Agenda

Time	Title	Lead
09.30	Welcome, Introductions and Housekeeping	Sarah Boul, Quality Improvement Manager, Yorkshire and the Humber Clinical Networks
09:35	Update on New National Guidelines	Moggie McGowan, Co-Chair, Clinical Advisor, Y&H IRIS, Y&H Clinical Network & NHS England North
10.00	Results of the NCAP Audit and Next Steps	Moggie McGowan, Co-Chair, Clinical Advisor, Y&H IRIS, Y&H Clinical Network & NHS England North
10.20	Group Discussion: COVID Concerns Impact on Teams and Impact on Patients and Q&A	All
10.50	Summary and Close	Dr Steve Wright, Co-Chair, Consultant Psychiatrist, TEWV & Clinical Advisor, Y&H Clinical Network
11.00	Close	

Implementing Early Intervention in Psychosis: 2020 Updated Guidance

A summary of new guidance from the 2020 NHS England refresh of the national EIP standard with a focus on recommendations for people with an at-risk mental state for psychosis.

Moggie McGowan, Co-Chair, Clinical Advisor, Y&H IRIS, Y&H Clinical Network
& NHS England North

NHS Long-Term Plan (LTP)

The LTP states that all areas must invest to ensure EIP services are commissioned in line with NHS England guidance which includes:

1. **Provision for all age groups (under 18s and over 35-year olds)** – areas should be aiming to deliver this now rather than planning for delivery in 2023/24
2. **Provision for people with an At-Risk Mental State -** areas should be aiming to deliver this now rather than planning for delivery in 2023/24
3. **Ensuring improvements are made in levels of NICE concordance** (NCAP level 3)
4. **The referral to treatment element of the standard is met**

- This is supported by significant new CCG baseline investment totalling **£52 million** for EIP nationally in 2020/21.
- There is now a ringfenced local investment fund worth at least **£2.3 billion** a year by 2023/24 covering the Long-Term Plan (LTP) ambitions for Mental Health

(NHS Mental Health Implementation Plan 2019/20 – 2023/24)

NHSE EIP Standard – New 2020 Guidance

- A refresh of the 2016 guidelines, capturing experience gained during the 5YFVMH and new evidence
- Reflects the LTP objective (95% Level 3 by 2024)
- Emphasises the 14-65 age range
- Increased contributions from service users and carers
- NICE 2014 remains the basis (CG155 & CG178)
- Promotes the PsyMaptic psychosis prediction tool for estimating local incidence
- Expanded sections covering key areas including ARMS

Expanded sections:

- **Models of care:** Dispersed teams removed
- **CYP:** Seamless care.

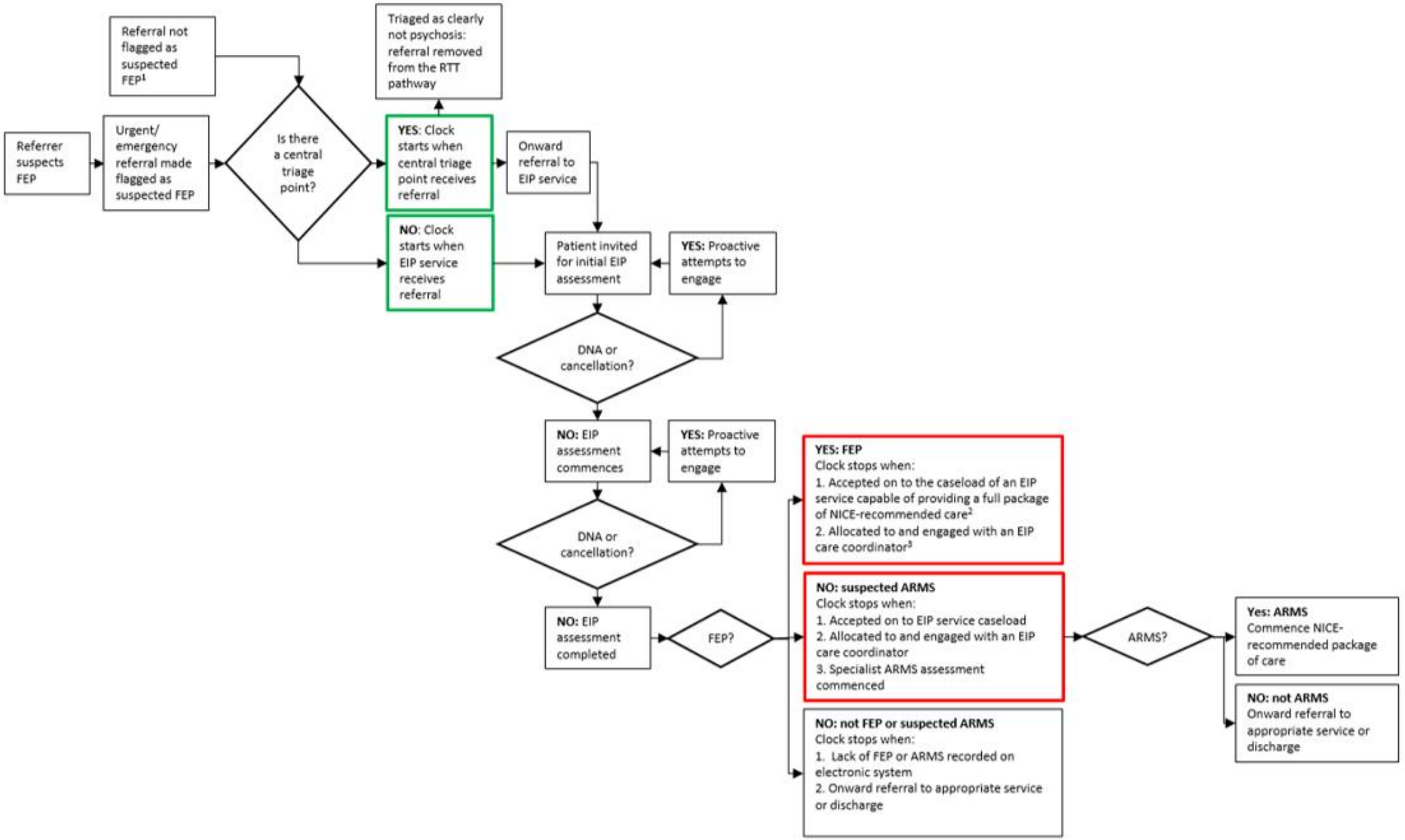
  'All children and young people, aged 14 and above, experiencing first episode psychosis should receive a comprehensive package of NICE concordant EIP care'

  'Ensure robust arrangements to ensure that specialist expertise in working with children and young people with psychosis is available'
- **Carer education:** Includes recommendations for a typical programme
- **Workforce:**

  - Improved workforce descriptors including social workers and peer workers

  - The HEE workforce calculator remains the formula for planning team skill-mixes (including caseloads of 15 for care coordinators).
- **New ARMS section**

EIP Full Referral to Treatment Pathway (original 2016 standard)



What is an At Risk Mental State (ARMS)?

Before an episode of psychosis, many people will experience a period of symptoms/experiences described as having an at risk mental state or ‘ARMS’.

This may be characterised by a more extended period of attenuated (less severe) psychotic symptoms; or

- An episode of psychosis lasting less than seven days; or
- An extended period of poor social and cognitive functioning (perhaps accompanied by unusual behaviour including withdrawal from school or friends and family) in the context of a family history of psychosis

When treating a person presenting with an at risk mental state, it is important both to support them with their **current needs** as well as to try to **prevent transition** to psychosis.

At Risk Mental State – **Refreshed Guidance**

‘A comprehensive EIP service should ensure that people, including children and young people, with an at-risk mental state have to access to evidence-based care and support’

ARMS – Putting the ‘Early’ in Early Intervention

The waiting time element of the EIP standard requires that anyone with a suspected first episode of psychosis should be referred for assessment. If the person is experiencing an at-risk mental state, the clock will stop when:

- the person is **accepted on to the caseload** of an appropriate secondary mental health service, and
- the person is **allocated** to **and engaged** with a care coordinator
- an at-risk mental state **assessment has commenced** by an appropriately trained and qualified clinician.

Core Activities:

- **Early detection** which focuses on early identification and provision of preventative strategies
- Providing a comprehensive and timely **assessment**, with subsequent **care and support** where this need is identified.
- **Preventing deterioration** in family and social life

Evidence shows that for people experiencing ARMS, many **protective social factors** are still intact:

- in education or work
- have a range of social contacts
- a supportive family group

Without prompt access to effective treatment, deterioration in family and social life can occur very quickly

DUP

- The Duration of Untreated Psychosis (DUP) is the length of time between the onset of psychotic symptoms and the commencement of treatment
- Reducing DUP has strong evidence for improved outcomes in FEP
- The RTT standard aims to reduce delay within secondary services
- ARMS provision can support a reduction in overall DUP by early case finding and by quickly transferring people to EIP if they do transition to a FEP.
- Minimising DUP is critical for service users, their families and the team providing care and support

At Risk Mental State: Key Aims

- To identify people who are experiencing an ARMS (particularly important in children and young people).
- Complete a comprehensive assessment*
- To provide a stepped care approach for people with emerging psychotic symptoms.
- To delay or prevent the onset of severe mental health problems/psychosis by
- Providing evidence-based care, treatment and support

*Assessment by a consultant psychiatrist or a trained specialist with experience in ARMS. Practitioners should be competent in completing a thorough assessment and formulation which also considers the effects on presenting symptoms of adverse childhood experiences, including **trauma** and **neglect**, as well as potential **learning difficulties** and **neurodevelopmental conditions**.

Treatment & Support: NICE guidance

The table provides an overview of the NICE guidance for individuals that are identified as experiencing an ARMS.

	Components of NICE guidance	
Component	**Children and young people**	**Adults**
Maximum waiting time for referral to treatment	Children and young people who are referred to a specialist mental health service with a suspected first episode of psychosis start assessment within two weeks	Adults with a suspected first episode of psychosis start assessment within two weeks of referral
Specialist assessment i.e. consultant psychiatrist trained or trained specialist with experience in ARMS	Children and young people's mental health services or an EIP service provide assessment if a child or young person experiences: • Transient or attenuated psychotic symptoms or; other experiences or behaviours suggestive or possible psychosis	Suitably trained clinician to provide an assessment if a person is distressed, has a decline in social functioning and has: Transient or attenuated psychotic symptoms; or other experiences or behaviours suggestive of possible psychosis; or first degree relative with psychosis or schizophrenia
Individual CBT with or without family interventions	Individual CBT with or without family intervention delivered by a trained therapist	Individual CBT with or without family intervention delivered by a trained therapist
Interventions for coexisting mental health problems	To be offered for depression; any of the anxiety disorders, emerging personality disorder or substance misuse, along with individual CBT (with or without family intervention).	To be offered for depression, any of the anxiety disorders, emerging personality disorder or substance misuse, along with individual CBT (with or without family intervention).

Treatment & Support: New NHSE guidance

- A period of active treatment lasting up to two years.
- Regular monitoring for at least another year after treatment up to a minimum of two years and a maximum of three years in total.
- Monitoring should include using a structured and validated assessment tool, for example the Comprehensive Assessment of At Risk Mental States (CAARMS).
- Individual CBT with or without family interventions and without antipsychotic medication
- Interventions for coexisting mental health problems
- ARMS provision may also need to include support for people to live well and maintain their social and family links:
    - Education and employment support
    - Support to maintain good physical health
    - Support for carers and families.
- The current evidence base for providing care and support for people with ARMS is 14-35 years

Options for ARMS Delivery

ARMS pathways tend to form a part of EIP services on the whole although there is some variation across England in relation to where this pathway sits within services. The latest recommendations include three options:

1. Stand-alone:

- Distinct, multi-disciplinary teams able to provide all recommended ARMS interventions, usually located in areas with high incidence of psychosis;

2a. Integrated with a separate dedicated ARMS caseload:

- Includes a dedicated team/s of care co-ordinators or clinical staff with a cohort of ARMS cases;
- ARMS team will have a shared manager/ clinical lead across psychosis and the ARMS pathway, with access to shared resource and support staff i.e. psychologists/ therapists.

2b. Integrated with clinicians with a mixed caseload:

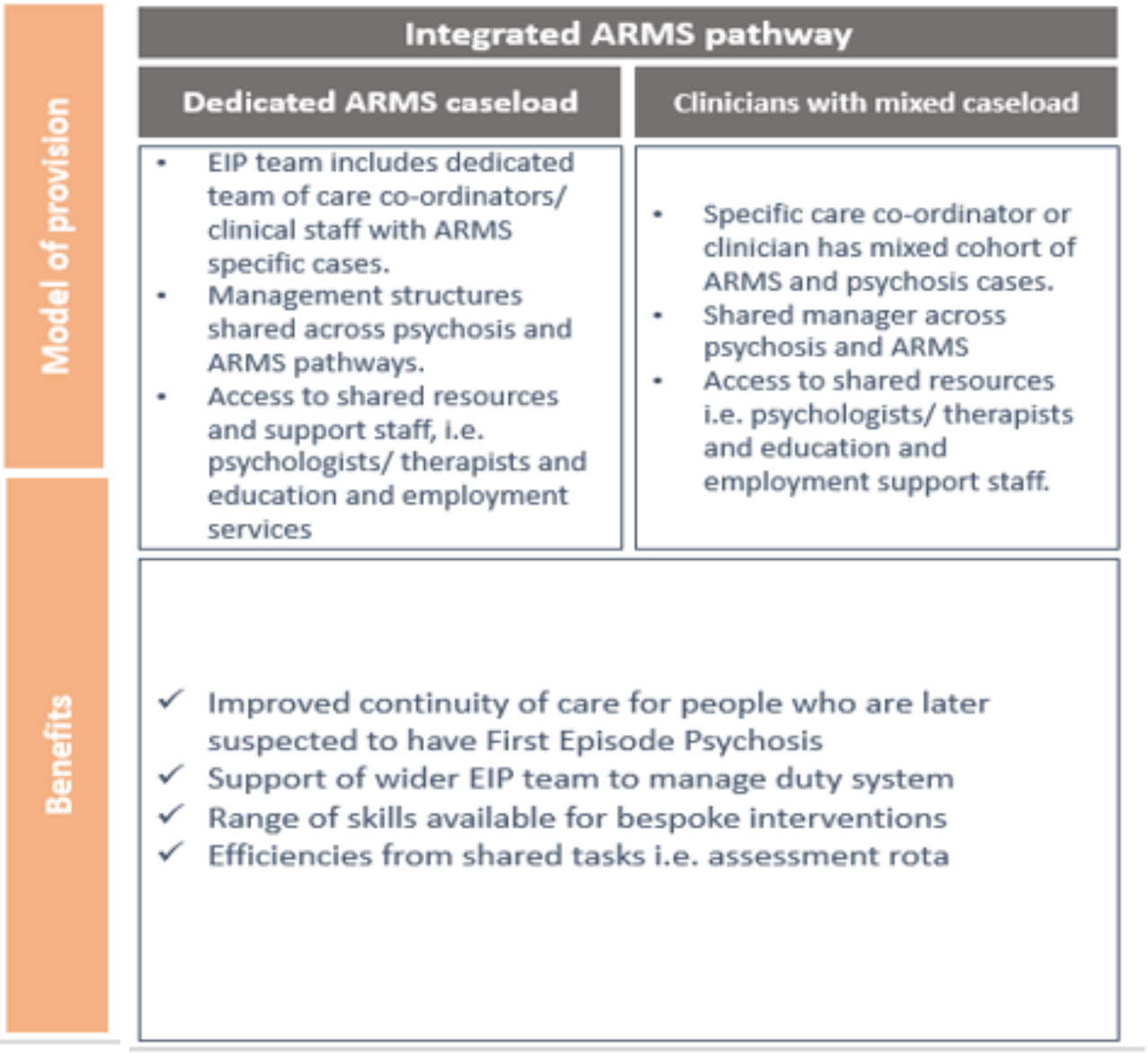
- Identified care co-ordinator/ clinicians has a mixed cohort of service users with ARMS and psychosis;
- Shared manager/ clinical lead across psychosis and ARMS pathways.

There are benefits of both models of delivery and commissioners and service leads should work together with service users, carers and their families (including experts by experience) to deliver a model based on the needs of their local population

At Risk Mental State – Stand Alone Model

Model of provision	Stand-alone
	• Stand-alone team • Require referral from other mental health services • Multi-disciplinary, can provide all recommended ARMS care and support • Strong links with EIP and other mental health services
Benefits	✓ Resources cannot get drawn into EIP ✓ Clarity of focus only on ARMS, including ability to provide specific ARMS provision ✓ Ability to provide input and develop expertise for a wider range of (non-psychosis) outcomes ✓ Wider impact of early detection and prevention of a range of mental health conditions ✓ Reduced potential of iatrogenic harms

At Risk Mental State – Integrated Model



Key considerations

- Demand and Capacity
- Inclusion criteria/Thresholds
- Service configuration
- Workforce and training
- Role of medics
- Assertive engagement?
- Outcomes?
- RTT clock-stop
- Trauma
- LTP opportunities
- DBT, EMDR, Systemic FT, Open Dialogue??

(NB – Deep dive workforce estimates were based on an equivalent number of ARMS cases to the number of FEP referrals per year, having an average 12 months of treatment with 50% requiring care coordination and a full MDT care plan)

Results of the NCAP Audit and Next Steps

Moggie McGowan, Co-Chair, Clinical Advisor, Y&H IRIS, Y&H Clinical Network & NHS England North

NHS England and NHS Improvement

Team Name	OVERALL SCORE	20/21 Trajectory	23/24 Trajectory	Support Offer (High/Medium /Low)
Bradford and Airedale Early Intervention Service	Needs improvement			M
North Cumbria Early Intervention in Psychosis				M
Psychosis Service for Young People (PSYPHER)	Performing well			L
EIP and Transition Service NAVIGO	Top performing			M
Gateshead EIP	Needs improvement			M
North Tyneside EIP	Needs improvement			M
Northumberland EIP	Performing well			L
Sunderland EIP	Performing well			L
Newcastle EIP	Performing well			L
South Tyneside EIP	Needs improvement			M
Early Intervention in Psychosis - Doncaster	Needs improvement			M
Early Intervention Team - North Lincs	Needs improvement			M
Early Intervention Team - Rotherham	Needs improvement			M
Sheffield Early Intervention Service	Needs improvement			H
Barnsley Early Intervention Team	Top performing			L
Calderdale Insight EIP	Top performing			L
Kirklees Insight Team - North	Needs improvement			L
Kirklees Insight Team - South	Top performing			L
Wakefield Early Intervention in Psychosis Team	Performing well			L
Harrogate, Hambleton & Richmondshire EIP Team	-			H
North Durham & Easington EIP	Needs improvement			M
Hartlepool Early Intervention in Psychosis Team	Needs improvement			M
Stockton Early Intervention in Psychosis Team	Needs improvement			M
Scarborough, Whitby & Ryedale EIP Team	Needs improvement			H
South Durham Early Intervention in Psychosis Team	Needs improvement			M
Middlesbrough Early Intervention in Psychosis Team	Performing well			L
Redcar and Cleveland EIP Team	Needs improvement			M
York & Selby Early Intervention in Psychosis Team	Needs improvement			H
Aspire (Leeds)	Needs improvement			M

NCAP, trajectories and Support

- High (H): Support with needs analysis and workforce planning. Help to develop and project manage recovery plans. CCG/STP engagement. Attendance at steering group meetings. Detailed assurance reports based on recovery plans. Clinical support from regional clinical lead and regional network.
- Medium (M): Advice and help to self-complete needs analysis and workforce plans. Ad. hoc. support to CCG/STP. Attendance at steering groups by invitation. Standard assurance reports based on self-completed Performance & Trajectory monitoring. Clinical support from regional network.
- Low (L): Ad. hoc support for improvement. Standard assurance based on self-completed Performance & Trajectory monitoring. Clinical support from regional network.

Self-completed Performance & Trajectory monitoring

Access 84%	**NICE** Level 3	**Outcome Data** Level 2	**NCAP 2019/20 Level 3**	**NCAP 2023/24**
Service Model Stand Alone MDT	**3-Year Service** 40 months	**Caseloads** 15	**Contextual Status**	**Contextual Status**
Provision for Children	**Demand/Capacity** 225/185	**Investment pp** £7,450		
ARMS Pathway	**Age Range** 14-65	**Data Quality & Snomed**		
Mental Health Outcomes	**Recovery Outcomes**	**Cost-economic Outcomes**	**Outcomes**	**Outcomes**

Group Discussion:
COVID Concerns: Impact on Teams and Impact on Patients
and
General Q&A

All

NHS England and NHS Improvement

Summary and Close

Dr Steve Wright, Co-Chair, Consultant Psychiatrist, TEWV & Clinical Advisor, Y&H Clinical Network

Thank you for attending!