NHS England
North

Early Intervention in Psychosis
Supporting services in the North

Guidance clarifying EIP and ARMS referral criteria

Introduction

The recent Access and Waiting Times Standard[1] will lead to a number of changes in the functions of Early Intervention in Psychosis (EIP) Services in the UK, and to the group of service users who can be referred to these services. This document aims to clarify the new criteria for referral, and is intended to update previous guidance[2]. The Access and Waiting Times Standard applies to referrals in which the referrer has either detected, or suspects a possible first episode of psychosis, **and makes an urgent or emergency referral, which is flagged as "suspected First Episode Psychosis".**

First episode psychosis

Psychotic illnesses are a major cause of disability in young people. EIP services have been developed worldwide to improve outcomes for people experiencing these conditions, by improving access to treatment, and by delivering best-practice, evidence based care.

EIP services will now provide care to all people between the ages of 14 and 65 who are experiencing a first episode of non-organic psychosis (FEP). This includes first episodes of schizophreniform, manic and depressive psychoses, puerperal psychoses and acute and transient psychoses amongst others. Although these conditions usually develop in adolescence and young adulthood, some may develop later, particularly in women, and the changes in age range reflect this. EIP teams will not provide care for people experiencing organic psychoses, e.g. psychosis in the context of dementia.

Diagnostic uncertainty

Diagnoses in FEP are often unstable and polymorphic, particularly in the early stages, so acceptance by EIP teams is usually determined by the presence of significant psychotic symptoms. These include hallucinations, delusions, conceptual disorganisation and others, which should be of sufficient severity to cause distress or impairment of social or occupational function.

The use of standardised assessments (eg PANSS[3], CAARMS[4]) to measure symptom severity and response to treatment is recommended. An item score of 4 or higher on the PANSS Positive items of hallucinations or delusions, or scoring 5 or above in the context of a cluster of symptoms, is indicative that a person has reached the threshold to be accepted by an EIP service. Additionally, the symptom must have lasted throughout the day for several days or have occurred several times a week, not limited to a few brief moments, and the above symptoms must be present for a period of over seven consecutive days duration over the last 12 months (or, if less than this, then the improvement must be attributable to antipsychotic treatment). Negative symptoms, however, are the strongest predictors of poor outcome[5]. Use of standardised and validated diagnostic assessments, for example, the Structured Clinical Interview for DSM IV (SCID)[6] or Diagnostic interview for Psychoses, Diagnostic Module (DIP-DM)[7] is recommended to clarify diagnostic uncertainty. Some people, in whom symptoms are suggestive of possible psychosis, may benefit from an extended assessment (usually for 4-6 months) to clarify whether they meet the criteria for FEP or At Risk Mental State (ARMS), or neither of these.

Comorbidities are extremely common, and should not preclude care from EIP services. If psychosis is not the primary problem that needs care, EIP teams may feel that it is appropriate to refer to another, more appropriate service, for example, drug and alcohol, autism, mother and baby or personality disorders services. In such cases, the EIP team should be able to remain involved to deliver interventions as necessary and appropriate.

Duration of treatment

EIP teams usually provide care for three years, to ensure that service users receive best practice treatment over the "critical period"[8]. On occasions, people may need longer care to achieve a stable personal recovery, while some people may make good progress earlier and feel that they no longer wish to be involved with services. On-going monitoring and contact with services, which may be of low intensity, are recommended for three years for all first episode psychoses, and early discharge should be for a small minority.

Acceptance criteria

- First presentation of psychosis
- Age 14-65
- Not previously in receipt of a full three years of EIP treatment
- Psychotic symptoms (hallucinations, delusions, catatonia, thought disorder present for one week and causing distress or impairment of function).

If psychosis is suspected, but does not meet the above criteria, assessment for an At Risk Mental State, using a validated ARMS assessment instrument, eg the

CAARMS, or the Structured Interview for Prodromal Symptoms (SIPS) SOPS, is recommended[9 10 11].

At Risk Mental States (ARMS)

In addition to providing care for people experiencing first episodes of psychosis, EIP teams should have the capacity to assess and treat those deemed to be at-risk of developing psychosis. Teams should have dedicated ARMS workers, who provide assessment and treatment for people who may be experiencing prodromal symptoms, and have a high risk of developing a psychosis in the near future. The aim of working with this group is to reduce the number of people making the transition, and developing psychotic illnesses.

Psychotic illnesses appear to develop over variable timescales. Some have a long, insidious onset, whilst others may develop acutely. Identification of prodromal states and intervention in prodromal phases may improve outcomes. At Risk Mental State assessments provide screening to detect people felt to be at higher risk of developing psychotic illnesses, and who may benefit from treatment. The most appropriate follow up period appears to be 3 years, with transitions rates of around 36% occurring up to this point.

CBT interventions in young people experiencing an At Risk Mental State have been shown to reduce symptom severity and, in some studies, to reduce the number of people going on to develop psychotic illnesses[12]. A recent meta-analysis concluded that 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[13]. If people develop a full psychotic illness, they will be in contact with services and should receive prompt treatment, which will reduce the Duration of Untreated Psychosis (DUP), a factor influencing outcomes.

As these services are intended to reduce future morbidity, they should aim to see people who do not meet criteria for a first episode psychosis, yet show features which are predictive of risk of development of an episode of FEP.

These include:

> Distress
>
> Young adulthood/adolescence (age 14-30),
>
> Recent (over past year) decline in social function

Plus:

> Attenuated psychotic symptoms or
>
> Transient psychotic symptoms or

Strong family history of psychotic illness or

Increasing unexplained distress or agitation or

Other risk indicators, eg schizotypal personality

Assessment

Standardised, validated instruments, such as the Comprehensive Assessment of At Risk Mental States (CAARMS), or the Structured Interview for Prodromal Symptoms (SIPS) SOPS will be used in the assessment. Those who are identified by these as being in the Ultra-High Risk (UHR) group will receive a CBT-based intervention for ARMS[14]. Use of a checklist in primary care may be valuable in identifying people who should be referred for ARMS assessment[15].

Evidence for the effectiveness of specialist ARMS interventions has been generated in younger adult populations (<30) so there is no current evidence that this approach will work with the over 35 age group that EI teams are now required to work with. Although providing ARMS interventions to this older age group is likely to be beneficial, and would not be considered a risk for harm, where EIP service capacity is limited it may be necessary to refer people over the age of 30 presenting with ARMS onwards to appropriate specialist Mental Health services, especially where other comorbidities make it clinically appropriate.

Acknowledgements
This paper was written by Dr Iain Macmillan Regional EI Clinical Lead for Psychiatry, NHS England (North).

NHS England Regional EI Leads, Alison Brabban, Paul French, Stephen McGowan and Guy Dodgson, and Prof Jo Smith, reviewed initial drafts and provided helpful comments which have been incorporated to produce this final version.

REFERENCES:

[1] Achieving Better Access to Mental Health Services by 2020 DOH 2014

[2] Early Intervention (EI) Acceptance Criteria Guidance. NIMHE National Early Intervention Programme. 2008 Dr Jo Smith, Joint National EI Programme Lead

[3] The Positive and Negative Syndrome Scale (PANSS) for schizophrenia. Kay SR, Fiszbein A, Opler LA. Schizophr Bull 1987; 13: 261–76.

[4] Mapping the onset of psychosis: the Comprehensive Assessment of At-Risk Mental States. Yung AR[1], Yuen HP, McGorry PD, Aust N Z J Psychiatry. 2005 Nov-Dec;39(11-12):964-71.

[5] Examination of the Positive and Negative Syndrome Scale factor structure and longitudinal relationships with functioning in early psychosis Michael W. Best, Michael Grossman, L. Kola Oyewumi and Christopher R. Bowie Early Intervention in Psychiatry 2014

[6] Structured Clinical Interview for DSM-IV-TR Axis I Disorders, Research Version, Patient Edition With Psychotic Screen (SCID-I/P W/ PSY SCREEN) First MB et al New York: Biometrics Research, New York State Psychiatric Institute, November 2002.

[7] The diagnostic interview for psychoses (DIP): development, reliability and applications. Castle DJ, Jablensky A, McGrath JJ *et al. Psychol Med* 2006; **36:** 69–80.

[8] Early intervention in psychosis. The critical period hypothesis. Birchwood M, Todd P, Jackson C. Br J Psychiatry Suppl. 1998;172(33):53-9.

[9] Psychosis and schizophrenia in adults: treatment and management NICE guidelines [CG178] Published date: February 2014

[10] Psychosis and schizophrenia in children and young people Recognition and management Issued: January 2013 NICE clinical guideline 155

[11] Prodromal Assessment With the Structured Interview for Prodromal Syndromes and the Scale of Prodromal Symptoms: Predictive Validity, Interrater Reliability, and Training to Reliability. Miller TJ et al. Schizophrenia Bulletin, Vol. 29, No. 4, 2003

[12] Early detection and intervention evaluation for people at risk of psychosis: multisite randomised controlled trial. Morrison et al BMJ 2012;344:e2233

[13] Cognitive behavioural therapy for psychosis prevention: A systematic review and meta-analysis. Hutton, P. and Taylor, P. J. (2014) Psychological Medicine, 44. pp. 449-468.

[14] Early Detection and Cognitive Therapy for People at High Risk of Developing Psychosis: A Treatment Approach. French, P. & Morrison A. P . Wiley, 2004.

[15] Identification of young people in the early stages of psychosis: Validation of a checklist for use in primary care. French, P, Owens J, Parker, S, Dunn, G. Psychiatry Research 200 (2012) 911–916