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Early Intervention Service Operational Policy

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Type of document	Policy
Target audience	All CWP Staff
Document purpose	Operational policy which sets out the background and evidence base for CWP Early Intervention in Psychosis services, evidence based care package provided by the teams and working practice guidelines.

Approving meeting	Specialist Mental Health Governance Group	Date 13-Mar-19
Implementation date	13-Mar-19	

CWP documents to be read in conjunction with	
MP1	Medicines Policy
CP42	CPA Policy
GR33	Lone Worker Policy
HR22	Supervision and Appraisal Policy
HR2.6	Annual Leave Policy
CP3	Trust Records Policy
CP37	Policy and procedure for managing informal service users' non-compliance with treatment and managing DNA (did not attend) or cancelled appointment
CP40	Safeguarding Children Policy
CP10	Safeguarding Adult Policy
CP1	Admissions, Discharge and Transfer of Care Policy
AM2	Protocol for 7 Day follow up following discharge

Document change history	
What is different?	New content and appendices.
Appendices / electronic forms	New appendices have been added to reflect NHSE access and wait time standards – checklist added to
What is the impact of change?	To provide a more timely, standardised offer.

Training requirements	Yes - Training requirements for this policy are in accordance with the CWP Training Needs Analysis (TNA) with Education CWP.

Document consultation	
Clinical Services	Team Mangers
Corporate services	Lauren Connah
External agencies	n/a

Financial resource implications	no

External references
1.

Equality Impact Assessment (EIA) - Initial assessment	Yes/No	Comments
Does this document affect one group less or more favourably than another on the basis of:		
- Race	no	
- Ethnic origins (including gypsies and travellers)	no	
- Nationality	no	
- Gender	no	
- Culture	no	
- Religion or belief	no	
- Sexual orientation including lesbian, gay and bisexual people	no	
- Age	no	
- Disability - learning disabilities, physical disability, sensory impairment and mental health problems	no	
Is there any evidence that some groups are affected differently?	no	
If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?		
Select		
Is the impact of the document likely to be negative? - If so can the impact be avoided? - What alternatives are there to achieving the document without the impact? - Can we reduce the impact by taking different action?	no no no no	
Where an adverse or negative impact on equality group(s) has been identified during the initial screening process a full EIA assessment should be conducted. If you have identified a potential discriminatory impact of this procedural document, please refer it to the human resource department together with any suggestions as to the action required to avoid / reduce this impact. For advice in respect of answering the above questions, please contact the human resource department.		
Was a full impact assessment required?	no	
What is the level of impact?	no	

Contents

1. Statement of Purpose

This policy aims to outline the Early Intervention in Psychosis Service (EIP) within CWP and define the service, operational procedures and pathways through the service. The document should be seen as a 'working draft' as it will need to be regularly reviewed and updated in order to remain relevant to service developments and changes in policy and practice.

EIS have an important and integral role to play in supporting service users and their families/carers in a community setting. The EIS is founded on an extensive and compelling evidence base which has demonstrated Early Intervention in Psychosis can contribute significantly to the amelioration of initial problems, and consequently improve long-term outcomes (Bertelsen et al., 2008; Hegelstad et al., 2012). Effective early treatment is thought to reduce the probability of the emergence of longer term "treatment resistant" symptoms, contributes to the avoidance of the "revolving door" syndrome of repeated relapse and, as suicide is highest in the first few years of First Episode Psychosis (FEP); EIS can reduce the risk of suicide.

The Early Intervention in Psychosis Service will provide help for young people and adults experiencing first episode psychosis to reduce distress, maintain independence and integrity of care networks, shorten illness duration, prevent relapse, promote recovery and social inclusion, and minimise the impact of disabilities.

In Cheshire West, Cheshire East and Central & Wirral Partnership the teams are managed through their own directorate management structures although a steering group remains in place to maintain consistency across the teams. Local deviations from this central operational policy will be detailed, where necessary, in the main text or otherwise documented in the appendices.

The EIP offers two distinct care pathways, at risk mental state (ARMS) and first episode psychosis (FEP) pathway for service users depending on need.

The service will provide specialist mental health assessment leading to appropriate treatment and care plans which enable integrated working. The core teams will consist of a full multidisciplinary team. The team has the ability to signpost to other services such as the IAPT, Substance Misuse Services, CMHT, CAMHS and other statutory and non-statutory agencies.

The service recognises that individuals with mental health needs have the same rights as other citizens. In particular, they have the right to be consulted, to be actively involved in their plan of care regardless of their disability and the right to choose the gender of their care coordinator and other members of the care team.

The service will embrace the 6 Cs of Care, Compassion, Courage, Communication, Competence and Commitment, outlined in the Francis Report 2013, and strive to provide service users and carers with the opportunities, choice and hope that will empower them to achieve a meaningful life and a positive sense of belonging to their community.

Adult mental health services aspire to continuously improve the quality of care it delivers by tackling unwarranted risks and supports everyone in delivering the best care possible for the best health outcomes of service users. The principles of zero harm and the Stop Listen Think Campaign are central to the team's philosophy, sharing learning through incidents, celebrating our successes and continuously developing our service through innovative evidence based practice and redesign.

2. National Context

Given the evidenced importance of EIP services (e.g. NICE guidance for Adults with Psychosis and Schizophrenia) and the need to improve access to these services, NHS England have introduced a national access and waiting time standard. This standard requires that from the 1st April, 2016, more than 50% of people experiencing first episode psychosis (FEP) commence a NICE-recommended package of care within two weeks of referral, this is a stretched target that will rise to 60 % by 2020/21. Furthermore, the criteria for services has been widened beyond the previous 35-year cut off and the service is now required to provide a service for all service-users aged 14-64 experiencing first episode psychosis for those individuals 'at high risk of developing psychosis' (NICE, 2014).

3. Service Model

Core features of the EIS service model are based on NICE guidance for young people and adults for psychosis and schizophrenia, 2014 (see Appendix 3 for information on NICE guidance). CWP has three teams which work in a standardised way (see appendix 5) as per the Trustwide treatment pathway.

3.1 Core Features

- Early detection and assessment within two weeks of referral;
- Care co–ordination under CPA through a fully integrated health and social care service within two weeks of referral;
- Specific ongoing assessment and intervention around co–morbidity e.g. alcohol, substance misuse, depression;
- Comprehensive assessments and interventions including housing, income, finance, physical health care and practical support;
- Pharmacological treatment; service users may be offered medication. This should be low dose, with the side effects clearly explained. Initial commencement of medication should be reviewed within a six-week period;
- Adults with a diagnosis of schizophrenia that has not responded adequately to treatment with at least two antipsychotic drugs will be offered clozapine;
- All service users will be offered evidence-based psychological interventions suggested by NICE guidelines for FEP, including individual CBTp and Family Interventions, offered as a first line treatment. NICE recommended psychological approaches for other presentations will be offered where there is capacity to deliver them within the team, or refer to more appropriate other local agencies (e.g. newer third wave interventions and psychological approaches);
- Robust clinical supervision structures. Care coordinators will receive regular clinical supervision;
- Early vocational assessments with a focus on valued social roles including access to education and occupation;
- Outreach work, prevention and awareness programmes for example, adults who wish to find or return to work will be offered supported employment programmes;
- Youth focus-low stigmatised settings, using GP surgeries/local community resources, where appropriate;
- Robust physical health care assessments and monitoring in accordance with the NICE guidelines - on starting anti-psychotic medication and at annual review;
- All service users will be offered combined healthy eating and physical activity programmes as well as help to stop smoking;
- Carers of service-users will be offered carer-focused education and support programmes;

- An assertive approach to engagement to reduce the risk of service users being lost to services and potentially experiencing a longer duration of untreated psychosis. To assertively engage in situations where service users miss multiple appointments or are resistant to working with the team. The EIS will be flexible and creative in the approaches it uses to establish engagement with 'hard to reach' service users (see Appendix 2 for more details on the service's response to disengagement).

4. Aims of the Service

The Early Intervention Service (EIS) and ARMS service aims to deliver care in line with the following principles identified in the Department of Health Policy Implementation Guidance:

- Culture, age and gender sensitive;
- Family orientated;
- Meaningful and sustained engagement based on assertive outreach principles;
- Treatment provided in the least restrictive and stigmatising setting;
- Separate, age appropriate facilities for young people;
- Emphasis on normal social roles and service user's development needs, particularly involvement in education and achieving employment;
- Emphasis on working with distressing experiences rather than diagnosis.

Taking this guidance into account, there are key features of the Early Intervention Service:

- It is oriented towards recovery;
- Promotes social inclusion and places a high value on social and peer group acceptance;
- Delivers care which is age-appropriate;
- Minimises stigma;
- Emphasises psychosocial interventions;
- Utilises an assertive approach to engagement;
- Focuses on optimising outcomes for service users and promotes awareness and understanding of psychosis across society.

5. Client Group

5.1 Inclusion Criteria

- Individuals who are aged between 14 and 64;
- Registered with a GP within the locality of the Early Intervention in Psychosis team (Central and East, West, Wirral);
- The presence of suspected or confirmed psychotic symptoms;
- Early intervention in psychosis services should be accessible to all people with a first episode or first presentation of psychosis, irrespective of the person's age or the duration of untreated psychosis. [NICE guidelines psychosis and schizophrenia, 2014];
- FEP in the context of bi-polar (see NICE guidelines wording);
- In the case of service users with a co-existing learning disability, EI services will adhere to the CWP Trustwide green light toolkit, in order to ensure fair access to specialist care for all.

As a rule of thumb a service user with a PANSS score of 4 or above in the delusion or hallucination category would usually warrant assessment and care coordination by an EI service.

5.2 PANSS score of 4:

Delusions: Presence of either a kaleidoscopic array of poorly formed unstable delusions or of a few well-formed delusions that occasionally interfere with thinking, social relations, or behaviour
Hallucinations: Hallucinations occur frequently but not continuously, and the patient's thinking and behaviour are affected to only a minor extent.

5.3 Inclusion criteria (ARMS):

To meet the criteria for being an ARMS patient, the assessment must identify whether a patient falls into one of three groups:

- Group one is the Vulnerability group. For a patient to meet this criterion they need to have a first degree relative with a diagnosis of psychosis (parent or sibling) or personally have a diagnosis of schizotypal personality disorder;
- Group two is the Attenuated psychosis group. Patients in this group will experience sub-threshold psychotic symptoms that will not be severe enough in intensity or frequency to be deemed FEP;
- Group three is the Brief Limited Intermittent Psychotic Symptoms (BLIPS) group. Patients in this group would meet the ARMS criteria if they have had a recent history of full a blown psychotic illness, that resolved spontaneously (without antipsychotic medication) within 1 week.

If a patient meets the criteria for one of the above groups, they must also achieve the following two elements identified in the CAARMS assessment. Firstly, the patient must be help seeking and secondly there must be a significant decline or chronic low functioning in the patients functioning levels.

The Social and Occupational Functioning Assessment Scale (SOFAS) is used to measure the functioning of an individual. Significant decline in functioning is operationalised as a 30% drop in functioning over the past year and attained for at least a 4-week period. Chronic low functioning is operationalised as a score of 50 or less on the SOFAS scoring continuum for the past 12 months or longer.

5.4 Exclusion Criteria

- Outside of the target age range 14 – 64;
- Those who have already received three years of EIS and have been discharged;
- Individuals who have already been prescribed and taken treatment for psychosis for a significant period of time more than 3 years prior to referral;
- Referrals of people who are experiencing psychotic symptoms with a confirmed organic cause, for example, brain diseases such as Huntington's and Parkinson's disease, HIV or syphilis, dementia, or brain tumours;
- Whose psychotic symptoms clearly occur only in the context of acute intoxication (i.e. when a clear link is observed between the remission of symptoms with cessation of drug or alcohol use within 7 days. In such scenarios the team will direct service users to other services);
- Service users who have been assessed as experiencing psychotic symptoms for the first time as a result of pre-existing and longstanding chronic mental health problems such as recurrent depression or Bipolar disorder, individuals with personality disorders who might experience hallucinatory voices encouraging self-harm or perceptual abnormalities representing historic traumas or individuals with neurodevelopmental disorders who have experienced long standing

perceptual abnormalities dating back to childhood. In the case of individuals with a personality disorder or neurodevelopmental disorder classic ICD or DSM criteria for schizophrenic spectrum diagnosis are useful to differentiate symptoms which may be as a result of a comorbid and therefore warrant assessment by EIS;

- Exclusion criteria for ARMS pathway, as for FEP, but in addition:
- Past history of suffering full threshold psychotic symptoms for more than a 7-day period (whether treated or not);
- Clients currently prescribed antipsychotic medication.

6. Definition of Psychosis

- Experiences that would score 4 or above on the hallucinations and delusions section of the PANSS, with other items on the positive section of the scale scoring 5 or above in the context of a cluster of symptoms;
- The symptoms must have lasted throughout the day for several days or several times a week, not being limited to a few brief moments;
- The above symptoms must be present for a period of over seven days duration over the last 12 months (or if less than this then the improvement must be attributable to antipsychotic treatment);
- PANSS scores are to be complimented by a range of other types of clinical assessment information.

6.1 Definition of ARMS

In psychotic disorders, an early pre-psychotic stage is known to exist, one in which much of the collateral psychosocial damage is known to occur. The earliest stage, in retrospect, can be termed a “prodrome”, i.e. the precursor of the psychotic stage. However, since the term prodrome can only be applied with certainty after the psychotic stage develops, and given that many prodromal symptoms and signs are non-specific and could be the result of a number of conditions, terms such as “at risk mental state” (ARMS) and “ultra high risk” have been developed to indicate psychosis is not inevitable.

To identify if a patient has an At Risk Mental State, as recommended within NHS England (2015) and the NICE guidelines (2014), a reliable and validated assessment tool should be utilised by a specialist practitioner. Within CWP the chosen tool being used is called the Comprehensive Assessment of At Risk Mental State (CAARMS) assessment. The CAARMS assessment tool incorporating the Social and Occupational Assessment Scale (SOFAS) was specifically developed to identify patients considered to be At Ultra High Risk of developing a psychotic illness. The assessment is a semi structured interview that focuses upon positive symptoms that a patient may experience and this is divided into 4 sub-scales namely, Unusual thought content, Non-bizarre ideas, Perceptual abnormalities and Disorganised speech.

7. Referral Procedure

To ensure that the EIS remains accessible and responsive to the needs of people experiencing a first episode of psychosis, referrals are:

- Accepted from any source, including self-referrals and referrals from statutory and voluntary sector agencies. Verbal, written, e-mail and telephone referrals are all accepted by the service.
- Made either to a central triage point (‘single point of access’) or direct to an EIS service.

Practitioners must ensure that this is correctly recorded on the electronic record keeping system (see Appendix 4 for a flowchart outlining the EIS referral to treatment pathway: clock start and stop).

8. Assessment

The initial assessment will be a full comprehensive assessment of health and social care needs conducted by the members of staff allocated for assessment.

Minimum standards for the initial assessment components:

- Assessments will include a range of standard assessment tools (e.g. standard clinical interview for PANSS and a risk assessment);
- On the first visit the service user and identified carers will receive information about who to contact throughout the assessment process and what to do if there is a crisis;
- Service user's hopes for their lives and their direct aspirations in relation to the service, which will be captured using appropriate assessments;
- Additional information provided by the service user, family, significant others, the referrer and other sources of information will be considered when completing a comprehensive assessment;
- Risk will be assessed using CARSO and may include specific specialist assessments (where relevant) and recorded on the clinical record system within 48 hours of the initial assessment. Other standardised assessment tools may be used if they are seen to be appropriate, such as the Beck Depression scale, the Beck Hopelessness Scale etc.;
- The assessment of DUP and pathways to care will be based upon PANSS (Positive and Negative Symptom Scale) and pathways to care tool.

Clients thought to have ARMS will be assessed using the CAARMS assessment tool. The three aims of a CAARMS assessment are to:

- To identity if a person meets the criteria of having an At Risk Mental State;
- To rule out or confirm whether somebody is presenting with a psychotic illness;
- To map a range of symptomatology and functioning decline over a period of time, in people deemed to be at high risk of developing psychosis in the future.

Referral for an ARMS service is currently via the referral pathway for somebody thought to be suffering from a FEP. If following that assessment, a client is deemed not to meet a PANSS 4 (FEP pathway) (see appendix 5) but scores 3, the assessing practitioner before considering a CAARMS assessment needs to then consider the following:

- Has the client experienced a significant drop in social or occupational functioning of 30%, sustained for a 1 month period within the past 12 months, or does the client have a Social and Occupational Functioning Assessment Scale score of 50% or less, attained for the past 12 months or longer and;
- Established that the client is help seeking.

If the above criteria are met, a referral should be made for a CAARMS assessment and an appointment will be offered at the earliest possible opportunity.

Minimum standards for assessment components on acceptance:

- Global functioning will be assessed using holistic assessments and the HoNOS. The Child and Adolescent version (HoNOSCA) should be used for under 18s. The HoNOS or the HoNOSCA should be administered during the initial assessment, at 6 and 12 months, and then annually, or on discharge from the EIS whenever this occurs;
- Recording of ARMS and FEP within DUP assessment;

- Recording of Dup within DUP assessment form;
- During the assessment process, information should be gathered using the Process of Recovery Questionnaire (QPR) which aims to collect aspects of recovery which are meaningful to service users. The QPR should also then be administered at 6 and 12 months and then yearly or on exit from the service to measure recovery;
- Information on quality of life, care needs and treatment satisfaction will be collected using the DIALOG measure (Priebe et al., 2007). The DIALOG measure should be utilised during the initial assessment and then administered at 6 and 12months, and then annually, or on exit from the EIS whenever this occurs;
- Physical Health Assessments will be carried out through the cardiometabolic screening tool which has been developed to capture the required data associated with the Lester Tool. This is routinely done for FEP, but on a case by case basis for FEP;
- Psychological Assessment;
- Occupational assessment, for example Model of Human Occupation Screening Tool (MOHOST), Occupational Circumstances Interview and Rating Scale (OCAIRS), workers role interview, ACIS, AMPS (where relevant);
- Family or carer's needs, aspirations and understanding of needs and areas of difficulty. This will be captured initially by offering the family or carer a Carer's Needs Assessment (Care Act 2014, Children and Young Families Act 2014). Standardised assessment tools during family interventions will include the General Health Questionnaire (GHQ), Relative Assessment Interview (RAI), Knowledge about Psychosis Interview (KAPI) and ECGI (Experience of Care giving inventory);
- The Service User will be encouraged to talk about their beliefs, attitudes and knowledge about medication that may have been offered or prescribed so that they can be supported in making informed and collaborative decisions about treatment;
- Side effects from medication will be assessed using the Glasgow Side-effect Scale (GASS) for atypical antipsychotics and the LUNSERS (Liverpool University Side Effects Rating Scale) for typical antipsychotics.

Minimum service standards for staff undertaking the initial assessment:

- The initial assessment and engagement is completed by one or two members of staff where this occurs in the service users own home (depending on risk and presentation);
- The assessment takes place as soon as possible and no later than 14 working days from the initial date of referral to the organisation;
- The progress note, care contact to be added and PANSS completed as soon as possible after the contact;
- The appointment is on time and the service user is not kept waiting;
- Staff to wear ID badges;
- There is clarity around data confidentiality and data protection;
- The assessment process is discussed and how long it is likely to take;
- Use non stigmatising settings where possible;
- Cultural, ethnic and religious or other differences in treatment expectations and adherence are addressed;
- Any conflicts which arise are resolved in a timely way;
- Safeguarding concerns are assessed and protection plans put into place where necessary;
- The person is aware they can refuse to have other people present such as students;
- The member of staff summarises the discussion at the end of the assessment and explains what happens next.

8.1 If a Service User DNAs Initial Assessment

The allocated clinician will continue to try to assertively engage the service-user and explore other possible methods of making contact.

Although this will not stop the clock, if it is still not possible to make contact with the service user, this will be discussed at the weekly referral meeting and a care coordinator will be allocated to assertively outreach the service user with the aim of establishing engagement and completing an assessment of their suitability for the EIS. The care coordinator will also continue to liaise with carers and the referrer. In these circumstances, if there is enough suspicion about the presence of psychosis that EIS continues to work with the family and carers.

It is vital in cases of poor engagement that EIS continue to make all efforts to engage the service user. Where contact is not made, discharge from the pathway should aim to be a collaborative decision with the referrer, and where appropriate, the carer. In such cases, details should be provided to enable rapid reassessment by the EIS if necessary (refer to Appendix 2 for more detail).

9. Outcome of Assessment

The final decision about whether to accept the service user will be taken at the team's weekly referral meeting. Please see Appendix 5 for the referral to treatment pathway: clock start and stop.

The EIS will contact the service user; a copy of the assessment letter will be sent to the GP and the referrer will be updated as to the outcome of the person's referral:

- Not accepted: EI staff will then complete the referral closure on Local IT system;
- Extended assessment Pathway.

If after two weeks it is still not clear whether the person meets criteria for EIS, they will be allocated to the extended assessment pathway. This will represent a planned breach of the AWT 2 week timescale. They will remain on the incomplete pathway. A member of staff will be allocated as primary worker.

The focus of the extended assessment is on gathering relevant information to make a decision about whether the service user meets criteria for EIS.

The primary worker will be asked to provide ongoing feedback to the weekly referrals meeting on the progress of the extended assessment. If there is any doubt about the presence of psychosis or an at-risk mental state, the person should remain in EIS until the diagnosis is clear.

A review should take place at a maximum of 3 months.

- Accepted First Episode Psychosis (FEP) Pathway;
- Service users will be allocated to and engaged by a care coordinator under the CPA system. Following completion of this, the clock for the access and waiting time standard will stop. The service user will then commence a NICE-concordant package of care which corresponds to NICE eight quality standards for young people and adults experiencing psychosis.

This will be offered for maximum of 3 years.

- At Risk Mental State (ARMS) Pathway.

Service users will be allocated to and engaged by a care coordinator under the CPA system. Following completion of this, the clock for the access and waiting time standard will stop. The service user will then commence a NICE-concordant package of care which corresponds to NICE eight quality standards for young people and adults experiencing 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.

The Early Intervention Service within CWP will offer an intervention in line with NICE guidance, to clients if the above criteria is met. The client is allocated a care coordinator and as stated in NICE guideline is offered CBTp and family interventions if a need is identified.

Other interventions will be offered as recommended in NICE guidance for people with any of the anxiety disorders, depression, emerging personality disorder or substance misuse.

In line with guidance, this group will be reviewed at the 12 month point to consider if they have transitioned into psychosis or can be discharged from the service. It is good practice for them to be reviewed with a CAARMS assessment at a mid-point and /or at the end of CBTp.

10. Procedure for Recording the RTT

- The clock for the two-week pathway starts when a referral received by any service has been flagged as 'suspected first episode psychosis' or is recognised as such upon receipt;
- If a single point of access or triage service receives a referral not flagged as 'suspected first episode psychosis' but the person is assessed as such, this should be flagged, moved onto the first episode psychosis pathway and passed immediately to the relevant EIS. In this case the clock will start on the date that the single point of access or triage service received the referral. If a single point of access or triage service receives a referral flagged as 'suspected first episode psychosis' but following consultation with the EI service it is triaged as clearly not psychosis, the referral will not enter the pathway or be counted against the access and waiting time standard, and should be processed as normal within the receiving team;
- If the EI service accepts a referral directly, the clock will start from the date of referral. The date the referral was received by the trust should be recorded on IT system and it is imperative dates are recorded accurately;
- Once a referral has been received by the EIS, the duty worker will gather some preliminary information about the service user and their difficulties, before carrying out an initial screen of their suitability for the service;
- Referrals for service-users who are assessed as not having psychosis, or an at-risk mental state (ARMS), and who therefore do not meet criteria for the EIS will be removed from the referral to treatment pathway and will not count towards the access and waiting time standard. If a service-user is deemed not suitable for assessment by the EIS (e.g. no first episode psychosis or ARMS) staff should add a progress note with the details 'Not a Care Contact' and the referral should be recorded as 'Not Accepted-Rejected' thereby removing the referral from the pathway;
- Service users who do not meet criteria for the EIS will be signposted to more appropriate services or referred back to their referrer.

11. Outcomes Measures

Three outcome measure tools are recommended for routine use in EIP services and initially should be collected during assessment, at 6 and 12 months, and then annually, or on discharge whenever this occurs. Ultimately, it is expected that these or other suitable measures are collected routinely. These will assess various domains of service efficacy and patient reported outcomes and will be supplemented with additional measures over time.

- Health of the Nation Outcome Scales (HoNOS) and Health of the Nation Outcome Scales for Children & Adolescents (HoNOSCA) for under19s (clinician-rated);
- DIALOG (service user-rated, Priebe et al., 2007);
- Process of Recovery Questionnaire (QPR) (developed in collaboration with service users, Law et al., 2014);
- cardiometabolic outcome measure;
- CBTp outcome measures.

12. Hours of Operation and Duty System

The EIS core hours of operation are Monday-Friday 9.00am - 5.00pm. The service operates a system whereby EIS staff are available throughout the day 9.00am – 5.00pm to respond to new referrals and crises.

As a proportion of service users will be at work or college, every effort will be made to adjust working patterns to accommodate these visits. The friends and family group will also be offered outside normal office hours to allow working parents, friends and family to attend.

13. Working with Families

The team will strive to engage and support all those who are important to the service user. In the event that this is not possible contact will be made at the earliest opportunity.

The team will provide support and offer a carer's assessment to all families and carer's of the service user in line with Government policy.

Family interventions will be routinely offered to all service users and their families following completion of the relative assessment interview template.

Service users' informed choice regarding their involvement in family interventions will be respected. Carers will be offered specialised support, based on need and demand.

14. Physical Health

NHS England guidance suggests all service users must have a completed cardiometabolic screening tool within 30 days of acceptance into the service as a baseline. Cardiometabolic screening will be carried out using the Lester tool and interventions recorded on the electronic record (see Appendix 6).

The Lester Positive Cardiometabolic Health Resource provides practitioners with a simple assessment and intervention framework to protect the cardiovascular and metabolic health of patients with severe mental illness receiving antipsychotic medication.

15. Treatments and Interventions

- Preference will be for low dose atypical antipsychotic medication, as per low dose prescribing protocol;
- Guidance suggests medication is not recommended for ARMS patients;
- Information will be provided about the pros and cons of different medications so that the individual is collaboratively involved in and able to make an informed decision about treatment;
- The efficacy of medication and potential side effects (including unpleasant subjective experiences) will be regularly reviewed. Efforts will also be made to assess and monitor the service user's/family/carer's understanding about medication, the rationale for its use, and the potential risks and benefits;
- For service users, with a diagnosis of schizophrenia that have not responded adequately to treatment with at least 2 antipsychotic medications will be offered clozapine.

15.1 CBTp

- All service-users will be offered individual cognitive behavioural therapy for psychosis (CBTp). This will involve a process of thorough assessment, and formulation leading to a problem list, and a collaborative process of focusing upon areas of service user's prioritised concerns. Work may include focusing upon voice hearing, unusual worrying thoughts, and Relapse prevention;
- Family interventions will be offered to all families/close friends with assessed need. These will range from brief interventions focusing upon normalizing rationales, psycho-education and friends & family support group;
- Longer term individual cognitive behavioural family interventions will be available where there is an assessed need;
- There are numerous options regarding delivery of psychological interventions. Service users can work with a clinical psychologist/psychological therapist on an individual basis, access therapeutic groups, or choose to continue working with the care coordinator who is trained in psychosocial interventions under the supervision of a clinical psychologist/psychological therapist.

15.2 Other psychological approaches

- All service users are offered a referral for psychological therapy at point of entry into the service. This is via a standardized letter and information leaflet;
- Service users will be frequently asked about their wishes regarding psychological therapy and whether they would like to be involved in any clinical trials with the Psychosis Research Unit;
- Possible referrals for individual, group or family psychological therapy are discussed weekly in the multidisciplinary team meeting;
- Access to psychological therapy will be regularly audited.

16. Educational and Vocational Rehabilitation

- Ongoing inter-agency working with local schools, colleges, and employment services can support service users to remain in education, employment and training and can help to reduce stigma and discrimination;
- For those service users who are unable to work, specific interventions should focus on meaningful daytime activity and/or pre vocational training to increase self-esteem and reduce social isolation;
- Monitor targets identify that supported employment programmes and vocational rehabilitation should be offered to people with psychosis who wish to return to work. This should be offered by trained vocational workers or employment specialists who use an IPS approach

(Independent Placement support), and are sensitive of the specific needs of people with psychosis.

17. Treating Co-Morbidity

- The service user will have a regular assessment of common co-morbidities, which will include substance misuse, depression, obsessive compulsive disorders, phobias and anxiety disorders. The care coordinator will coordinate provision of care as appropriate and this may include referral for specialist help, although every effort will be made to provide the relevant interventions in house. If referral is necessary, the EIS will continue to have overall responsibility for the service user;
- The service will strive to provide a coherent range of interventions focusing upon psychosis and substance use issues/other co-morbid difficulties. Psychologist involvement in order to facilitate detailed formulations is likely to be required with service users with considerable complexity due to co-morbidity;
- As alcohol is the largest problematic substance used by young people and in keeping with NICE guidelines, staff will use Motivational Interviewing to improve engagement with the service, reduce alcohol misuse and encourage engagement with local drug and alcohol services;
- Guidance states service users may also experience difficulties such as depression, anxiety, PTSD, and personality disorder. In these circumstances, interventions will be delivered in line with the relevant NICE guidelines.

18. Discharge Pathways from EIS

18.1 Discharge before Three Years

All efforts will be made to ensure that a service user engages with the service when a first episode psychosis is suspected. Working with a service user through an assertive approach to care, multidisciplinary team discussions, supervision and risk management, the team will adopt a creative response when it is difficult to establish engagement. Work will be in accordance with the Trust's policy on disengagement and missed appointments. The team will continue with CPA responsibilities and the care coordinator will remain in place. A clearly documented care plan to address the service user's non-engagement will also be developed.

Service users who have capacity to take informed decision not to continue to receive care will have the option of discharge back to the care of their general practitioner. They will, however, retain the option of resuming contact with EIS providing they still meet criteria.
Please see Appendix 2 for disengagement flow chart.

Service users who make a full recovery within the three-year period may not need further input from the team. Following a thorough review, and a collaboratively agreed period of supportive monitoring, such cases will be closed, with fast track referral pathways being clearly identified to the service users and their GP/other health professionals.

18.2 Discharge Following Three Years' Involvement

Some service users will need ongoing care following their three-year involvement with the EIS. It will be important that transfers to appropriate services (likely to be Community Mental Health Teams CMHT for the majority of people) are done as seamlessly as possible. Discharge and transitions should be openly discussed as part of the patients' journey through the service.

To facilitate this, referrals to CMHT will be made at an early stage to ensure that the service providing ongoing care has adequate time to allocate a care coordinator to the service user at the point of transfer. It is recommended that this process starts 6 months prior to discharge from the EIS.

19. Interface with CAMHS

As a proportion of service users will be under 18 years of age, joint working with local CAMHS is essential. There is some variation in the interface between EIS and CAMHS across the 3 CWP teams. This can be kept as an agenda point with the EIP network meetings.

20. Local Variations

Whilst every effort has been made to ensure consistency in the operating practices of the East, South and Central Cheshire, West Cheshire and Wirral teams which comprise the EIS, some local variation does exist. Regular network meetings are in progress to ensure this variability is highlighted and managed.

Team Composition and Management Structure is led by the workforce calculator that Health Education England (HEE) has developed, with input from EIP ERG, to support commissioners and providers to plan for capacity and skill mix. The tool employs a range of assumptions, using estimates developed from published literature and clinical input, which can be varied according to local circumstances. The tool is available on the HEE website.

21. CWP Early Intervention Clinical network

A Trustwide Early Intervention clinical network provides a forum for sharing of good practice, research, service development and standardisation of practice within CWP. This shall be held quarterly.

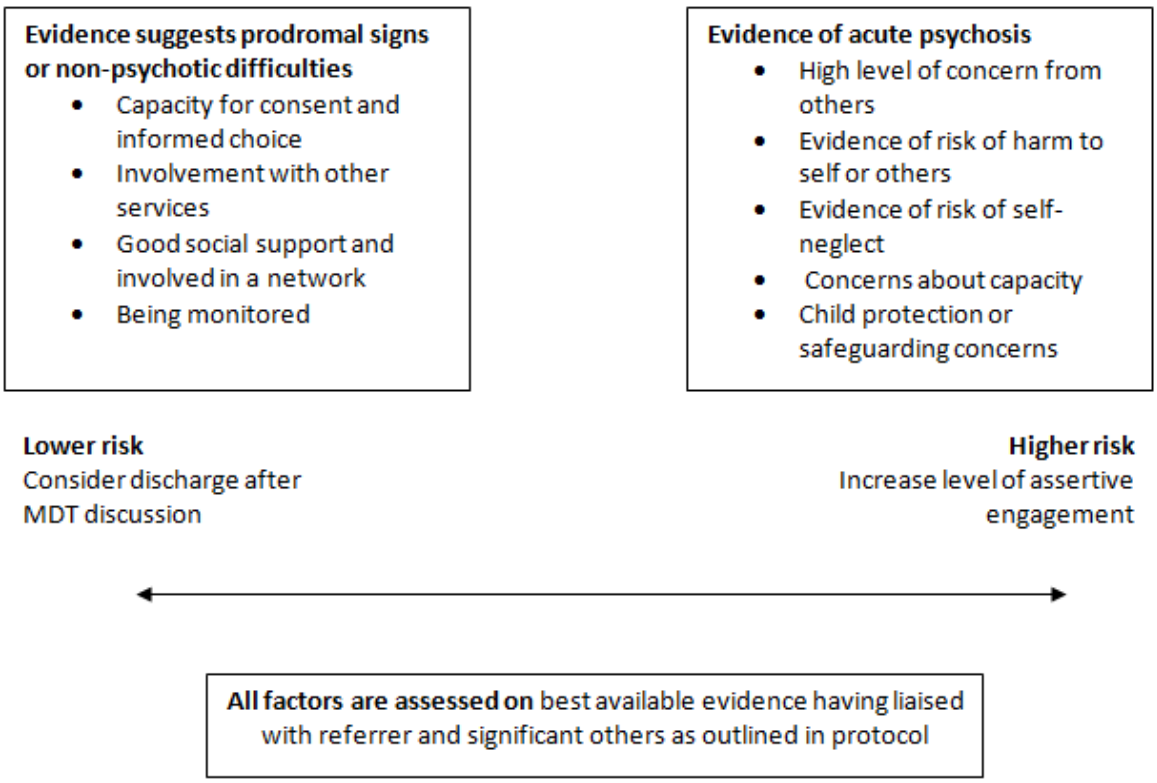
Appendix 1 - Glossary of Terms

ARMS	At Risk Mental state
CAARMS	Comprehensive Assessment of At Risk Mental State
DUP	Duration of untreated psychosis
DIALOG	Outcome measure
EI	Early Intervention
EIP	Early Intervention in Psychosis
EIS	Early Intervention Service
EPD	Early Psychosis Declaration
FEP	First Episode Psychosis
QPR	Outcome measure
MDA	Multidisciplinary Assessment
NICE	National Institute for Health and Care Excellence
PANSS	The Positive and Negative Syndrome Scale
SNOMED	Systematised Nomenclature of Medicine - Clinical Terms (information standard for clinical terminology)
IPS	Independent Placement Support

Appendix 2 – Service Response to Disengagement

The diagram below is designed to help clinicians working in the EIS make decisions about how to respond when a service user disengages from the team.

Attempts will be made to promote engagement over an appropriate period of time. This will be reviewed weekly in MDT (and reference the access and waiting time standard report for incomplete pathways, if a new referral). Depending on risk and need there is a 100 day cut-off point; if attempts have not been successful. The referrer and other involved agencies, and the patient will be sent a letter of discharge, outlining the pathway back into services and out of hour's contacts.



Appendix 3 – MSHDS / SNOMED-CT

The Mental Health Services Data Set (MHSDS) is used to assess the degree to which NICE-recommended interventions are being delivered within EI services. This requires that when a NICE-recommended intervention is offered during clinical contact with a client, this should be recorded in the form of a relevant Systematised Nomenclature of Medicine- Clinical Terms (SNOMED-CT) intervention codes. Please see Appendix 4 for a table listing the interventions which must be offered for the EIS to be deemed to be providing a NICE-recommended package of care and to be meeting these eight quality standards. The table also details the name of these interventions on local IT system as well as where to locate them. The local IT system codes and the SNOMED-CT codes which correspond to these NICE-recommended interventions are also documented.

Intervention	SNOMED CT Concept ID	Reported by NHS Digital
Cognitive Behavioural Therapy for Psychosis (CBTp)	**718026005** Cognitive behavioural therapy for psychosis **Placeholder** Referral for cognitive behavioural therapy for psychosis	• Was the service user offered CBT? • Did the service user receive CBTp? • How many sessions of CBTp did the service user receive, per year, and on discharge, while under the care of the EIP service?* • At discharge, what was the duration from the first session of CBTp to the last session of CBTp, while under the care of the EIP service?
Family Interventions (FI)	**985451000000105** Family intervention for psychosis **859411000000105** Referral for family therapy	• Was the service user and their family offered FI? • Did the service user and their family receive FI while under the care of the EIP service? • How many FI sessions did the service user and their family receive per year, and on discharge, while under the care of the EIP service? • At discharge, what was the average duration from the first session of FI to the last session of FI, while under the care of the EIP service?
Clozapine	**723948002** Clozapine therapy	• Was the service user offered clozapine therapy?

* There is currently no set minimum number of expected sessions for therapy.

Cardiometabolic Parameter Assessment	SNOMED CT Concept ID	Reported by NHS Digital
Smoking status	**196771000000101** Smoking assessment	• Was a comprehensive*** physical health assessment carried out within 12 weeks from acceptance onto the EIP caseload? • Was a comprehensive physical health assessment carried out, one year after the first assessment (+/- 6 weeks)? • For any service users in the care of the EIP team for longer than a year, was an annual comprehensive physical health assessment carried out in the previous 12 months?
Lifestyle (including exercise, diet, alcohol and drug use)	**443781008** Assessment of lifestyle	
Body Mass Index	**698094009** Measurement of body mass index	
Blood pressure	**171222001** Hypertension screening	
Glucose regulation*	**43396009** Haemoglobin A1c measurement **271062006** Fasting blood glucose measurement **271061004** Random blood glucose measurement	
Blood lipids**	**121868005** Total cholesterol measurement **17888004** High density lipoprotein measurement **166842003** Total cholesterol: HDL ratio measurement **1085971000000102** Assessment using QRISK cardiovascular disease 10 year risk calculator	

* It is recommended that services take consideration of all three measurements and record at least one.
** Services may also want to consider recording Triglycerides (TG) and non-HDL cholesterol for completeness.
*** 'Comprehensive' should indicate that all physical health assessment parameters have been considered by the clinician and the service user.

Cardiometabolic Parameter	Intervention	SNOMED CT Concept ID	Reported by NHS Digital
Smoking status	Help with smoking cessation	**225323000** Smoking cessation education **Placeholder** Provision of smoking cessation therapy **871661000000106** Referral to smoking cessation service	• What percentage of service users assessed by the EIP service were identified as in the 'red zone' on the Lester tool and requiring an intervention? • What percentage of these service users were offered/received an intervention to address their increased risk (either within the EIP team, or referred to another service)?
Lifestyle (including exercise, diet, alcohol and drug use)	Advice about diet and exercise, aimed at helping the person to maintain a healthy weight	**715282001** Combined healthy eating and physical education programme **1094331000000103** Referral for combined healthy eating and physical education programme **281078001** Education about alcohol consumption **425014005** Substance use education **Placeholder** Referral to alcohol service **Placeholder** Referral to substance use service	

Cardiometabolic Parameter	Intervention	SNOMED CT Concept ID	Reported by NHS Digital
Body Mass Index	Treatment for people with an elevated BMI and rapid weight gain.	**699826006** Lifestyle education regarding risk of diabetes **Placeholder** Referral for lifestyle education **Placeholder** Weight management programme **Placeholder** Referral for weight management, and lifestyle education	• What percentage of service users assessed by the EIP service were identified as in the 'red zone' on the Lester tool and requiring an intervention? • What percentage of these service users were offered/received an intervention to address their increased risk (either within the EIP team, or referred to another service)?
Blood pressure	Treatment for hypertension	**Placeholder** Referral to General Practice **Placeholder** Referral for antihypertensive therapy **308116003** Antihypertensive therapy	
Glucose regulation*	Treatment for diabetes	**Placeholder** Referral for diabetic care **385804009** Diabetic care	
	Treatment for high risk of diabetes	**Placeholder** Referral to General Practice **Placeholder** Diet modification **Placeholder** Metformin therapy	
Blood lipids**	Treatment for dyslipidaemia / or if high (>10%) risk of CVD based on Q-RISK assessment	**Placeholder** Lipid modification therapy **Placeholder** Referral for lipid modification therapy	

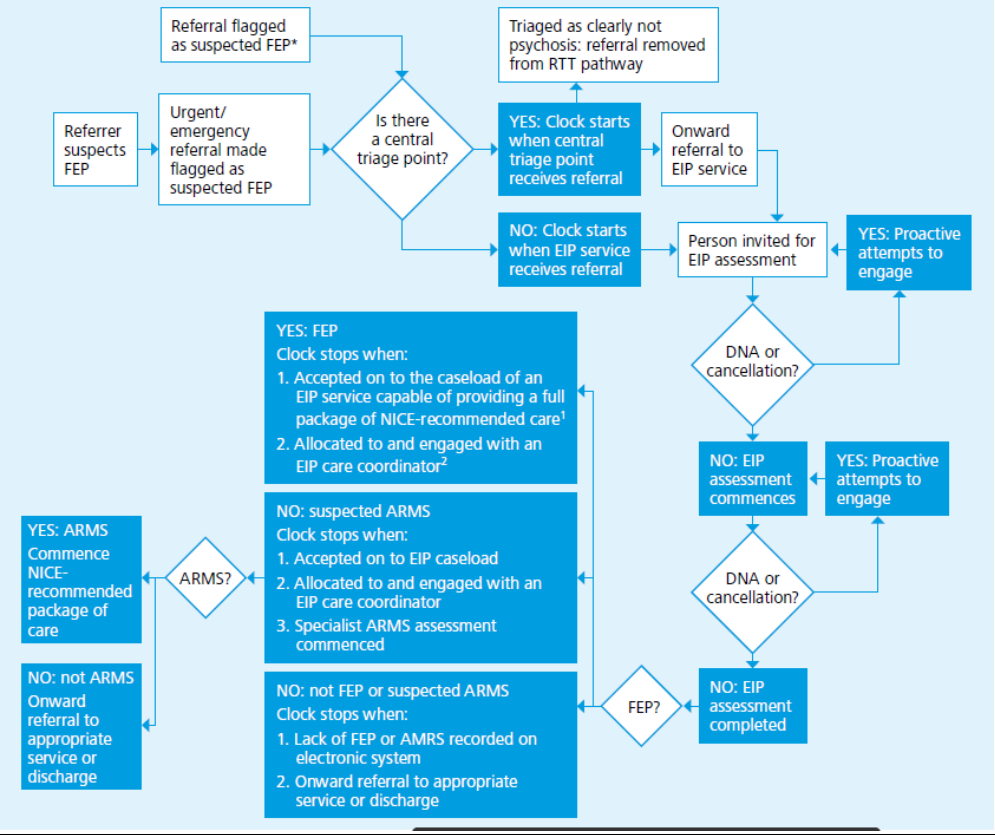
*It is recommended that services take consideration of all three measurements and record at least one.

**Services may also want to consider recording Triglycerides (TG) and non-HDL cholesterol for completeness.

Intervention	SNOMED CT Concept ID	Reported by NHS Digital
Education Support	**183339004** Education rehabilitation **415271004** Referral to education service	• Did the service user receive any type of education and/or employment support? • How many sessions of education and/or employment support was the service user given per year and in total, by the EIP service? • What was the average duration of any type of education and/or employment support (from first to last session) given to each service user per year and in total, by the EIP service? • How many referrals for education and/or employment support were made per year by the EIP service? • How many EIP service users received Individual Placement and Support (IPS) per year?
Vocational Support	**70082004** Vocational rehabilitation **18781004** Patient referral for vocational rehabilitation	
Employment support	**335891000000102** Supported employment **Placeholder** Employment support **Placeholder** Referral to an employment support service	
IPS	**1082621000000104** Individual Placement and Support **1082611000000105** Referral to an Individual Placement and Support service	

Intervention	SNOMED CT Concept ID	Reported by NHS Digital
Carer focused education and support	**726052009** Carer focused education and support programme **Placeholder** Referral for carer focused education and support programme	• Did the carer receive carer focused education and support? • At what time point after acceptance to the EIP service was the carer given carer focused education and support? • How many sessions of education and support were carers given per year and in total, by the EIP service? • What was the average duration of carer focused education and support for each carer? • How many referrals for carer focused education and support were made per year by the EIP service to another service?

Appendix 4 – EIS Referral to Treatment Pathway: Clock Start and Stop



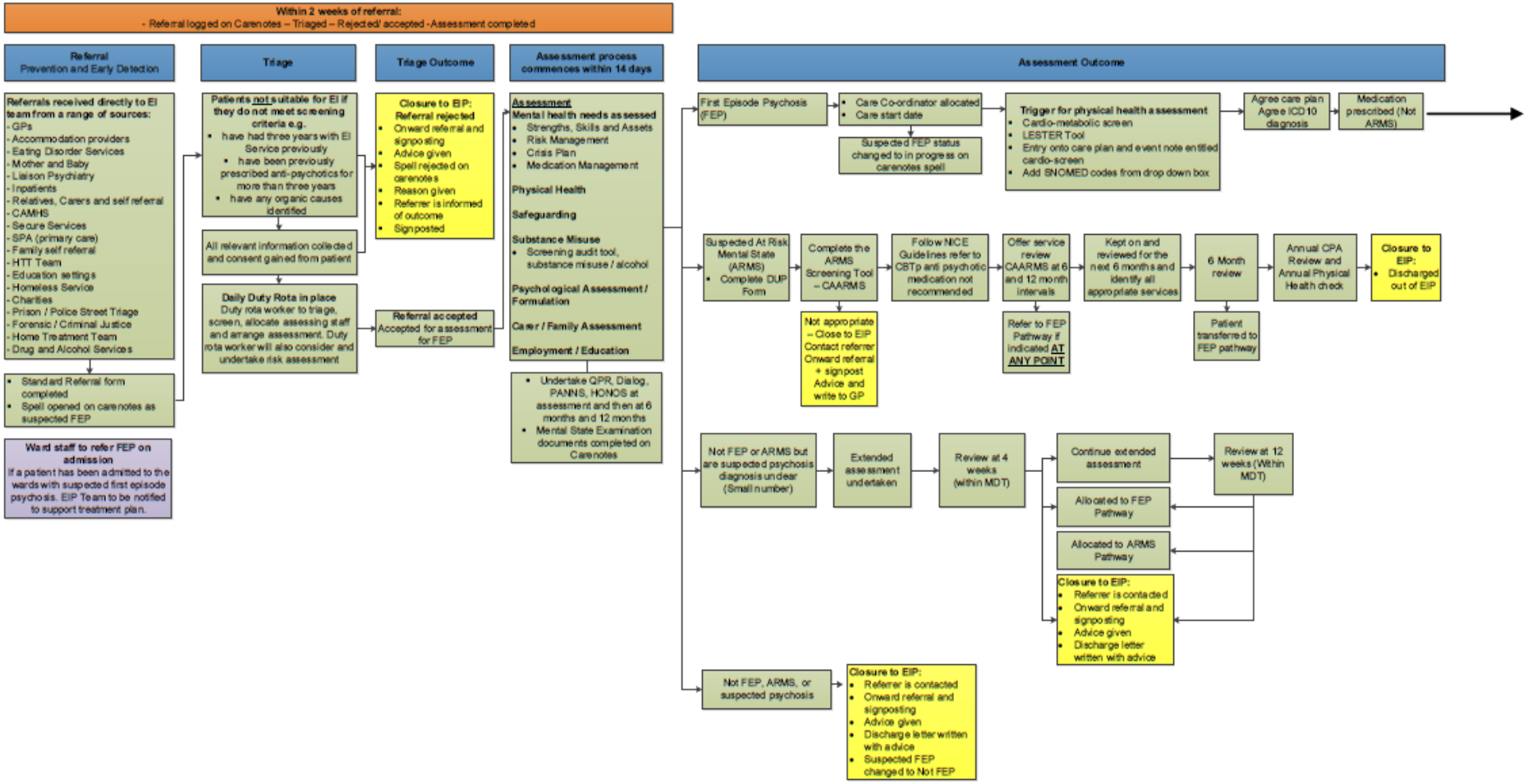
Notes

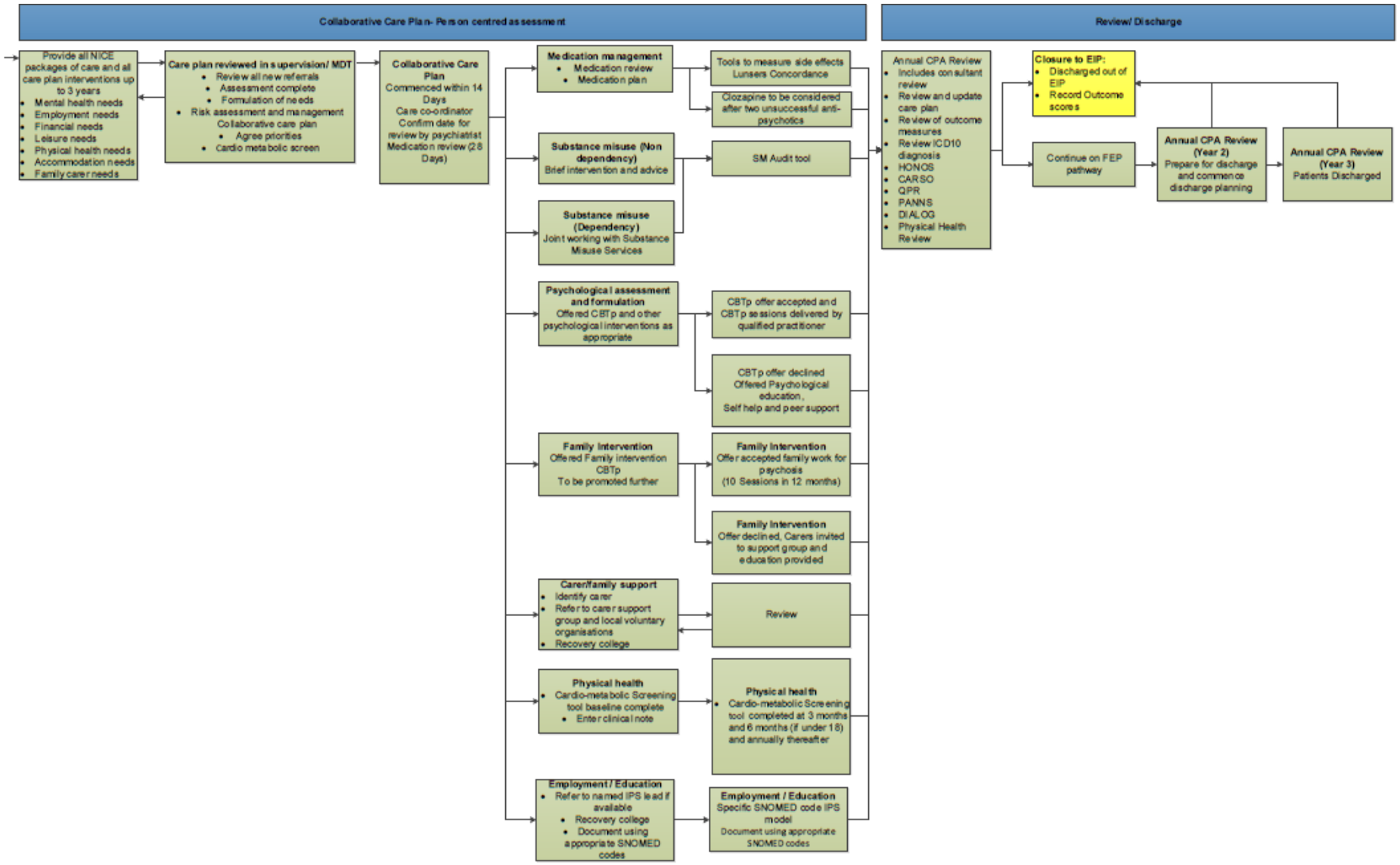
1. If assessed by the central triage point as suspected first episode psychosis this referral should be flagged and moved on to the first episode pathway, and the clock will start on the day the central triage received the referral.
2. A service will be judged 'capable of providing a full package of NICE-recommended care' via the CCQI quality assessment and improvement programme (see section 4.34) and through the recording via the electronic care record of NICE-recommended interventions delivered (to be submitted as part of the Mental Health Services Dataset through use of SNOMED-CT codes – see section 4.32).

   The quality assessment and improvement will be phased in during 2016/17. Until this has been established, the clock will be stopped when a person is: (1) Accepted on to the caseload of an EIP service following an EIP service assessment, and (2) allocated to and engaged with an EIP care coordinator.
3. 'Engaged with an EIP care coordinator' means that the care coordinator actively attempts to form a therapeutic professional relationship with the person and offers treatment to them.

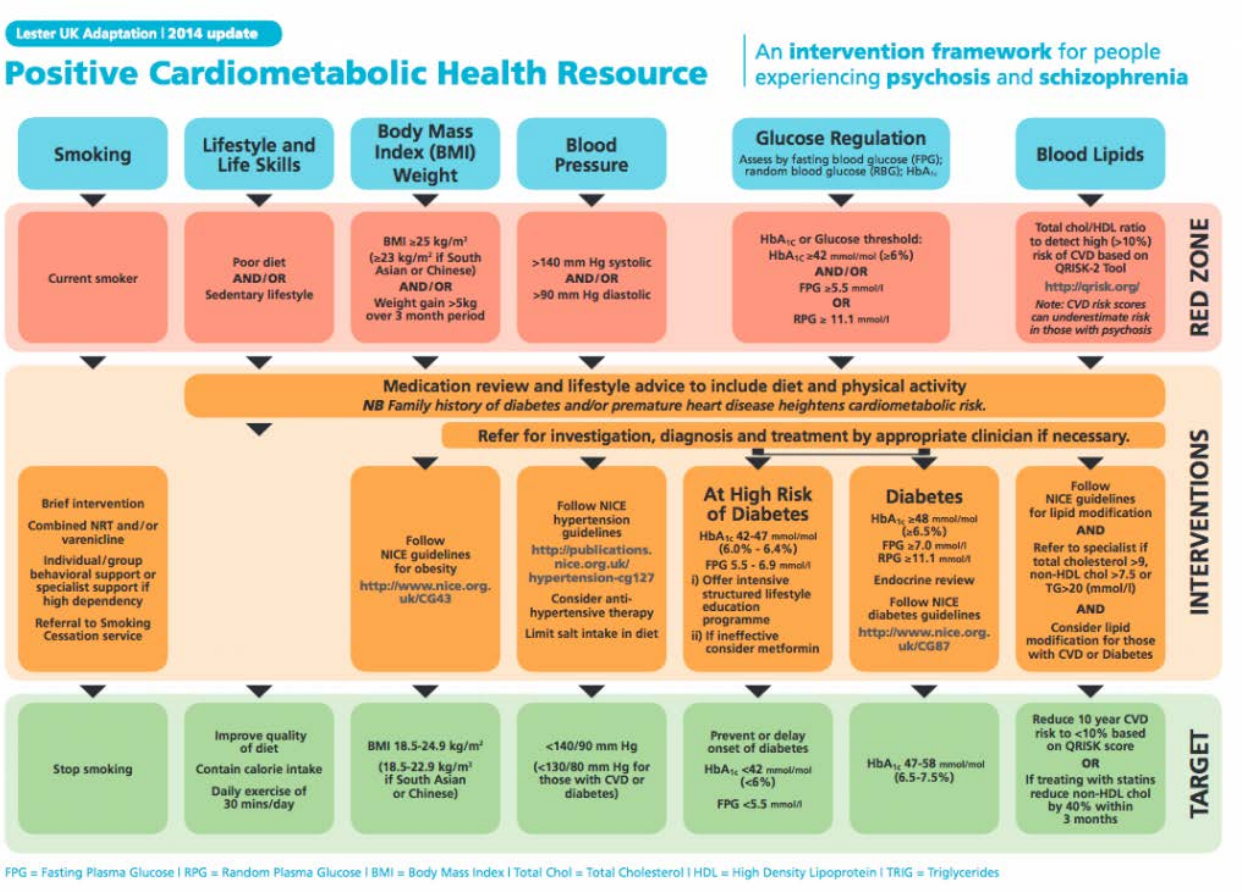
Appendix 5 – Early Intervention Team (Future State Map)

Early Intervention team – Future state map





Appendix 6– The Lester Tool (positive cardiometabolic health resource)



Appendix 7 – Checklist for service users who request discharge or who disengage prior to the end of the three year period of care co-ordination who are at higher risk

The following should be considered if someone at higher risk requests discharge or is not engaging with Early Intervention and document any reviews, discussions pertinent to these in the Electronic Patient Record (EPR).

Action	Check (✓ / X)
Consult care plan and CARSO summarised view of risk.	
Use an assertive outreach approach to increase engagement, using texts, phone calls and cold calls if this is considered safe after consulting CARSO summarised view of risk.	
Discuss and consider if symptoms are of the degree and nature that the use of the MHA (1983) for further assessment is indicated.	
Assess capacity to make a decision in regard to discharge.	
Contact family / carers / friends if there is consent to seek information and / or facilitate contact.	
Consult safeguarding if there is no consent to contact family / carers / friends to seek information about potential risk.	
Discuss in Early Intervention MDTM.	
Ensure all professional agencies with relevant involvement, i.e. GP, substance misuse services, criminal justice services internally and externally to CWP, Social Care etc. are involved in discharge decision making and are aware if discharge goes ahead.	
Make relevant people aware of open re referral pathway considering that Early Intervention offer a 3 year period of care co-ordination. These include self-referral, referral from family, carer's friends, and referral from any statutory or non-statutory organisation.	