iris Early Intervention in Psychosis
Achieving Ordinary Lives

Rethink Mental Illness.

Mental Health Network NHS CONFEDERATION

IRIS Guidelines Update September 2012

Revision of the original 1998
IRIS guidelines

Contents

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The views put forward in this guidance are the collective views of the individuals listed and in no way represent the views of any organisations with whom the authors may be linked.

Alison Brabban and David Shiers are members of the Guideline Development Group (GDG) for the NICE guidance for adults affected by psychosis and schizophrenia; David Shiers is also a member of the GDG for the NICE guidance for children and young people affected by psychosis and schizophrenia; the views expressed are not those of either GDG, NCCMH or NICE.

Foreword from Patrick McGorry

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The IRIS initiative was the inspiration behind the ground breaking reforms scaled up across England over the past decade which has seen early intervention for psychosis become a standard feature of mental health care. As the most systematic demonstration of the value of early intervention in psychiatry to date this UK reform has not only transformed the lives of thousands of young English people but has inspired and encouraged leaders and professionals in many other countries to move in the same direction. There are now many hundreds of early psychosis programs in Australia, Canada, Denmark, the Netherlands, New Zealand, Hong Kong, Singapore, the USA and many other nations. This is an international reform process that is vital in symbolic and practical ways to the future of people with mental illness and to the psychiatric field as a whole. Early intervention in psychosis is clearly the most evidence-rich mental health system reform that has occurred to date and we really are just at the beginning. We have been able to show that early

detection and stage-specific treatment and care is as critical in potentially serious mental illness as it is in physical illnesses such as cancer, diabetes and cardiovascular disease. The Director of the National Institute of Mental Health in the USA, Dr. Tom Insel, calls this “pre-emptive psychiatry”.

The new IRIS guidelines capture and condense the wisdom and experience gleaned from a decade of English and international experience with this new model of care which has lessons for the rest of the mental health field. Specific guidelines are provided on every aspect of care from how to create a youth friendly culture to specific evidence-based statements regarding drug and psychosocial interventions.

One of the best demonstrations of the stage specific principle is that in early psychosis much lower doses of antipsychotic medication are essential and that the second generation antipsychotic medications are generally superior because of a lower level of adverse effects and better adherence. The EUFEST study and other evidence supports this advantage which is not usually seen in later stages of illness. This distinction between early and late psychosis needs to be acknowledged more widely – one size does not fit all! However the metabolic problems which are usually increased by both first and second generation medications at similar rates must also be tackled from the very first episode, as the new IRIS guidelines emphasise strongly. A comprehensive array of individual, family and vocationally focused interventions must be on offer within an optimistic and intensive

program of care. Recent evidence shows that the tenure of care within EIP services for most patients needs to be longer than two years and probably closer to five years, with a minority only then requiring sustained intensive care for even longer. Premature discharge to traditional adult community mental health teams has been shown to adversely affect outcomes and blending these types of services, an attractive option financially to health service managers, is clearly not in the interests of patients and families, as the evidence now confirms.

The future of the EIP reform may lie within a wider and more ambitious reengineering of the health system to provide early intervention and recovery within a broad spectrum youth mental health model. The recognition that 'mental disorders are the chronic diseases of the young' with 75% of cases emerging prior to age 25 means that early intervention requires the creation of youth friendly cultures of care able to provide stage specific interventions for the range of syndromes and co-morbidities that unfold in young people. This will need to have primary care and specialist care domains which intersect closely. This reform is underway across Australia, Ireland and parts of the UK and Canada and is gaining substantial support from the public and from policy makers and clinicians. The wonderful beachhead for early intervention established in the UK as a result of the efforts of the IRIS initiative and successive governments provides a unique opportunity for England to be at the forefront of this next wave of international progress.

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Who has written these guidelines?

Welcome to these updated 2012 IRIS guidelines. They replace the original 1998 IRIS guidelines which had informed the National Service Framework for Mental Health (NSF; DH 1999) and its accompanying Policy Implementation Guide (MH–PIG; DH 2001). Many of this guideline's contributors supported this service reform as regional or national leads of the NMHDU EIP Development Programme (2004–10). Indeed many were closely involved as clinical practitioners in the setting up and provision of EIP services, and in some instances actively involved in conducting research. Thus this guidance offers a distillation of the knowledge, evidence and understanding gained over this period, providing insights into the principles of good practice, and practical advice on how these become translated into local service delivery.

Who are the guidelines for?

These guidelines are for service providers and commissioners of mental health services to help them to ensure high quality and cost effective delivery of care and support for people experiencing a first episode of psychosis. Anticipating a new era of practice and policy development, these 2012 guidelines describe the key elements of service design for the delivery of Early Intervention in Psychosis (EIP). In doing so it is important to emphasise that Early Intervention in Psychosis does not describe an intervention but rather a distinctive model of service and ethos/philosophy of care, with an evidence base of clinical and cost-effectiveness and positive service user evaluation. These guidelines lay out the service principles and the key elements of provision.

"The last 10 years have seen the establishment of a specialised service model that provides evidence-based interventions for treating psychosis in the early phase and at a relatively young age (14–35 years old). There is an increasing body of evidence that supports this approach as more effective than the traditional generic community mental health team approach. This includes evidence that early intervention for psychosis results in a better course of illness, fewer symptoms at eight years on and a halving of the suicide rate."

DH 2011 No Health without Mental Health; Section 7.13; p66

"Early intervention services for psychosis have demonstrated their effectiveness in helping to reduce costs and demands on mental health services in the medium to long-term."

'Paying the Price' (Kings Fund, 2008)

Max Birchwood

"In my view any attempts to dilute the EIS reform is a recipe for mediocrity. Where for example EI staff operate within CMHT teams, half the number of first episode clients are identified than in specialised teams. Young people simply don't engage in the context of an 'adult' focused service."

Now fourteen years on from the original IRIS guidelines, EIP has become established as a preferred model of service for young people with emerging psychosis and their families:

- Endorsed by NICE core Schizophrenia Guidelines (NICE CG 82 2009)
- Highlighted in current mental health policy (DH 2011 No Health without Mental Health; Section 7.13; p66)
- A commitment in the 2012/13 NHS operating framework (DH Nov 2011)
- Featuring in the emerging PbR (Payment by Results) toolkit of the Department of Health as 'cluster 10'.

Moreover the economic impact of EIP services (McCrone et al, 2009; Mihalopoulos et al (2009) reveal the potential for significant savings when compared to standard care.

Why does youth mental health matter?

Because the peak appearance of psychosis is in late adolescence and emerging adulthood, then the core challenge is to optimise the service delivery and treatment experience through the adolescent-to-adult transition. The difficulties transition poses for young people with psychosis was explored in a recent audit of EIP services and CAMHS Joint Working at the Interface. Moreover, given that most adult mental health disorders first arise in adolescence and emerging adulthood, these challenges are not unique to psychosis.

Indeed the importance of improving youth mental health is now advocated by current policy which embraces an early intervention approach within a life-course view. See No Health without Mental Health (DH 2011):

- Take a life-course view (Executive summary 1.2)
- Shift the focus of services towards promotion of mental health, prevention of mental illness and early identification and intervention as soon as mental illness arises (7.13).

"Roughly half of all lifetime mental disorders in most studies start by the mid-teens and three quarters by the mid-20s. Severe disorders are typically preceded by less severe disorders that are seldom brought to clinical attention."

Kessler et al, Current Opinion Psychiatry, 2007

'One quarter to one half of adult cases in the population might be prevented by effective treatment of youths with psychiatric disorders.

Kim-Cohen et al 2003

This does not mean that early intervention is any less important in other stages of life: whether one is considering childhood eating disorder or dementia in later life the principle is the same: to intervene as early and effectively as possible to prevent or limit the secondary and tertiary consequences of these disorders, and to ensure continuity of care. However, intervening early is likely to be very different in older clients than in younger. Service resources and required staff skill-sets will need to be tailored to the needs of clients at different stages of life-development. This requires service planners to avoid operating to rigidly defined chronological age ranges but to offer a flexibility which accommodates relevant life-developmental needs, emphasising the significance of this stage of personal development and targeting resources to those in this most vulnerable and critical time of change.

Why intervene earlier?

The early phase of illness constitutes a critical period for treating psychosis, with major implications for secondary prevention of impairments and disabilities and a rationale for intervening intensively and early. EIP services have evolved over the last ten years to ensure timely access to appropriate, evidence based treatment, mirroring approaches now considered routine for conditions such as coronary heart disease and cancer.

This concept of the early phase of psychosis as a critical period for addressing drivers of future disability and premature death has underpinned the emergence of a strong bio-psycho-social model of care.

Why is psychosis important for young people?

The onset of psychosis usually occurs sometime between adolescence and emerging adulthood (About three quarters of men and two thirds of women experience their first episode by age 35; most are in their late teens and twenties (Kirkbride et al, 2006). Because of the typically young age of onset, psychosis can be particularly debilitating with far-reaching implications for the individual and his/her family. Interrupted or halted personal and social development can have life-long consequences and accounts for much of the disability experienced by people with chronic mental illness.

All aspects of life are affected – education and employment, relationships and social functioning, physical and mental wellbeing. Life expectancy is reduced by 16-25 years from a combination of high rates of suicide mainly within the first five years, and high rates of physical illness, in particular premature cardiovascular disease. (Parks et al, 2006; Brown et al, 2010)

Furthermore significant burden may be felt by family and close caregivers as highlighted by the World Health Organisation, who calculated that, at a family level, the burden and human suffering caused by psychosis was exceeded only by quadriplegia and dementia. (WHO 2001)

First three years of psychosis as a CRITICAL PERIOD

SOCIAL: affects young people at a key time for establishing social capital to draw on for their futures.	The longer these developmental processes are compromised the worse the personal and social consequences.
PSYCHOLOGICAL: experience of psychosis is traumatic and drives disabling psychological responses; accumulative cognitive disturbance.	These are the psychological engines of disability; the longer they persist the more pervasive and enduring their effects will be.
BIOLOGICAL: structural brain changes appear very early in the illness.	These changes, whether the cause-of or caused-by the illness process, should be curtailed as soon as possible.

Why did EIP happen when it happened?

EIP has been a radical service reform stimulated by growing dissatisfaction from young people and their families to the 'one size fits all' approach of the late 1990s, when ineffectual community services too often failed to give people good and timely support and resulted in crisis responses, hospitalisations, poor outcomes and long-term dependency on health and social services. Demand for more person-centred services, sensitive to age and phase of illness, was led by voluntary sector organisations such as Rethink Mental Illness, illustrated by its campaign 'Getting help early':

As a result EIP became a government priority via the National Service Framework (NSF: 1999–2010). IRIS was established in the West Midlands, as a multidisciplinary group of expertise drawn together to improve local service provision. The group produced the initial IRIS guidelines in 1998 based around the best evidence at that time. Subsequently policy commitment, and an increasingly robust evidence base, encouraged the establishment of the EIP service model in most parts of England. From two teams supporting around 80 people in 1998, the capacity grew to about 150 teams providing care at any one time for about 22,000 people by March 2010 (Local returns to DH).

Important as this growth in capacity and coverage was, ultimately success must be judged by the quality of the personal service experience that these young people and their families receive and how effectively it helps them achieve or regain control of their lives. Professor Louis Appleby, Mental Health Tsar (2009), reflecting on the achievements of the NSF described EIP as:

> "The jewel in the crown of the NHS mental health reform because:
>
> Service users like it
>
> People get better
>
> It saves money"
>
> Professor Louis Appleby; Track conference Birmingham April 29th 2009

In its 2011 review of EIPs clinical and cost-effectiveness the NHS Confederation briefing demonstrated EIP's relevance to current policy and the importance of seeing Early Intervention as a cornerstone of future mental health development:

The Quality standard for service user experience in adult mental health (NICE 2011) helps maintain a focus on the quality of service experience; the following examples illustrate their relevance to EIP

Extracts from QUALITY STANDARDS FOR SERVICE USER EXPERIENCE (NICE 2011)

Standard 1. People using mental health services, and their families or carers, feel optimistic that care will be effective.

Standard 3. People using mental health services are actively involved in shared decision-making and supported in self-management.

Standard 4. People using community mental health services are normally supported by staff from a single, multidisciplinary community team, familiar to them and with whom they have a continuous relationship.

Standard 6. People can access mental health services when they need them.

What has remained constant from when the IRIS guidelines were first launched is that EIP at its heart describes a philosophy and service model, structured to engage and deliver interventions and to act as a cultural ambassador of values and of hope, all prerequisites to delivering a positive service experience and improved outcomes. These include:

- Maintaining service engagement above 90%
- Addressing interventions to support the aim of improving NEET (not in education, employment, or training) status at least to the level of youth from the locality
- Reducing relapse and readmission to below 25% in any year
- Promoting recovery so that a minimum of 50% of service users can be discharged to Primary care after the three years of intervention.

These are the sort of outcomes that can guarantee social recovery and cost-effectiveness, and which distinguish EIP services in 2012. The challenge facing service planners is to maintain and build on these outcomes for those discharged onwards to generic CMHTs, and to view the EIP service model as the blueprint for a transformation of these other mainstream services.

Investing to save

In the continuing search for efficiency and quality in the NHS ascertaining which services add value is a key consideration for commissioners, professionals and service users, alike; the value added by EIP is amongst the most impressive in mental health. No Health Without Mental Health (DH 2011) describes the health economic impact assessment of EIP:

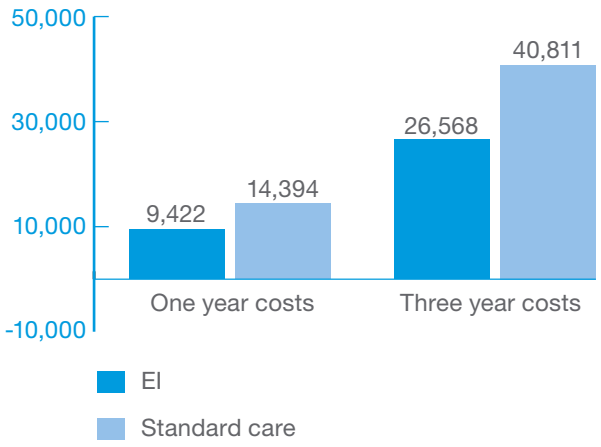
> "Through innovative practice, EIP has evidenced substantial clinical improvements; met productivity targets; reduced costs; and, importantly, has been well received by the clients, families and the referral agencies that have experienced them. EIP also offers mental health providers opportunities to support the delivery of key objectives within the Mental Health Strategy."
>
> (NHS Confederation briefing on Early Intervention in Psychosis Services, May 2011 p7)

Commissioners and service planners can be confident that upstream investment in a more intensive evidence-based approach can save in the order of £5,000 in year one, rising to £14,000 by year three per case compared to treatment as usual (McCrone et al 2009: Table 3).

EIP: A BEST BUY FOR MENTAL HEALTH

Commissioners and service planners can be confident that upstream investment in a more intensive evidence-based approach can save in the order of £5,000 in year one, rising to £14,000 by year three per case compared to treatment as usual (McCrone et al 2009: Table 3).

Table 3: EI Cost Impact of Early Intervention (McCrone, Dhanasari, Knapp 2007)



These savings reflect mainly reductions in admission and readmission rates achieved by EIP impacting on more traditional pathways into mental health services by:

- Detecting and treating psychosis earlier through improved collaboration with primary care and other community agencies
- Stronger engagement and more age/phase appropriate intervention with individuals and families.

What is the optimum service model?

> "EIP does not describe an intervention but rather a philosophy of care and a model of service provided to an individual and their family during the critical first 3–5 years of psychosis"
>
> Professor Max Birchwood 2012

The EIP service model can draw on an extensive evidence base of clinical and cost-effectiveness. Moreover these updated IRIS guidelines reflect the experience gained from EIP policy implementation over the era of the NSF. Whilst the principles and vision remain encompassed in the Early Psychosis Declaration, the last ten years has seen a translation of an EIP evidence-based service approach into different and varied clinical settings. The service approach initially recommended by the MH–PIG (2001) was mainly derived from specialist teams operating successfully in urban areas, e.g. Birmingham, Lambeth (London) and Melbourne (Australia). Emerging EIP services had to take into account pre-existing services and how they were configured, as well as local variation in incidence and prevalence of psychosis. In some these factors precluded the development of stand-alone specialist teams as originally envisaged by the MH-PIG. For example, in very rural areas the geographical dispersal of clients across large areas might determine the nature and intensity of the EIP service that can be offered. Because of the need to reflect this potential breadth of clinical settings the National Institute for Mental Health in England (NIMHE) published guidance for commissioners and providers of mental health services on the scope for flexibility; 'Counting Community Teams: Issues in Fidelity and Flexibility' (NIMHE, 2003) described criteria against which proposed variations from MH–PIG models could be assessed. This encouraged the development of locally pertinent service delivery models, whilst still ensuring that different models worked to the same ends.

However what has become increasingly clear over the last ten years of development is that a specialist team model is most able to deliver clinical and cost effectiveness. For instance recent research in Norfolk (Fowler et al., 2010) examined differences in outcomes between clients provided with CMHT based EIP and those under the care of a comprehensive EIP service. Only 24% of individuals made a full or partial functional recovery at two years under the

Paul McCrone

A key message from the experience of the EIP service reform is that it demonstrates a cost effective way to provide services with a more holistic and person-centred approach and which should be made available beyond just the early phase of illness.

CMHT model compared with 52% of the cases who were under the care of a comprehensive EIP service. A large reduction in inpatient admissions was a further measured benefit of specialist EIP. Furthermore, a systematic review of research evidence (Bird et al., 2010) attributed the effectiveness of EIP to the specialist model of service delivery, recognising its role in enabling the implementation of NICE guidelines and psychological therapies.

This evidence informed the National Institute for Health and Clinical Excellence in its 2009 review of the treatment of schizophrenia. NICE favoured the specialist EIP service model as the optimal service configuration system, concluding:

> "Early intervention (for psychosis) can be effective with benefits lasting at least 2 years"
>
> (NICE, 2009, p79)

> When commenting on the previous model, the review went on to say:
>
> "Despite the fact that CMHTs remain the mainstay of community mental health care (for psychosis), there is surprisingly little evidence to show that they are an effective way of organising services (for psychosis)"
>
> NICE CG 82, 2009; Section 9.3.4; p336.

It is clear from the evidence that a specialist EIP team model achieves better clinical outcomes and in a more cost-effective way than the generic CMHT service model and should therefore be the preferred way to provide early intervention in psychosis.

EIP Service Design Rationale

The following table summarises the key evidence-based considerations for providing an EIP service.

Summary of EIP Service Design Rationale

Intervening early and effectively in the course of psychosis can limit initial problems and improve long-term prospects for recovery.

Adolescence & young adulthood, typically when psychosis first appears, is a vital phase for social development, vocational attainment and relationships. In terms of service provision, the care needs for this age group are as distinct as for childhood, adulthood and old-age.

The early phase of psychosis is now understood to be a 'critical period' for determining future recovery trajectories. The importance of this brief 'window of opportunity' provides a clear rationale for a specialist, intensive, age-appropriate service model.

Pathways and inter-agency relationships for EIP differ significantly and may be more complex than for Community Mental Health Teams (CMHT).

- The interface between Child & Adolescent MH Services to Adult MH Service transitions are enormously problematic for this group
- There is NO EVIDENCE that a standard or enhanced CMHT can match the service outcomes of a specialised EIP service model

Specialist EIP teams have proved effective at implementing research evidence, clinical guidelines and core service features into practice.

- Bird et al, (2010) showed that the effectiveness of EIP may be linked to services being able to deliver interventions recommended by NICE schizophrenia guidance (NICE CG 82).

Common ingredients of effective EIP teams include

- Orientated particularly to working with young people and their families, a therapeutic culture of respect and recovery needs to be nurtured, with the effects of stigma being appreciated and actively countered. The radical, transformational change called for by EIP will not be achieved by top down approaches alone, but must be complemented by a grass roots desire for bold, sustainable change.
- Dedicated leadership is vital to service culture, ensuring that EIP services are led in accordance with research-based best practice and for the continuous improvement of the service, workforce development and clinical governance.
- Team approach: the ability to share information and to work effectively within the multi-disciplinary team is essential. This involves a willingness to share roles within the team to meet the needs of individual clients.
- Multi-disciplinary Team skill mix: able to provide youth working, psychosocial and occupational skills, family work, service user posts. The skills for working with children and people with a dual diagnosis are essential and support workers are vital to maintaining high levels of community support. Recovered EIP service users can help enormously in such roles.
- Assertive Community Treatment, flexibly applied according to need: A team-based approach which will vary in intensity depending on the individual's needs and their progress: the aim is to ensure young people feel meaningfully engaged to receive evidence-based interventions, promote their recovery and reduce risk.
- Low Caseloads: A team caseload should equate to no more than an average of 12–15 cases per key worker, i.e. a team with 10 key workers should manage 120–150 clients.

Psychiatric Mapping Translated into Innovations for Care – PsyMaptic

PsyMaptic offers service planners and commissioners a way to predict incident case numbers at a local level

The annual incidence of psychotic illnesses such as schizophrenia is relatively stable over time1-2 but varies enormously from place to place. This complicates the planning and commissioning of Early Intervention Psychosis Services [EIS]. The number of people with first episode psychosis [FEP] in any locality varies according to the sociodemographic characteristics of its residents such as their age, sex and ethnicity, but is also greatly affected by neighbourhood-level factors such as population density and socioeconomic deprivation 2-3. These epidemiological features underpin new models to predict the expected incidence of psychotic disorders in different populations. Using detailed epidemiological data from four areas in England 4–5, researchers at the University of Cambridge have predicted the incidence of psychotic disorders in different and contrasting localities in East Anglia. Their model predicted that 508 people aged 16–35 years would present over a 2.5 year period (with 95% prediction intervals of 446-575); the observed figure 6 was 524. An easy-to-use prediction tool, known as PsyMaptic, now covers localities throughout England and Wales, arming healthcare commissioners and other stakeholders with precise epidemiological forecasting tailored to their local populations. PsyMaptic is freely available at **www.psymaptic.org**.

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EIP Intervention principles

The following table summarises the evidence-based principles of care and treatment

Intervention principles – An evidence-based approach
• **Age-appropriate services and youth friendly approach** – age, culture and gender sensitive.
• **Family orientated – supporting the family as part of the care team**
• **Engagement alongside expert management** – Meaningful and sustained engagement based on assertive outreach principles – Promote early detection and referral by community agencies – Reduce treatment delay – Tolerate diagnostic uncertainty whilst addressing key problems by managing symptoms rather than the diagnosis – Optimise initial service experience – home treat/youth friendly inpatient care.
• **Maximise recovery and prevent relapse during critical period** – Provide age and phase biological, psychological and social interventions – Emphasis on normal social roles and service user's development needs, particularly in terms of accessing education and achieving employment – Address co-morbid substance misuse and treatment resistance early – Screen for and modify physical health risks – promote wellbeing.

What should an EIP service be able to offer?

Access

Key components	Key elements	Comments
Promote early detection and prompt referral by community agencies.	Operate clear referral routes e.g. from primary care; youth agencies; other secondary mental health services. • Facilitate access by offering • Low threshold for assessment – tolerate diagnostic uncertainty e.g. watchful waiting/extended assessment.	For detailed information on who EIP services are designed to support see ELIGIBILITY CRITERIA (National Institute for Mental Health 2008) Regular audit of pathways to care with the aim of reducing Duration of Untreated Psychosis (DUP) can explore the nature of local pathways and indicate ways to improve local access.
Reduce treatment delay.	• Prompt access to assessment (e.g range from same day to a week according to urgency). • Symptom awareness programmes for primary care, educational institutions, social services and other relevant agencies. Measure and report the duration of untreated psychosis (DUP i.e. the time spent undiagnosed and untreated) as part of clinical audit and improvement programmes.	Providers and commissioners can get an indication of the timeliness of the local service response from the Duration of Untreated Psychosis, a measure which has been linked to clinical outcomes (Marshall et al 2005), and now a recording requirement within the Mental Health Minimum Dataset.
Minimise coercive crisis entry.	Offer low stigma approach to encourage help seeking and engagement via youth friendly and culturally appropriate settings e.g.: • Avoid psychiatric outpatients/see people in their own homes or neutral settings. • Age/gender appropriate in-patient services when admission required.	However it is important to recognise that much of the avoidable delay within DUP may not be due to EIP services per se, especially if EIP is set up as a tertiary service, requiring young people to first negotiate generic mental health services. Active involvement in community-based programmes to reduce stigma associated with psychotic illness see Time for Change national campaign to combat mental health stigma. Engage in low stigma settings e.g. home, GP surgery, cafes, college.

What should an EIP service be able to offer?

Assessment

Key components	Key elements	Comments
Provide age appropriate services and a youth friendly approach.	Clarify person's own perceptions and concerns. Offer gender, ethnic and communication specific information and support as necessary Provide comprehensive risk assessment. Seek family perspective on development of the illness. Assess for co-morbid conditions e.g. • Depression; suicidal ideation; personality disorder; learning disabilities; substance misuse. • Appropriate individual sexual health considerations.	The essence is to offer a person-centred approach: holistic, multi-disciplinary assessment which takes account of their social circumstances, physical and mental wellbeing and psychological mindedness. The first episode psychosis is a high risk time for suicide, but these young people are amenable to skilled help. EIP teams must have the expertise to assess and manage suicide risk effectively EIP SUICIDE RISK MANAGEMENT RESOURCE

What should an EIP service be able to offer?

Individual engagement

Key components	Key elements	Comments
Optimise initial service experience. Tolerate diagnostic ambiguity whilst addressing key problems by managing symptoms rather than diagnosis. Provide meaningful ongoing engagement based on assertive outreach principles applied flexibly according to need.	Early engagement is the most important initial therapeutic goal. • Creative and assertive approaches to suit individual young person/ adult. • Supportive & empathic relationships working with individual strengths and aspirations and priority needs/aims. • Tolerate diagnostic ambiguity: focus on person's symptoms and problems rather than diagnosis. • Wide understanding of good multi-agency working to address needs and goals, with therapeutic optimism. Deliver ongoing engagement based on a flexible application of the principles of assertive outreach. • As a general principle failure to engage does not lead to case closure; and service users are not 'lost' to follow-up. • For many, once engaged and clinically improving, ongoing service contact should be through flexible agreement with the service user which for some may require no more than an agreed monthly meeting. • Peer support provides a vital contribution to engagement and encouragement of an optimistic, youth-friendly service culture. • Where individuals are ambivalent or resistant to service support and clinical improvement lacking, the team will work assertively to maintain contact, for example by supporting the family while trying to repeatedly engage the individual. Provide care coordination • Dedicated key worker allocated to work intensively. • Supported by full multi-disciplinary team working to a bio-psycho-social formulation.	The service seeks common ground with the individual and avoids premature confrontation of personal explanatory model for psychotic experiences. Failure to take prescribed medication, continuing substance misuse, or non attendance should not lead to discharge: instead the service uses an assertive outreach model to avoid clients being lost to services and support their re-engagement. A recent EIP study of user and carer acceptability (Lester et al, 2011) revealed that for some the assertive outreach approach sustained over three years, could feel intrusive and controlling and potentially breed resistance. Engagement, via regular contact with an identified and consistent named case manager and is based on clients self reported needs. The intensity of the treatment requires a capped caseload and a multi-disciplinary team approach, otherwise the effectiveness is significantly reduced (Fowler et al., 2009).

What should an EIP service be able to offer?

Family engagement

Key components	Key elements	Comments
All EIP services should be family orientated, supporting the family as part of the care team. Engaging families is a core service aim irrespective of how well engaged their relative is with the service. Engaging and supporting families & carers features in the WHO Early Psychosis Declaration (Bertolote & McGorry 2005).	EIP services should work in partnership with service users and families to: • Engage carers/family early. • Provide information, support and guidance to maintain hope and optimize coping. • Involve family/carers in treatment planning, reviews and monitoring of mental health. • Ensure family/carers know whom to contact in crisis. • Provide information on self-help support groups. • Offer Carer's Assessment. Provide early engagement with families as routine part of the assessment process to enable • Gathering of invaluable information about the young person who has developed their FEP • Low-key assessment and consideration of family members' physical, social and mental health needs, particularly the welfare of dependent children, siblings and vulnerable adults. Collaborative engagement of families requires sensitive ongoing negotiation about the extent of information-sharing with the person with psychosis.	Involving families in a collaborative partnership cf Triangle of Care (Worthington & Rooney 2010) from the beginning can create a very different long-term relationship with services and facilitates the development of an environment that promotes recovery. Most young people with a FEP are in close contact with their families. Relatives commonly initiate contact with services, and provide much of the practical care and support. However families have traditionally struggled to initiate help and have felt excluded from their relative's care. When the lives of young people with psychosis are chaotic and poorly engaged with services, working with family members is sometimes the best way to maintain therapeutic input. Relatively straightforward information, support and guidance can encourage medication concordance, enable family coping strategies, prevent formation of unhelpful attitudes/interactional patterns.

What should an EIP service be able to offer?

Individual interventions

Key components	Key elements	Comments
All EIS services should provide interventions suited to age and phase of illness: these include a range of evidence-based biological, psychological and social interventions.	Interventions should be formulation based, and evidence-based (as per NICE guidelines): • Psychological – e.g. CBT; coping skills, making sense of symptoms and experiences, addressing previous traumas and significant life experiences. • Biological – careful and judicious use of antipsychotic medicines; and other mood stabilisers/anti-depressants. • Social – eg self-directed support, peer support, vocational interventions. Help the young person make sense of the experience. • Inform about psychosis, treatments, support options • Specific information about medicines – informed choices • Positive risk management	These should be individually tailored to the young person with psychosis. Interventions are based on a strengths model which supports the young person to practice new skills and to retain autonomy and control; designed to be sensitive to adolescent development issues, including individuation from the family and developing self identity.
Address co-morbid substance misuse and treatment resistance early.	Adapting care to an individual's personal framework builds on the values that EIP places on person-centred approaches. These might include: • Spiritual interventions • Voice hearing interventions • Unusual beliefs work • Mindfulness techniques • Cognitive remediation • Systemic therapy Relapse prevention – use of early warning signs; effective care planning for relapse. Treat co-morbidity: a 'normal' part of EIP service provision is to deal with substance misuse, depression, suicidal ideation.	Interventions are delivered flexibly, offering practical assistance focussed on the resolution of identified problems important to the individual.

What should an EIP service be able to offer?

Cognitive behavioural therapies for psychosis

Key components	Key elements	Comments
CBT can help people with positive symptoms (delusions and hallucinations) as well as associated negative symptoms (e.g. motivational problems and social withdrawal). Cognitive Behavioural Therapy is based on the premise that there is a relationship between thoughts, feelings and behaviour. Cognitive therapists often explore and modify unhelpful or erroneous thoughts in order to produce changes in mood and behaviour.	CBT for Psychosis (CBTp) helps individuals understand and normalise their psychotic experiences, thereby reducing associated distress, risk of relapse and impaired social functioning. Many people with psychosis have additional presenting problems including depression, social anxiety, trauma related symptoms and drug and alcohol problems. CBT can also treat these co-morbidities. NICE recommends that all patients should be offered CBT (NICE CG 82 2009). The course of CBT should be of more than six months' duration and include more than ten planned sessions. In CBTp there is an emphasis on working collaboratively to evaluate a person's beliefs. Socratic questioning and behavioural experiments are the core methods of exploring and testing these. CBTp interventions may include: • Formulation: making sense of symptoms (why they occurred and what is maintaining them). • Coping strategy enhancement • Normalising • Exploring and modifying unhelpful beliefs • Behavioural experiments	Cognitive psychology has demonstrated that delusional beliefs are on a continuum with normal thinking. In addition, we now know that it is not uncommon for people in the general population to hear voices and not be distressed by this phenomenon. These recent understandings of psychosis have led to the successful adaption of interventions to treat non-psychotic conditions for psychosis. Psychosis was previously regarded as 'un-understandable' and not amenable to psychological treatments. Research has now demonstrated that CBT is an effective treatment for people suffering psychotic symptoms. The populations targeted for CBTp have expanded, with recent developments focussing on the treatment of first episode psychosis and people diagnosed with both schizophrenia and co-morbid substance use disorders.

What should an EIP service be able to offer?

Family interventions

Key components	Key elements	Comments
Providing care for families is a core EIP service requirement. NICE recommends that family interventions (FI) should include at least ten planned sessions over a period of between three months to one year. Family Interventions (FI) sessions should be tailored to meet the needs of family members and offered irrespective of how well engaged their relative is with the service.	All EIP services should offer single family interventions (e.g. psycho-education, family therapy) and multi-family group interventions. Formal structured goal oriented FI sessions can: Help improve partnership with families as part of routine care • Validate and normalise the family's emotional reactions • Provide tailored information about psychosis, stress and vulnerability, treatment etc • Explore appraisals to reach a more helpful shared understanding about what has happened • Goal set and encourage realistic steps towards recovery • Practice clear, direct, positive communication • Identify and help change unhelpful interactions • Problem-solve about everyday issues • Identify early warning signs of relapse and agree an intervention plan • Promote stress management and encourage all family members to look after their own needs, referring to mental health/carer support services when required.	FI reduces relapse and hospital admission rates in FEP (Bird et al 2010). Social functioning and 'family burden' are improved and overall treatment costs are reduced (Onwumere et al 2011). FI approaches are based on the stress-vulnerability model, helping families develop problem-solving skills, communication skills and ways to achieve low stress environments. Families are encouraged to support goals tailored to the family member's stage of recovery. These psychoeducational cognitive-behavioural approaches may be augmented by a focus on systemic issues where families have become trapped by unhelpful patterns of belief and behaviour, or in exploring socio-cultural and intergenerational beliefs, roles, and family life-cycle issues.

What should an EIP service be able to offer?

Family interventions (continued)

Key components	Key elements	Comments
	Families identify very diverse difficulties, requiring different types of intervention. Ideally services offer a menu of ways to support families e.g. Systemic and Behavioural family therapy, Care Support Groups and other modes of multi-family working. • Structured FI should be offered where there are high levels of family tension. • Not all families require formal, structured FI and the approach should always be tailored to each family. • A small number of families may require more in-depth psychotherapeutic input to address complex and entrenched negative interactions and conflicts; or to address significant pre-existing or recently developed risk factors (e.g. abuse or violence).	Stepped-care models enable the most highly trained staff to respond to those families with the most complex needs; contrasting with families with simpler needs who may only require basic levels of engagement, information and support (Cohen et al 2008; Mottaghipour & Bickerton 2005).

A number of useful treatment guides are available which provide examples of services for families of young people with a FEP (Addington & Burnett 2004; Birchwood et al 2002; Burbach et al 2010; Crisp & Gleeson 2009; Fadden & Smith 2009; Gleeson et al 1999). A useful guidebook for implementing family work (Froggatt et al 2007) is also available.

What should an EIP service be able to offer?

Antipsychotic medication

Key components	Key elements	Comments
Antipsychotic medication should be offered as part of a comprehensive package of evidence-based interventions (NICE CG82 2009). Medication requires expert and careful consideration as these typically young people, previously treatment naive, may be embarking on treatments which for some may run for several years. This should be provided in conjunction with a psychosocial and vocational programme including family interventions, preferably delivered by a coherent specialist EIP service.	Informed patient choice should underpin treatment decisions: • Provide understandable information regarding medications, benefits and risks. • Include information for benefits from psychosocial, vocational and family interventions. • Respect an individual's informed choice to decline medication. Early symptom control should be the main initial goal in order to reduce distress, agitation and aggression, improve/stabilise mood. Skilled engagement and specialist assessment by practitioners expert in prescribing for FEP: • Should ensure appropriate dosage regimens, sensitive to the impact of antipsychotics on issues such as drug tolerability and concordance. • Take account of evidence for FEP patients requiring lower doses of antipsychotics than those with more established psychotic illnesses. • Careful assessment should precede any plan to prescribe, to avoid prescribing antipsychotics to those without evidence of psychosis. • Supporting people to discontinue medication is an important responsibility in EIP, requiring team support for additional psychosocial support and contingency plans. • Careful consideration of potentially adverse metabolic risk from antipsychotic medication both prior to initiation and in the early treatment phase. • Systematic monitoring of weight gain and other factors associated with diabetes and metabolic syndrome should commence from the initiation of treatment. • Positive health promotion of issues such as healthy diet, physical activity, tobacco smoking.	Antipsychotic medication remains an important aspect of treatment in FEP, especially early on during the acute and recovery phases. • Many individuals benefit from treatment for at least one, and ideally two years. • Some may benefit from treatment for several years depending on the course and occurrence of relapse. • However some may choose to avoid medication and should not be made to feel they are not cooperating. Indeed although difficult to predict who, evidence shows that some can do well without medication. Most current antipsychotics show similar efficacy against positive symptoms in FEP. Thus choice of drug should be based on tolerability and side effects experienced, and the individual's ability to manage these (Leucht et al 2009) whilst maintaining therapeutic benefit. For a useful summary of prescribing: www.bap.org.uk/pdfs/Schizophrenia_Consensus_Guideline_Document.pdf

What should an EIP service be able to offer?

Support, social, educational and vocational roles

Key components	Key elements	Comments
All EIP services should emphasise normal social roles and service user's development needs, particularly in accessing education and achieving employment. EIS should link with relevant networks of community support agencies.	Accommodation needs: • Assess and monitor • Support as necessary e.g. offer advice/advocacy/link to other specialist advice/support. Consider finance/benefits/debt review and specialist advice. Assess for and where needed provide support on activities of daily living. Supporting service users to develop wider social networks is essential to recovery: • Consider befriending service for those who would benefit – trained volunteers, e.g weekly contact, 2–6 months. • Implementing personal budgets and self-directed support may offer a practical way of building social capital. • Provide social activity groups as a first step to increase confidence in social situations. • Social isolation and disability should be assessed after six months and are identified as 'at risk of social exclusion'. This sub-group require dedicated support to encourage active participation and meaningful social interaction. Meaningful occupation is a key objective for EIP services and maintaining or obtaining employment is important for recovery and quality of life. • Provide vocational assessment and support: interventions are informed by evidence based practice models including Individual Placement Support (IPS), client-centred practice, Occupational Therapy and solution-focussed approaches.	Increase stability in the lives of service users facilitate development and provide opportunities for personal fulfilment. EIP values all contributions to the recovery journey – family, individual themselves and staff: all need help to play their role and education and training are key in this (e.g. support groups, skills workshops for service users, staff training). An essential skill of EIP practitioners includes the ability to support service users to generate and mobilise social resources to build their social capital as a way to enhance quality of life and improve recovery. Evidence from the National EDEN study (personal communication Prof Max Birchwood) shows that about a third of those entering EIP services have significant social disability. This may be resistant to change, especially in those who are socially isolated, unless explicitly targeted. Maintenance of existing, or early restoration of pathway to education or valued employment is vital as length of time out of work/ education ultimately determines successful reintegration. See Meaningful Lives consensus statement developed by the iFEVR (International First Episode Recovery Network). IPS has strengthening evidence for its effectiveness in increasing the opportunities of mainstream employment for those who have experienced first episode psychosis.

What should an EIP service be able to offer?

Physical health

Key components	Key elements	Comments
Screen for and modify physical health risks and promote wellbeing Ensure ongoing assessment of physical health informs the initial treatment plan. see NICE Schizophrenia Guidelines 2009	Promote healthy lifestyles and physical wellbeing and practically support these in care planning. • Get the basics right, address poor housing, poverty and social isolation. • Value and support families and other key care-givers as partners in care. • Facilitate health awareness and how to seek help on physical health issues from primary care. • Address lifestyle issues through health promotion on issues like diet, smoking and physical activity. From the onset of treatment build collaboration with primary care to minimise adverse cardiometabolic risk. • Establish good communication with primary care to ensure the young people themselves receive clear and consistent information. • Involve patients right from the start of treatment, supporting informed choice and skilled medicines management which balances the trade-offs between symptom control and physical health risk. • Provide baseline cardiometabolic assessment prior to commencing antipsychotics. • Systematic annual cardiometabolic monitoring should be in place within 12 months of first diagnosis, and be provided by primary care, unless exceptional circumstances prevent. • Detected cardiometabolic risk should be treated.	Life expectancy reduced by 16–25 years mainly due to premature cardiovascular disease (CVD), underpinned by metabolic disorders like diabetes, hyperlipidaemia and high rates of obesity and smoking.(Parks et al 2006; Brown et al 2010). Poor physical health negatively affects mental health and vice versa. Physical health issues like obesity impact on self-esteem and can effect treatment concordance. The first 12 months of treatment is a critical period for acquiring weight gain and adverse cardiometabolic risk (Foley et al 2011; Alvarez-Jimanez et al 2009). For a practical summary of how to address cardiometabolic risk see Holt RIG. Cardiovascular disease and diabetes in people with severe mental illness: causes, consequences and pragmatic management PCCJ Practice Review 2012. Clinical audit and reflective practice should focus on improving the effectiveness of prevention and early intervention for adverse cardiometabolic risk. A new clinical resource has just been developed between the RCGP and the RC Psychs' College Centre for Quality Improvement: *Positive cardiometabolic health resource: an intervention framework for patients with psychosis on antipsychotic medication*. www.rcpsych.ac.uk/quality/NAS/resources

What should an EIP service be able to offer?

Discharge

Key components	Key elements	Comments
Planning for discharge should begin from early on in the pathway through EIP. At the end of the treatment period, ensure best practice in discharge so that forward care is transferred thoughtfully and effectively.	In planning for future care beyond EIP the particular needs of individual service users should be taken into account as they approach their discharge. Plan with service user and carers/ family, with primary care, and with ongoing specialist mental health teams where relevant for those with ongoing needs • Continuity of care arrangements to ensure a smooth transition • Build a robust transition plan to protect social and vocational strengths. • Ensure families support needs are planned for • Agree relapse prevention plans with clear pathways back to care if things go wrong. • Regular physical monitoring for those remaining on anti-psychotic medicines. Communicate plans to all concerned.	Most people using EIP require about three years of care. It is vital that gains made in the first three years of EIP are maintained. For about 30–50% of individuals a satisfactory recovery means their ongoing need for care and monitoring can reasonably be managed entirely by primary care. For those clients with ongoing impairments, preparation for discharge requires careful planning of service transitions to ensure an integrated approach can be maintained between specialist services and primary care.

Useful resources

Glossary

CMHT	**Community Mental Health Team**
CVD	**Cardiovascular Disease**
DUP	**Duration of Untreated Psychosis**
EIP	**Early Intervention in Psychosis**
FEP	**First Episode of Psychosis**
FI	**Family Interventions**
MHMDs	**Mental Health Minimum Dataset**

IRIS seeks to improve the lives of young people affected by psychosis and their families by embracing the aims and principles of the Early Psychosis Declaration. IRIS emerged in the West Midlands in 1997 as a community of interest in the issue of early intervention for psychosis. Influential in national policy and its implementation, IRIS has evolved to become a social enterprise through which it continues to support the sharing of knowledge and good practice through a network of regional leads from across England and Wales. For further information about IRIS visit website: **www.iris-initative.org.uk**

Resources (weblinks)

EIP Service ELIGIBILITY CRITERIA

Mental Health Minimum Dataset

No Health without Mental Health

NHS Confederation EIP Briefing

NICE Schizophrenia guidance (CG 82)

NICE Bipolar guidance (CG 38)

Positive Cardiometabolic Health Resource

Suicide risk management resource

Meaningful Lives consensus statement

Early Psychosis Declaration

Guidance for the Commissioning of Public Mental Health Services (in press) produced by the Joint Commissioning Panel for Mental Health.

www.jcpmh.info

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