Early Intervention Achieving Better Access

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NHS England

35% OF PEOPLE

under EIP care are in employment

compared to

12% OF PEOPLE

in standard mental health care

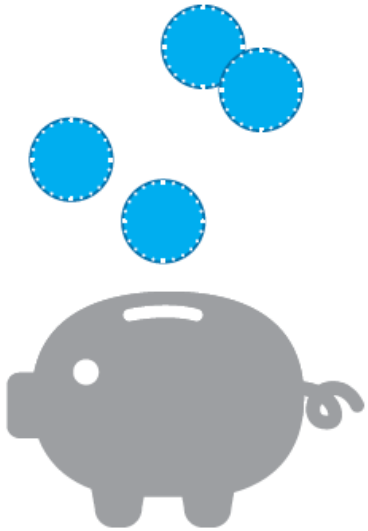
EIP support reduces the probability of someone being 'sectioned'

FROM 44%  TO 23% 

in the first two months of psychosis

If everyone who was eligible received early intervention, it would **save** the NHS

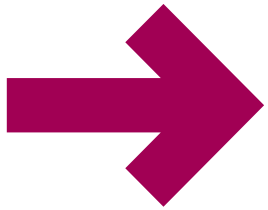
£44 MILLION EACH YEAR



EIP support **reduces the risk** of a young person taking their own life

FROM UP TO 15%
TO 1%

“After more than a decade of progress and success, EIP care is effectively disappearing in some areas of the country” - Rethink



50% OF EIP SERVICES

have been **cut** in the past year

www.england.nhs.uk

NHS England

LSE PSSRU

Centre for Mental Health

Institute of Psychiatry at The Maudsley

KING'S College LONDON

Mental Health Promotion and Prevention:

The Economic Case

Table 13: Total returns on investment (all years): economic pay-offs per £1 expenditure [a]

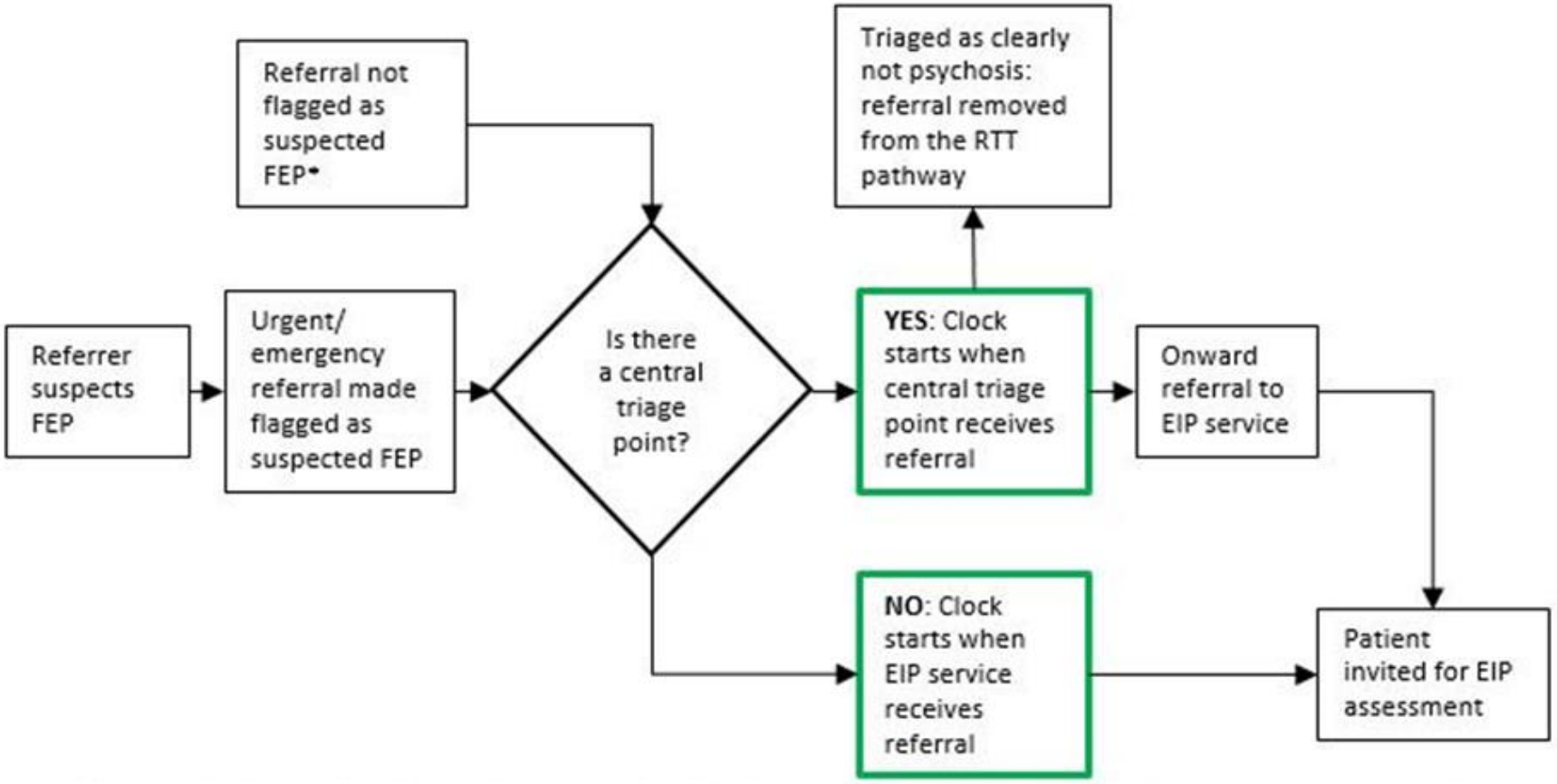
	NHS	Other public sector	Non-public sector	Total
Early identification and intervention as soon as mental disorder arises				
Early intervention for conduct disorder	1.08	1.78	5.03	7.89
Health visitor interventions to reduce postnatal depression	0.40	–	0.40	0.80
Early intervention for depression in diabetes	0.19	0	0.14	0.33
Early intervention for medically unexplained symptoms [b]	1.01	0	0.74	1.75
Early diagnosis and treatment of depression at work	0.51	–	4.52	5.03
Early detection of psychosis	2.62	0.79	6.85	10.27
Early intervention in psychosis	9.68	0.27	8.02	17.97
Screening for alcohol misuse	2.24	0.93	8.57	11.75
Suicide training courses provided to all GPs	0.08	0.05	43.86	43.99
Suicide prevention through bridge safety barriers	1.75	1.31	51.39	54.45


1. THE NEW ACCESS & WAITING TIME
TWO WEEKS
FROM REFERRAL TO TREATMENT
TREATMENT DELIVERED IN ACCORDANCE WITH NICE GUIDELINES

Aims of EI services

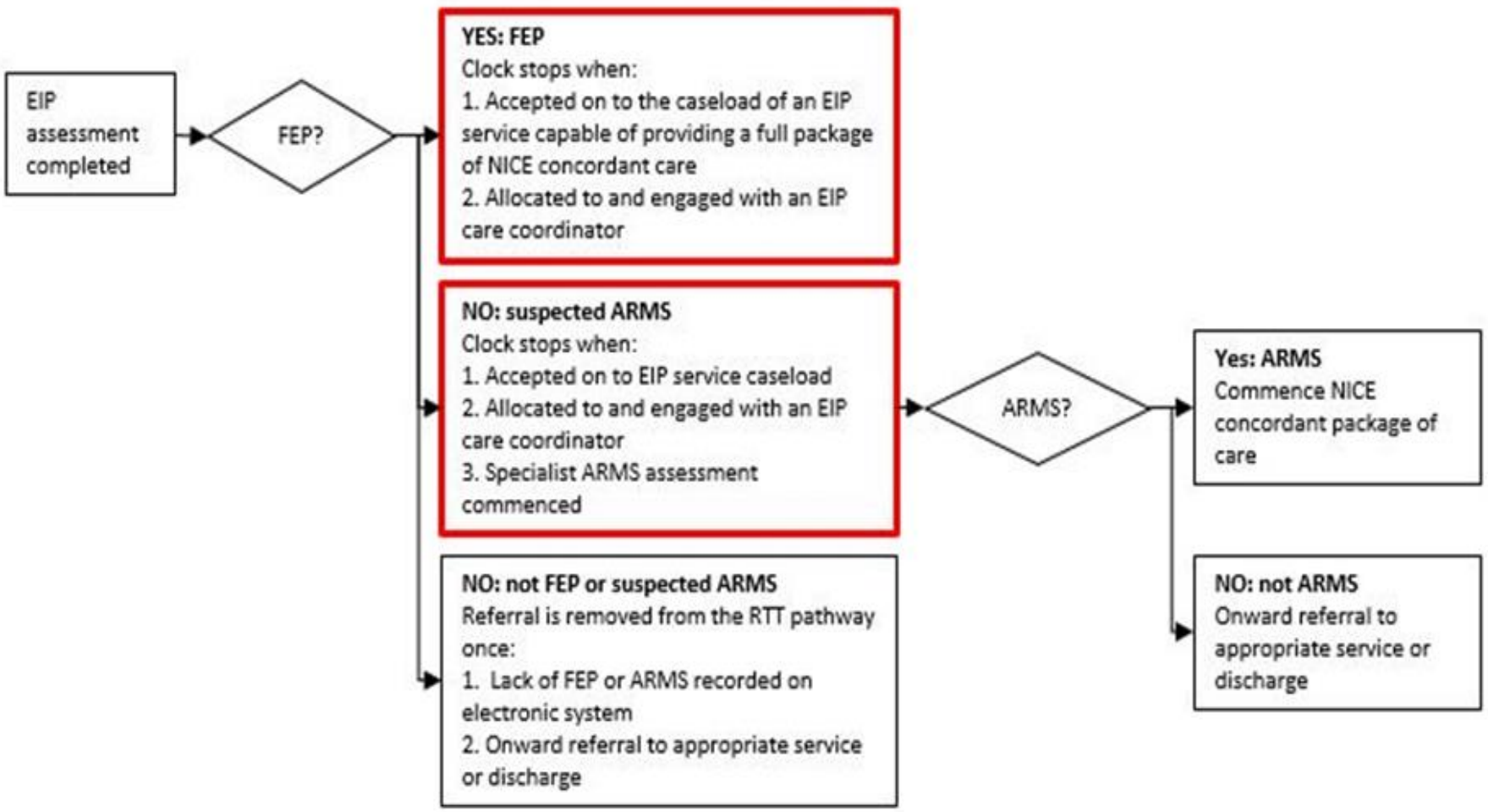
1. **Prevent psychosis in the ultra high risk individuals**
   - *identify and intervene on cusp of psychosis*
2. **Reduce DUP (Duration of Untreated Psychosis):**
   - *promote early detection & engagement by community agencies*
   - *Comprehensive initial mental health assessments & diagnosis*
3. **Optimise initial experience of acute care & treatment:**
   - *'Youth friendly' Acute Home based/Hospital Treatment*
4. **Maximise recovery & prevent relapse during critical period:**
   - *Provide integrated bio/psycho/social interventions*
   - *focus on functional/vocational as well as symptomatic recovery*
   - *address co-morbidity and treatment resistance early*
   - *Support carers and network of community support agencies*

Clock start



* If assessed by the central triage point as suspected FEP 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

Clock Stop


EIP assessment completed
FEP?
YES: FEP
Clock stops when:
1. Accepted on to the caseload of an EIP service capable of providing a full package of NICE concordant care
2. Allocated to and engaged with an EIP care coordinator
NO: suspected ARMS
Clock stops when:
1. Accepted on to EIP service caseload
2. Allocated to and engaged with an EIP care coordinator
3. Specialist ARMS assessment commenced
ARMS?
Yes: ARMS
Commence NICE concordant package of care
NO: not ARMS
Onward referral to appropriate service or discharge
NO: not FEP or suspected ARMS
Referral is removed from the RTT pathway once:
1. Lack of FEP or ARMS recorded on electronic system
2. Onward referral to appropriate service or discharge

This means three stretches for EIP:-

1. Over 35s, this is likely to lead to an increase of 20-25% in caseload.

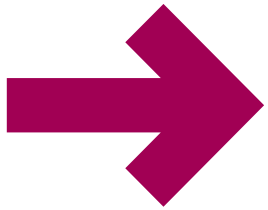
   Issues - dilute youth focus, new ‘organise’ boundary at 65, do they need the same help?.

2. ARMS, the workforce calculator assumes one ARMS case for each new FEP case. The workforce calculator adds additional resource for this work.

   Issues - Will we get flooded with these referrals?. How much time allocated to ‘watch & wait’. Should this be under 30s only?

3. NICE compliance – NICE Guidance has evolved since EIP teams set up. Suggests increase in CBTP, FT and employment support.

   Issues – Is this workforce available? Do we really understand the demand for these intervention.



How are we doing?

Region	Cases	People meeting 2 week standard
England	1052	65.3%
North of England	323	70.3%
Midlands and East of England	262	54.2%
London	249	62.7%
South of England	218	74.3%

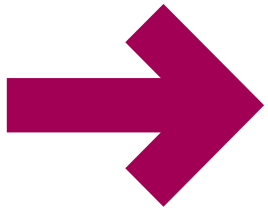
Providers and commissioners need to involve people who use their services and work together to ensure the EIP teams have resources to be able to provide NICE recommended packages of care.

Together, we must recruit and train EIP staff so that people with first episode psychosis can access EIP services that can allocate to an EIP Care Coordinaor within 14 days of referral AND deliver:

- CBT for Psychosis (CBTp)
- Individual Placement Support (IPS) for education and employment
- Family Interventions
- Medicines management
- Comprehensive physical assessments
- Support with diet, physical activities and smoking cessation
- Carer-focused education and support programmes

What about NICE concordant care?

- Patients with first episode or suspected psychosis are offered CBTp 41% range 0-88%
- FI is offered to those in contact with their families 31% range 0-100%
- Clozapine is prescribed to patients for whom this treatment is indicated (or valid reason is given for not prescribing clozapine) 35% range 0-100%
- Patients looking for work are offered supported employment programmes 63% range 0-100%



Outcomes framework

- **Health of the Nation Outcome Scales (HoNOS)** – These clinician-rated scales cover safety, substance use, physical health, symptoms and social issues (Wing et al., 1998).
- **DIALOG** - A service user-rated outcome measure, which focuses on quality of life, care needs and treatment satisfaction (Priebe et al., 2007).
- **The Process of Recovery Questionnaire (QPR)** - Developed in collaboration with service users (Law et al., 2014), it asks about aspects of recovery that are meaningful to them including those concerned with relationships and their views about themselves and their future.

GP Guidance: Early Detection of Emerging Psychosis – What you Need to Know

KEY LEARNING POINTS

- Psychosis is usually heralded by a gradual deterioration in intellectual and social functioning.
- GP recognition of early changes, clinical intuition, and acting on family concerns are the key to early detection.

Ask yourself:

"Would I be surprised if this turned out to be psychosis within the next six months?"

To cite: **French P, Shiers D, Jones P. GP Guidance: *Early Detection of Emerging Psychosis* – 2014 update**; Royal College of General Practitioners & Royal College of Psychiatrists; 2014.

Early signs of emerging psychosis

Emerging psychosis tends not to present in neat parcels. Many GPs suspect that something is *not quite right* prior to the emergence of clear symptoms of psychosis, such as hallucinations or delusions.

Early symptoms which are often difficult to define or indeed uncover may include:

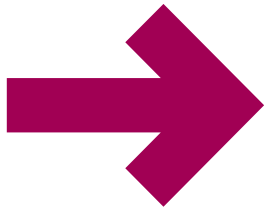
- Poor sleep
- Panic, mood changes
- Social withdrawal and isolation, including; job loss, poor education attendance and broken relationships
- Early psychotic thinking such as suspicion, mistrust or perceptual changes.

If uncertain, do not simply dismiss as *adolescence* or substance misuse. Be prepared to monitor the patient and follow up any missed appointments. Family concerns should also be taken seriously; they can often provide important clues.

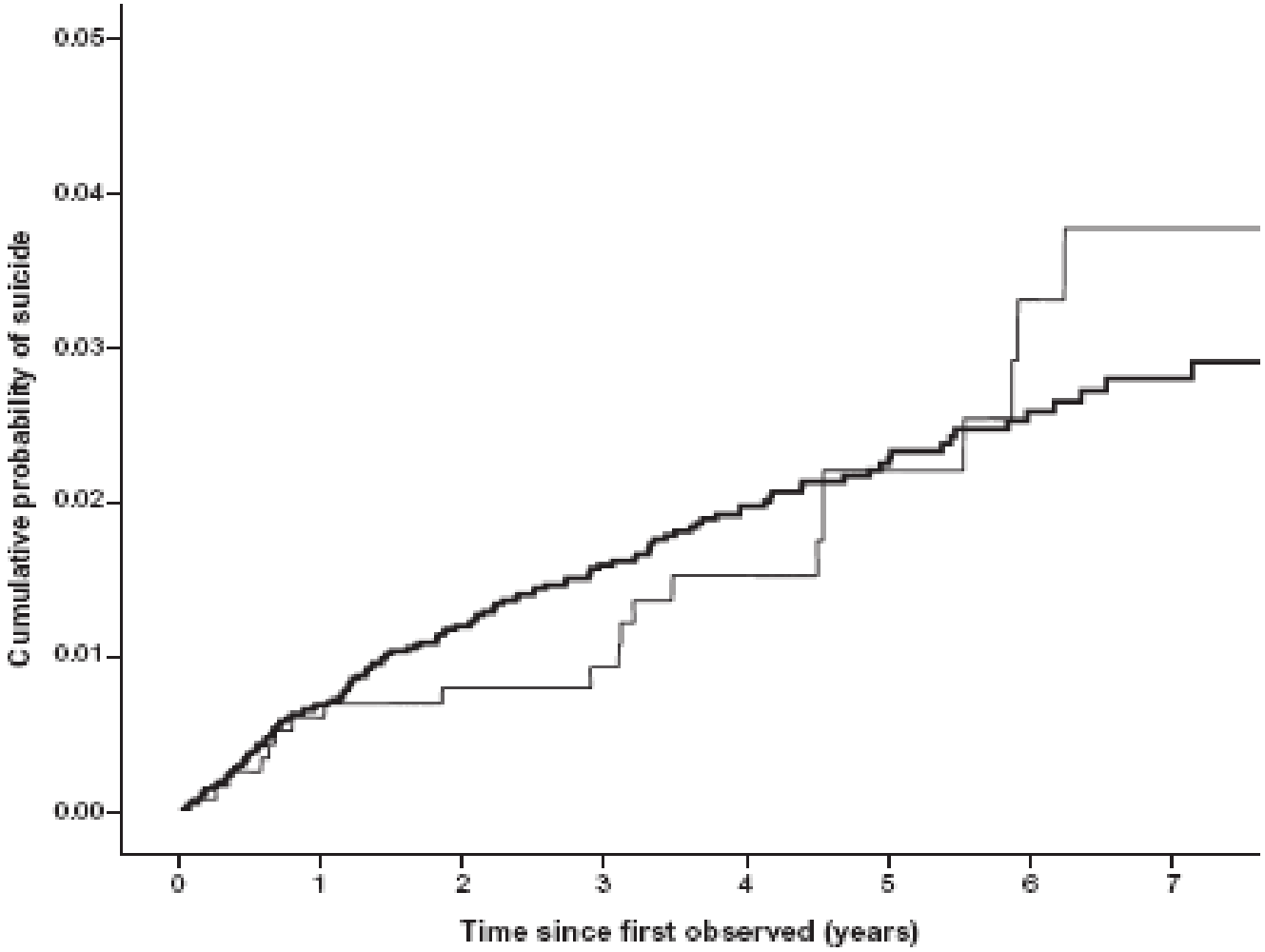
GP recognition of early changes, clinical intuition, and acting on family concerns are the key to early detection.

Future challenges

- Length of time in EIP – currently 3 years perhaps for some people shorter and others longer



Survival probability for suicide, by EP Treatment group, and time in years since first observed



Impact of a specialized early psychosis treatment programme on suicide. Retrospective cohort study Harris, Burgess, Chant, Pirkis McGorry *Early Intervention in Psychiatry* 2008; 2: 11–21

Thank you

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