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Implementing the early intervention in psychosis access and waiting time standard

Version 3, 16 February 2023

All significant changes – excluding the foreword – from the previous edition of this guidance (version 2, published December 2020) have been highlighted in **yellow**.

Contents

Foreword	3
Key messages	5
1. Introduction.....	8
1.1 Document purpose.....	8
1.2 The early intervention in psychosis access and waiting time standard	9
1.3 Expectations of commissioners and providers	9
2. What is first episode psychosis and why is rapid access to effective treatment so important?	11
2.1 Experiences of first episode psychosis: a service user and carer perspective	11
2.2 Expectations of commissioners and providers	12
2.3 How common is first episode psychosis?	13
2.4 What is the impact of not having timely access to effective treatment?	14
2.5 What are the benefits/ impact of having timely access to effective treatment?.....	15
2.6 What is an EIP service?	16
2.7 Relevant NICE guidelines and quality standards	17
2.8 Other key functions of EIP services	20
2.8.1 Supporting identification of psychosis and rapid referral.....	20
2.8.2 Recognising and addressing co-existing health problems	22
2.8.3 Support with social issues.....	23
2.8.4 Families and carers.....	23
2.9 The EIP workforce	25
2.9.1 Other staffing	29
2.10 A service user perspective	29
2.11 EIP service models	30
2.12 At-risk mental state	33
3. The access and waiting time standard	37
3.1 Requirements of the standard.....	37
3.2 Measuring and reporting performance against the referral to treatment (RTT) waiting time requirement.....	38
3.2.1 Measuring the clock start: referral, recognition and initial assessment	38
3.2.2 Measuring the clock stop: start of treatment.....	42

3.2.3 Reporting performance against the referral to treatment (RTT) waiting time requirement	44
3.3 Measuring and reporting performance against the requirement that the treatment accessed is in line with NICE recommendations	45
3.3.1 What is NICE-recommended treatment?	45
3.3.2 Reporting NICE-recommended interventions using SNOMED-CT codes	46
3.3.3 National Clinical Audit of Psychosis	46
3.4 Routine collection of outcomes data	47
4. Key commissioning and service development considerations	50
Appendix 1: Expert Reference Group membership	56
Special acknowledgments	58
Appendix 2: Expert Reference Group 2020 refresh membership	60
Appendix 3: Essential components of a NICE-approved care package.....	62
Appendix 4: The full referral to treatment pathway	69
References	70

Foreword

In 2016 I wrote the foreword for the original version of this guidance document. The 2016 version of *Implementing the Early Intervention in Psychosis Access and Waiting Time Standard: Guidance* acknowledged the success of early intervention in psychosis (EIP) services at improving service users' outcomes and experience and ushered in one of the first waiting time standards for mental health in the NHS's history. Importantly, as well as timely access, this standard also carried an expectation that service users should have access to the full range of NICE recommended treatments once they were in the service.

In that foreword I talked about parity of esteem and the clear need for more investment into mental health services. With the publication of the [NHS Long Term Plan](#) we are further along in that mission to have parity for mental health services with a commitment of a ringfenced local investment fund worth at least £2.3 billion a year in real terms by 2023/24 to ensure that the NHS provides high quality, evidence-based mental health services.

The [NHS Long Term Plan](#) reconfirmed the NHS's commitment to the EIP access and waiting time standard that 60% of people with a first episode of psychosis should start treatment within two weeks of referral and receive a high quality NICE recommended care package. The [NHS Long Term Plan](#) also highlighted that EIP teams should provide care to people aged 14-65 years and support those at high risk of developing psychosis. These commitments sit within wider transformation work to improve England's community mental health services and crisis services. EIP services now form a key part of a rapidly transforming mental health offer.

This updated guidance document is the work of a group of service users, carers, clinicians and commissioners, and provides further clarity on our [NHS Long Term Plan](#). It is updated with more recent evidence and research and also provides more detail on the type of care that children and young people and those most at risk of developing psychosis should receive from EIP services. This guidance remains focused on supporting commissioners to invest in and deliver world class EIP services.

Since 2016, EIP services have made huge improvements in the quality and timeliness of care. From May 2021 to May 2022, EIP services nationally saw nearly 34,000 new referrals and have continued to meet and exceed the national waiting

time standard. There have been continued improvements in the percentage of people receiving psychological interventions – such as CBT for psychosis and family intervention – and 2021/22 data shows marked improvements in the percentage of people receiving physical health interventions and employment support, and an increase in service user outcomes being measured.

While we have seen significant improvement, we continue on the journey to improve mental health services and support the establishment of world class early intervention services. So much progress has been made at a time when the pandemic has made the provision of high-quality care particularly challenging but all the more critical. I want to thank EIP services for all their incredible work and dedication to date and ICBs for their support for these critical services going forward.

Professor Tim Kendall

National Clinical Director for Mental Health

Key messages

1. Psychosis is characterised by hallucinations, delusions and affects the perception of reality, with the potential to cause considerable distress and disability for the person and their family or carers. A diagnosis of schizophrenia, bipolar disorder, psychotic depression or other less common psychotic disorder will usually be made, although it can take months or even years for a final diagnosis.
2. Treatment can begin as soon as a **first episode of psychosis has been identified** – it does not have to wait for a final diagnosis **and services are encouraged to embrace diagnostic uncertainty**. Treatment should be provided by a service capable of providing a full and effective early intervention in psychosis (EIP) package of National Institute for Health and Care Excellence (NICE)-recommended care, normally a specialist EIP team.

These services are evidence-based, cost-saving and preferred by service users and carers over generic services. Services should ensure there is a competent skill mix to provide necessary care and support to people experiencing first episode psychosis of all-ages, including children and young people.

3. People who experience psychosis can and do recover. The time from onset of psychosis to the provision of evidence-based treatment has a significant influence on long-term outcomes. The sooner treatment is started the better the outcome and the lower the overall cost of care.

4. **The short and longer-term economic benefits of EIP services are significant, with estimated net cost savings of £7,972 per person after the first four years, and £6,780 per person in the next four to 10 years if full EIP provisions are provided. Over a 10-year period this would result in £15 of costs saved for every £1 invested in EIP services.**

The majority of these cost savings can be attributed to the reduction in use of crisis and inpatient services, improved employment outcomes and the reduction in risk of future hospitalisation as a result of improved management and reduced risk of relapse.

5. The access and waiting time standard **is targeted at** all people aged 14-65 experiencing first episode psychosis (including that associated with trauma or substance misuse). The standard is also relevant for people at high risk of psychosis ('at-risk mental state').

By 2023/24, 60% of people experiencing first episode psychosis should commence a NICE-recommended package of care within two weeks of referral. Treatment will be deemed to have commenced when the person:

- a. has had an initial assessment, AND
 - b. has been accepted on to the caseload of an EIP service capable of providing a full package of NICE-recommended care, AND
 - c. has been allocated to and engaged with an EIP care co-ordinator.
6. All services providing EIP will be expected routinely to record data regarding EIP waiting times, NICE-recommended interventions and outcome measures via the mental health services dataset.
 7. All EIP services should provide the full range of psychological, psychosocial, pharmacological and other interventions shown to be effective in NICE guidelines and quality standards, including support for families and carers. Effective and integrated approaches are needed to address the social and wider needs of people with psychosis to help them live full, hopeful and productive lives and achieve the best recovery possible.

EIP services also need the capacity to triage, assess and treat people with an at-risk mental state, as well as to help those not accepted to access appropriate treatment and support.

8. Commissioning EIP services should be underpinned by an estimated local incidence of psychosis, derived to incorporate a range of demographic features such as ethnicity, age, population density and deprivation to ensure services are designed to serve fully the needs of a particular locality and the specific cohorts of people that it comprises.
9. Commissioners and providers should ensure that everyone aged 14-65 years old, including children and young people (aged under 18) benefit fully from the standard and that there are robust local arrangements in place to ensure that specialist expertise in working with children and young people with psychosis

is available. This is in the context of the NHS Long Term Plan commitment to provide a comprehensive offer of care for 0-25 year olds.

10. It is likely that services will require investment and significant development in order to meet the two key conditions of the access and waiting time standard and that this can be met equally for children and young people and the relevant data flowed. Commissioning and service development plans should be co-produced with a range of stakeholders, including service users, carers, partner organisations and relevant voluntary sector organisations.

1. Introduction

“I was so wary of help and advice from others, that when I was referred into EIP, I felt I could relax in a way that I hadn’t been able to in so long. Upon referral, I initially met with my designated care co-ordinator (CC). She became my ‘guide’ to the service as she led me through recovery.

“Having a CC worked so well for me as an individual – I think being so scared and unsure initially meant I was well suited to having just one person of contact whom I could build trust, familiarity and security with. My CC helped me evaluate the things I was doing in life that were more unhelpful than helpful and I started making small changes for the better. Looking at my symptoms closely helped me to identify when things were getting worse – or better; important for being able to ask for help.

“For me, I felt medication was a good route to try in tandem with talking therapies, but everybody finds different things useful. Slowly the fog started lifting and I began to feel more like me again. I was able to make good use of CBT (cognitive behavioural therapy) sessions with my CC and sessions with the team psychologist. This helped me understand the way I was feeling when I developed psychosis and look at new ways of coping in future situations.

“With the continued support of EIP across three years I feel like ‘me’ again; I have recently been discharged from the service and am no longer on any medication. I am very ambitious in my career, working full time for the last 2.5 years and am enjoying being a first-time mum to my 10-month old baby.”

Source: Taken from the Early Youth Engagement (EYE) in First Episode Psychosis project.^{1 2}

1.1 Document purpose

This guide is intended to support local implementation of the EIP access and waiting time standard by commissioners and mental health providers. This document was originally published in 2016, and **was** subsequently updated in 2020 **(and again in 2022)** to reflect the new ambitions in the [NHS Long Term Plan](#) and [NHS Mental Health Implementation Plan 2020/21-23/34](#), as well as experience gained in the first five years of implementation.

To support the refresh of this guidance NHS England convened an expert reference group (ERG), which has provided clinical, operational, and lived experience expertise. See Appendix 2 for details of the ERG membership.

1.2 The early intervention in psychosis access and waiting time standard

The Five-Year Forward View for Mental Health (FYFVfMH) set the ambition that by 2021, at least 60% of people with a first episode psychosis would start treatment with a NICE-recommended package of care with a specialist early intervention in psychosis service within two weeks of referral.

The [NHS Long Term Plan](#) specifies that all areas should commission services in line with this guidance, providing a service that covers an age range of 14-65 and has a provision with an 'at-risk mental state' (ARMS).

The EIP access and waiting time standard is 'two-pronged' and both conditions must be met for the standard to be deemed to have been achieved:

1. A maximum wait of two weeks from referral to start of treatment
2. Treatment delivered in accordance with NICE guidelines and quality standards for psychosis and schizophrenia – either in children and young people [CG155 \(2013\)](#) and [QS102](#), or in adults [CG178 \(2014\)](#) and [QS180](#).

The approach to measurement of performance against the standard has been designed to ensure that both elements can be assessed and that outcomes (clinician and service user reported) are routinely collected and reviewed.

1.3 Expectations of commissioners and providers

The [NHS Long Term Plan](#) and associated [NHS Mental Health Implementation Plan](#) re-affirm the NHS's commitment to ensure that all people experiencing first episode psychosis are able to access NICE-concordant care, this includes children and young people (aged 14 and above), as part of the commitment to develop a comprehensive 0-25 offer.

Commissioners are responsible for ensuring that local plans are developed and implemented in collaboration with service users and their families or carers, as well

as the local mental health provider and partner organisations, including voluntary and third sector organisations, drug and alcohol commissioners and providers and local authorities (social care, housing, debt, benefit advice, employment and education) to provide a framework for collaborative action.

The reduction of inequalities in access and outcomes should be central to the development of EIP services. Local commissioners must make explicit in their plans how they have taken into account the duties placed on them under the [Equality Act 2010](#) and their duties with regard to reducing health inequalities as set out in the [Health and Social Care Act 2012](#). Service design and communications should be appropriate and accessible to meet the needs of diverse communities (see [Guidance for Commissioners on the Equality and Health Inequalities Duties](#)).

2. What is first episode psychosis and why is rapid access to effective treatment so important?

2.1 Experiences of first episode psychosis: a service user and carer perspective

“My first experience of psychosis occurred when I left home to go to university. This was a sudden change and there was a heavy party culture there involving late nights and increased alcohol consumption. This on top of the stress of a heavy workload all contributed to triggering my first episode of mania which led to psychosis.

“Although I had previously suffered from depression since my early teenage years this episode led to my current diagnosis of bipolar affective disorder. In this manic state I started behaving erratically, spending large amounts of money and having endless energy, racing thoughts and elated mood. This led to me staying up all night, feeling no need for sleep. I had new found confidence and would talk excessively at a fast pace about unusual and irrelevant things.

“This obvious change in behaviour concerned my friends who tried to talk to me but at that point I was in denial anything was wrong. However soon this developed into psychosis where I had paranoid and delusional thoughts that someone was out to harm me. I became increasingly scared and whenever I heard sirens outside, I thought they were relating to me. The whole experience was incredibly scary and distressing as even though the thoughts and feelings had no basis, they felt very real to me at the time.”

Source: Taken from the Early Youth Engagement (EYE) in First Episode Psychosis project.^{1 2}

“When my daughter first became ill, she was unreachable. She was in a place that I didn’t recognise. At first, she wasn’t able to communicate at all; she was completely mute. Little by little she found the ability to start talking and spoke about events that had apparently happened to her.

“I recognised some of the real- life events that had been incorporated into her own version, but when she related an incident where she was in a police station being beaten up and she could hear me outside saying ‘Stop, stop, they’re really hurting her’, I knew that hadn’t happened. But to her it was as real as any other event. I felt that she was very lost and I wasn’t able to help her.

“I remember feeling that I was completely out of my depth. It was as if my daughter had been taken over and I no longer knew her, I no longer knew what was happening to her. But it was very obvious that she was in extreme psychic pain. Her stories didn’t make sense to me, although they did seem to link, in her mind, to what she had been through. To me, she displayed every sign of somebody who had been traumatised and that this was post-traumatic stress. At that stage I think we both needed help.”

Source: Taken from the Early Youth Engagement (EYE) in First Episode Psychosis project.^{1 2}

2.2 Expectations of commissioners and providers

Table 1 provides an overview of the clinical definitions for first episode psychosis and ARMS:

Table 1: Clinical definitions for first episode psychosis and ARMS

First episode psychosis	<ul style="list-style-type: none">• Term used to describe the first time a person experiences a combination of symptoms known as psychosis.• During an episode of psychosis, a person’s perception, thoughts, moods and behaviour are significantly altered: each individual’s experiences are unique and will include a combination of symptoms.• Core clinical symptoms ‘positive’, ie they are added experiences, including hallucinations and delusions.
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	<ul style="list-style-type: none"> • Core clinical symptoms ‘negative’, ie where something is reduced, such as emotional apathy, lack of drive, poverty of speech, social withdrawal and self-neglect. • Common mental health problems eg anxiety and depression may also be present, as well as co-existing substance misuse.
At-risk mental state (ARMS)	<p>Prior to an episode of psychosis, many people will experience a period of symptoms, which is described as having an ‘at-risk mental state’ (ARMS), which may include:</p> <ul style="list-style-type: none"> • an extended period of attenuated psychotic symptoms • an episode of psychosis lasting less than seven days • an extended period of very poor social and cognitive functioning (perhaps accompanied by unusual behaviour, including withdrawal from school or friends and family) in the context of a family history of psychosis.

2.3 How common is first episode psychosis?

Incidence rates refer to the number of new cases during a given period. The predicted incidence for the whole of England (for ages 16-64) in 2020 is 25.2 per 100,000.³ However, it is important to note that incidence levels can vary significantly from one area to another according to age, sex, ethnicity, population density and social deprivation.

For this reason, studies conducted to date in England have tended to be conducted in more urban settings and have reported a higher incidence rate of 31.7 per 100,000.⁴ The [PsyMaptic](#) prediction tool takes these issues into account to provide estimates of future incidence of psychotic disorders for [local systems of care](#) in England up to 2025.⁵

First episode psychosis occurs most commonly between late teens and late twenties, with more than three quarters of men and two thirds of women experiencing their first episode before the age of 35.⁶ This means that areas serving younger populations (eg areas with higher education colleges and universities) may have higher rates of psychosis.

Some people will also experience an onset of psychosis before the age of 16 years, with an additional peak in incidence in women in their mid-to-late 40s.⁷ Local planning should take into account incidence across the life course, as well people experiencing an ARMS.

Higher rates have also been found across several ethnic minority groups, notably migrants and descendants of Black Caribbean and Black African origins. Geographically, the incidence rates of psychosis are also higher in more urban, more deprived and more densely populated settings.⁸

2.4 What is the impact of not having timely access to effective treatment?

Psychosis and psychotic disorders can be extremely debilitating. A long duration of untreated psychosis is associated with poorer personal recovery, increased service use and poorer economic outcomes in both the short and long term.⁹ People who do not access effective treatment quickly are far more likely to experience poor physical health, lower levels of social functioning, poorer occupational and educational outcomes and increased contact with the criminal justice system.

- In the UK, only 8% of people with schizophrenia are in work, despite many more being willing and able to work.¹⁰
- If untreated or poorly treated, psychosis can become a long-term condition with high levels of relapse, high rates of inpatient admission, increased detentions under the [Mental Health Act](#) and high rates of comorbid physical health conditions.
- For society, the current cost of psychosis is estimated to be £11.8 billion per year. This results from direct healthcare costs, lost productivity due to unemployment or death and informal costs to families and carers. There are significant gains to be made by ensuring that people experiencing psychosis for the first time have rapid access to effective, evidence-based treatment.

People with severe and prolonged mental illness (diagnoses that usually involve psychosis, such as schizophrenia and bipolar disorder) are at-risk of dying on average 15 to 20 years earlier than the general population,¹¹ this is largely because of preventable physical health conditions, including cardiovascular disease and smoking. This is further exacerbated by the effects of antipsychotic medications

which can increase appetite, resulting in rapid weight gain, increase lipids and risk of type 2 diabetes, and ultimately, cardio-metabolic disturbances.

Two-thirds of these premature deaths are from avoidable physical illnesses, including heart disease and cancer, many caused by smoking. This is one of the greatest health inequalities in England. People with psychosis are three times more likely to attend A&E with an urgent physical health need and almost five times more likely to be admitted as an emergency.¹²

Furthermore, people experiencing psychosis are at particularly high risk of suicide. Most suicides occur in the early years of illness and, as such, EIP teams are uniquely placed to support people at risk of suicide and prevent avoidable deaths.¹³

2.5 What are the benefits/ impact of having timely access to effective treatment?

Recovery from a first episode of psychosis is possible; if people of all ages, in particular children and young people receive the right treatment at the right time from an EIP service they can go on to lead full, hopeful and productive lives.

- People experience improved outcomes when receiving care from an EIP service compared with standard care. Improved outcomes can be facilitated by the positive, therapeutic relationship with a care co-ordinator.¹⁴
- Evidence shows that early treatment with CBT can prevent at-risk mental states from developing into first episode psychosis.^{15 16}
- Family intervention has been shown to improve outcomes significantly, predominantly through supporting the family to understand the experience of psychosis and to respond appropriately,¹⁷ resulting in relapse rates reducing by 40%.
- There is evidence that CBTp reduces rehospitalisation rates and length of stay, reduces symptom severity and can improve social functioning. There is also a strong indication that it reduces symptomatology and has a positive effect on social functioning.¹⁸
- In the long term, a 10-year follow-up study reported higher rates of symptomatic recovery (50%) and a 90% reduction in risk of unnatural-cause mortality when full family involvement was present at the first contact.¹⁹

- In the short and long term, supported employment appears to improve employment outcomes, functioning and quality of life.

The short and longer-term economic benefits of EIP services are significant, with estimated net cost savings of £7,972 per person after the first four years, and £6,780 per person in the next four to 10 years if full EIP provisions are provided. Over a ten- year period this would result in £15 of costs saved for every £1 invested in EIP services. Most of these cost savings can be attributed to:

- the reduction in use of crisis and inpatient services
- improved employment outcomes, and
- the reduction in risk of future hospitalisation because of improved management and reduced risk of relapse.

Economic data from the South London and Maudsley NHS Foundation Trust EIP demonstration sites for the Improving Access to Psychological Therapies – Severe Mental Illness (IAPT-SMI) programme suggest that, despite the increased cost of therapy, the provision of NICE-recommended psychological therapy within EIP services is cost effective. This comes from reduced inpatient costs during the course of therapy and improvements in quality of life and employment status post-therapy.

2.6 What is an EIP service?

An EIP service is a multidisciplinary community mental health service that provides treatment and support to people experiencing or at high risk of developing psychosis. This support typically continues for three years.

The defining characteristic of an EIP service is its strong ethos of hope and whole-team commitment to enabling recovery through the provision of effective, individually tailored, evidence-based interventions and support to service users and their families/carers.

A service user and carer/family perspective: key components of a high quality EIP service – based on NICE guidelines

- ✓ **Timely assessment** completed by a practitioner competent in recognising First Episode Psychosis, accessed via a readily accessed point of contact.
- ✓ Practitioners who instil **trust and confidence**.
- ✓ Provision of **helpful information** to support an understanding of psychosis and treatment options
- ✓ A **care coordinator** who will support throughout time in the service. This includes: helping with self-management skills; social care issues such as housing or debt management; and relapse prevention work.
- ✓ A choice of **psychological and pharmacological interventions**.
- ✓ Support, information and advice **for families and carers, including carers' assessments where required**.
- ✓ Support with **employment, training and / or education**.
- ✓ Regular **physical health checks, monitoring and appropriate treatment**, with support and / or education.
- ✓ Regular risk monitoring.
- ✓ Routine monitoring of other **co-existing conditions, including depression, anxiety and substance misuse**, particularly in the early phases of treatment
- ✓ A **crisis plan and prompt service response** to help them to manage when in crisis
- ✓ NICE also recommends **assertive community treatment where needed**

2.7 Relevant NICE guidelines and quality standards

The following NICE guidelines and their accompanying quality standards are directly relevant to the provision of EIP services:

- [Psychosis and Schizophrenia in Children and Young People NICE guideline](#)
- [Bipolar Disorder, Psychosis and Schizophrenia in Children and Young People NICE quality standard](#)
- [Psychosis and Schizophrenia in Adults NICE guideline](#)
- [Psychosis and Schizophrenia in Adults NICE quality standard](#)

The key requirements of the quality standards (the individual statements) are summarised in the table below. Tables providing further detail regarding the interventions recommended by NICE can be found in appendix 3.

	Children and young people quality statements	Adults quality statements
Maximum waiting time from referral to treatment	Children and young people who are referred to a specialist mental health service with a first episode of psychosis start assessment ⁱ within two weeks.	Adults with a first episode of psychosis start treatment in early intervention in psychosis services within two weeks of referral.
Psychological therapy	<p>Children and young people newly diagnosed with a first episode of psychosis and their family members are offered family intervention.</p> <p>Children and young people newly diagnosed with bipolar depression or a first episode of psychosis are offered a psychological intervention.</p>	<p>Family members of adults with psychosis or schizophrenia are offered family intervention.</p> <p>Adults with psychosis or schizophrenia are offered cognitive behavioural therapy for psychosis (CBTp).</p>
Support for carers and families	Parents and carers of children and young people newly diagnosed with bipolar disorder, psychosis or schizophrenia are given information about carer-focused education and support.	Carers of adults with psychosis or schizophrenia are offered carer-focused education and support programmes.

ⁱ The QS102 Committee reasoned that it was not appropriate to say ‘start treatment’ within two weeks of being referred because many children and young people will need to undergo a period of assessment before a diagnosis can be made and treatment can be started. Please note, however, that the ‘Early Intervention in Psychosis Access and Waiting Time Standard’ is for people aged 14 -65 and treatment will be deemed to have commenced when the person:

- has had an initial assessment, AND
- has been accepted on to the caseload of an EIP service capable of providing a full package of NICE-recommended care, AND
- has been allocated to and engaged with an EIP care co-ordinator.

	Children and young people quality statements	Adults quality statements
Physical health and healthy lifestyles	Children and young people with bipolar disorder, psychosis or schizophrenia are given healthy lifestyle advice at diagnosis and at annual review.	Adults with psychosis or schizophrenia are offered combined healthy eating and physical activity programmes and help to stop smoking. Adults with psychosis or schizophrenia have specific comprehensive physical health assessments.
Medicines management	Children and young people with bipolar disorder, psychosis or schizophrenia prescribed antipsychotic medication have their treatment monitored for side effects.	Adults with schizophrenia who have not responded adequately to treatment with at least two antipsychotic drugs are offered clozapine.
Education, employment and training	Children and young people with bipolar disorder, psychosis or schizophrenia have arrangements for accessing education or employment-related training included in their care plan.	Adults with psychosis or schizophrenia who wish to find or return to work are offered supported employment programmes.
Crisis care	Children and young people with bipolar disorder, psychosis or schizophrenia who are in crisis are offered home treatment if it is suitable.	

EIP services are also expected to continue to offer care and treatment to people with psychosis who may go on to receive a diagnosis of bipolar disorder or unipolar psychotic depression. Therefore, depending on the emerging diagnosis, other guidelines and quality standards might also be relevant to the continuing treatment of people accessing EIP services, including:

- [Bipolar Disorder in Adults NICE quality standard](#)
- [Bipolar Disorder NICE guideline](#)
- [Antenatal and Postnatal mental health quality standard](#)
- [Antenatal and Postnatal mental health guideline](#)
- [Depression in Children and Young People NICE quality standard](#)
- [Depression in Children and Young People NICE guideline](#)
- [Psychosis and Coexisting Substance Misuse NICE guideline](#)
- [Depression in Adults NICE quality standard](#)
- [Depression in Adults NICE guideline](#)
- [Service User Experience in Adult Mental Health Services NICE quality standard](#)
- [Service User Experience in Adult Mental Health NICE guideline](#)
- [Anxiety disorder NICE quality standard](#)
- [Post-traumatic stress disorder](#)
- [Rehabilitation for Adults with Complex Psychosis NICE guideline](#)

2.8 Other key functions of EIP services

2.8.1 Supporting identification of psychosis and rapid referral

Failure to identify first episode psychosis and refer appropriately to EIP services can have a significant detrimental impact on service user experience and outcomes.

There are still too many instances of people with first episode psychosis accessing mental health services for the first time only when they reach crisis point. Another common scenario is that the person is initially referred to generic community mental health services (adult or children and young people's), resulting in an increase in delay and the duration of untreated psychosis as the person will not commence the right expert treatment and is more likely to disengage with mental health services.²⁰

Due to these complexities for some people it is important to offer an extended assessment. This can be up to three months so that the team can make use of the time to fully understand the key difficulties a person is experiencing and decide upon the most appropriate care pathway. It is important to note that the extended assessment pathway and the at-risk mental state pathway have similarities but are in fact quite different.

There are several reasons why identification of psychosis in people of all-ages may be impaired or delayed:

- the clinical signs, which may not be easily identifiable, are often missed; a [guide](#) is available to aid referrers if they suspect psychosis to enable prompt access to services.²¹
- there may be other comorbid health problems that disguise or compound symptoms, for example when a child or young person has a learning disability or autism or where psychotic experiences are attributed to trauma or substance use.
- people may not seek help from mental health services, or fully disclose their experiences, because of stigma, lack of insight or distrust of services that are not attuned to youth culture or the cultural characteristics of the communities they serve.
- due to transitions (such as moving to university) there may be difficulties in communication between services and concerned families and friends.

People who are experiencing psychotic symptoms related solely to substance use may be best supported in another part of the core community-mental health offer. Clinicians should work alongside the individual to agree the most appropriate place for the individual to receive care and support.

Supporting referrers and colleagues to identify first episode psychosis and refer appropriately and rapidly is an important function of any EIP service

- In addition to clinical protocols between EIP teams and generic community mental health services, it is especially important that there are regular liaison and training arrangements with community children and young people's mental health services. This will help to ensure that they are well equipped to identify first episode psychosis and ARMS in young people and can confidently refer rapidly and appropriately to **an EIP team**.

2.8.2 Recognising and addressing co-existing health problems

A person may experience first episode psychosis with several comorbidities, including other mental health problems. This can impact directly on health outcomes and indirectly by introducing potential barriers to care. It is vital, therefore, that any coexisting problem is recognised and addressed.

Mental health problems

Co-existing mental health problems are extremely common for people of all ages with psychosis; for example, anxiety disorders and/or depression are present in over 50% of first episode psychosis patients and can have significant impact on recovery.^{22 23}

Around 40% of people with first episode psychosis misuse substances at some point in their lifetime. As a result, people may present under the influence of a range of substances, including alcohol, cannabis, cocaine or amphetamines.²⁴

People of all ages with psychosis may also present with history of trauma. This may include emotional, physical and/or sexual trauma and a range of other adverse life experiences.^{25 26}

Neurodevelopmental disorders are common in children and young people presenting with psychosis. It has been estimated that in childhood-onset psychosis, premorbid autism is present in 28-55% of children^{27 28} and extremely low premorbid IQ (lower than 70) has been found in 30%.²⁹

An EIP service should comprise of staff who have experience and skills in working with people who have co-occurring problems with substance misuse, a history of trauma and neurodevelopmental disorders. This should include clinicians with expertise in working with children and young people.

Physical health problems

People with psychosis often have poor physical health.³⁰ This is the primary cause of premature mortality and higher rates of death in this population. Being exposed to antipsychotic medication for the first time can make people particularly vulnerable to side effects, such as rapid weight gain^{31 32} and adverse cardio-metabolic disturbance.³³ A combination of weight gain, poor diet and nutrition and lack of physical activity can also lead to high rates of illnesses such as diabetes and cardiovascular diseases.³⁴

Other key physical health issues for people with first episode psychosis include:

- an increased risk of smoking and substance misuse^{35 36}
- poor access to physical healthcare in both primary and secondary care.³⁷
- low rates of recognition of physical health symptoms are often ignored because of a co-occurring psychiatric diagnosis.³⁸

This highlights the importance of EIP services meeting the requirements of NICE quality standards in relation to physical health and healthy lifestyles. Services that do not meet these quality standards are not delivering care in line with NICE-recommendations.

2.8.3 Support with social issues

After an acute episode of psychosis, there is an increased likelihood of social adversity, poverty, loneliness and social isolation, unemployment and homelessness, which can impair and slow recovery. Social issues such as housing, debt, benefit advice, employment or education as well as the strength of cultural and community support are often central to the lives of people experiencing psychosis.

EIP services should be equipped to address these important care needs and work closely with local government, social care workers and other agencies to address any key social care needs to ensure people with psychosis, their families and carers can access additional support, as outlined in the [Care Act 2014](#).

2.8.4 Families and carers

Families and carers play an invaluable role in helping people to recover from psychosis. It is vital that this is acknowledged, valued and supported, both in terms

of recognising families and carers as expert partners in care and in ensuring that they can access support both as individuals and in their caring role.

“Faced with the turmoil of a loved one’s emerging psychosis, their very first experience of specialist mental health services is pivotal for carers. Repeated failed attempts to get help from a service which seems indifferent to the needs of their family member or close friend will never be forgotten... but get that initial encounter right and the way is paved for a positive collaborative relationship with the carer(s) which may prove crucial to the ongoing care and recovery of an individual.”

Source: A carer, 2015.

NICE Guidelines (CG 178) recommend that carers of people with first episode psychosis should be offered a carer-focused education and support programme as soon as possible (QS 80 ref).

Programmes should provide information about psychosis and its treatment and provide support (including access to mutual support through group forums) to help people manage their caring role and to provide a positive message about recovery.

While Family Intervention, referral for a carer’s assessment and carers’ involvement in the planning and delivery of care are all important, a carer-focused education and support programme would be regarded as distinct from these. The principle aim is to support carer resilience and to equip carers with the knowledge, information and resources to fulfil this vital role.

There should be an explicit resource actively promoted to all carers. A programme can be delivered in groups or individually and will typically (but not exclusively) include:

- orientation to the EIP service
- understanding psychosis and its causes
- treatments available, including psychological therapies
- medication and side-effects
- recovery approaches
- managing different symptoms/unusual experiences
- dealing with difficult behaviours

- substance misuse
- staying well/ relapse prevention/early warning signs
- accessing help during a crisis
- carer health and wellbeing
- carer rights and carer's assessments
- carer support and local/external resources
- discharge (and for some, transition to other services).

The carer-focused education and support programme offer should be reviewed regularly to ensure that it meets the needs of families and carers as the service user's needs change.

Where a carer is identified who appears to have a need for support, it is likely that the carer will be entitled to an assessment of their needs by the local authority under the Care Act 2014 (or the Children and Families Act 2014 in the case of a child carer or parent carer of a child experiencing psychosis), and may receive support in their own right.

This assessment is not reliant on whether the person they care for has any care and support needs. Arrangements should be put in place to support signposting to relevant local authority services so that assessments may be carried out.

2.9 The EIP workforce

Having the right EIP workforce with the right skills is essential to ensuring that care can be delivered in line with NICE recommendations. EIP services are multidisciplinary and the key staff roles, functions and necessary competencies are described below.

EIP services should be provided by a team of staff, with specialist knowledge and appropriate training in working with people with psychosis. Teams should work in a truly holistic way to support the individual. A workforce tool developed by Health Education England is available to support planners with designing their [workforce and skill mix](#). All staff should have specialist knowledge and should have appropriate training to work with people with psychosis.ⁱⁱ Table 2 provides an overview of the key roles within EIP teams:

ⁱⁱ <https://www.nice.org.uk/guidance/CG178/ifp/chapter/Your-care-team>

Table 2: Key roles within EIP teams

Role	Functions and necessary competencies
Care co-ordinator	<ul style="list-style-type: none"> • Skilled in engagement and working with a biopsychosocial formulation (ie supporting people across the spectrum of their biological, psychological and social needs), and function as part of a multidisciplinary team and utilise recovery-based approaches to care planning. • Work flexibly and creatively with people in order to achieve their individual goals, supporting them across a range of health and social care needs, including housing, benefits and debt advice. • A mix of care co-ordinators is recommended which come from a range of professions but typically will be nurses, occupational therapists, social workers. Care co-ordinators may also deliver family intervention if they are trained and supervised in their delivery. Care co-ordinators working with CYP should have specific CYP knowledge and experience, including the wider services supporting them, including education and local authority children’s services & social care. • Evidence shows that lower caseloads for care co-ordinators support greater client involvement and can improve service user outcomes. The EIP workforce calculator can be used to support areas to assess local workforce requirements.
Psychiatrist	<ul style="list-style-type: none"> • Dedicated consultant psychiatrist input is essential,³⁹ to provide both direct service user contact and to support to the multidisciplinary team (MDT). Consultant should be involved whenever there are doubts or conflicting opinions about diagnosis, safety or prescribing. • Medical team members should proactively be involved in clinical assessment, particularly if other members of the workforce complete the face-to-face assessment. • All EIP services providing to under 18’s should include a consultant psychiatrist with training in child and adolescent mental health • Should also be involved in decisions about acceptance on to caseload and discharge especially where this is unplanned.

Psychological therapist/ Clinical psychologist	<ul style="list-style-type: none"> • Psychological therapists and clinical psychologists should have had formal training in CBT for psychosis and/or family intervention and be assessed as having the competencies to deliver these interventions, in line with the available competency framework. • Psychological therapists and clinical psychologists in CYPMH services offering an EIP response should also have had formal training in CBT for psychosis and/or family intervention for psychosis. • All staff delivering psychological therapies must have regular clinical supervision from a suitably qualified supervisor.
Education and employment specialists	<ul style="list-style-type: none"> • Education and employment specialists are skilled in supporting people in work, training or education, with an emphasis on employment or education as a primary goal. These workers should be an integral part of the clinical team, not an external resource. Competencies and attitudes should include high levels of initiative, empathy and persistence with specific knowledge of the local job market. There is some evidence that workers should be trained in motivational interviewing to help people achieve better long-term outcomes.⁴⁰ • Those working with young people should have training in working with those who have additional learning needs as a result of atypical neurodevelopment. • As part of a comprehensive package of NICE care, individuals should be able to access Individual Placement and Support (IPS), either via the secondary mental health service or via other locally commissioned services.
Peer-support workers	<ul style="list-style-type: none"> • Lived experience of mental distress and work alongside others with mental health difficulties to support one another, peer support is based on shared understanding, respect and mutual empowerment between people in similar situations. • Peer support workers add to the skill mix of a team by offering a type of relational work that complements the learned expertise of their clinical colleagues. People with lived experience of accessing Early Intervention in Psychosis services or of caring for someone who uses these services (Experts by Experience) can be well suited to the role of peer support worker.

Social workers	<ul style="list-style-type: none">• As care co-ordinators, social workers focus on personalisation and recovery to support people to make positive, self-directed change.• Trained to work in partnership with people using services, their families and carers, to optimise involvement and find collaborative solutions
Clinicians with expertise for working with children	<ul style="list-style-type: none">• Teams should include as an integral part of the service, clinicians (particularly clinical psychologists and child and adolescent psychiatrists) who should also have specialist neurodevelopment assessment and management skills and an understanding of the role of trauma, including that experienced by looked-after children.

2.9.1 Other staffing

Teams will require sufficient management and administrative support. Support workers and peer support workers should also form part of the workforce and EIP service users should have access to specialist mental health pharmacists and occupational therapists.

Teams working with children and young people will also need to include clinicians (particularly clinical psychologists and child and adolescent psychiatrists) who will also offer specialist neurodevelopmental assessment and management skills and an understanding of the role of trauma including that experienced by looked after children.

2.10 A service user perspective

“I encountered Early Intervention services in 2011 while I was taking a year out of university. I had travelled to Thailand and after the third week there I started getting symptoms of paranoia that led to a psychotic episode where I saw, heard and smelled things that weren’t real. I was travelling alone so I was scared by these experiences which seemed very real at the time. I was very anxious and did not understand how I could carry on in the world if these things were real.

“When back in England, I thought that my family were imposters with Thai people in their bodies. I did not trust them and didn’t eat or drink anything they gave me or want to leave the house. It was a stressful time for all of us and my family contacted the GP. The GP and crisis team assessed me and I was taken to hospital on a section of the Mental Health Act.

“After 4 weeks of being in hospital I was introduced to the Early Intervention service. They looked after me through my hardest times and empowered me to understand my experiences, look after myself and pursue my goals. I took medication and had some side effects, but I was given choice and control over what medication I took to limit side effects and maintain my health.

“CBT therapy helped me to challenge my thoughts and understand my condition through identifying early warning signs and triggers. Under their guidance I recovered from psychosis.

“I wrote this in 2016 and it is now 2020. I was able to get my psychology degree and my journey has continued through and out of services. I now inform clinical psychology teaching and influence the national clinical audit of psychosis from a service user perspective. I am doing a PhD in Psychology and realising my goal of going from Psychosis to Psychology.

“My journey of recovery has not always been linear, and I have experienced relapses, but I have been able to apply the skills and tools learned from Early Intervention services to maintain my mental health. I found discharge difficult and think there need to be a clearer pathway back into services for patients deteriorating or relapsing prior to risk levels increasing.

“Early intervention in Psychosis helped in my recovery. Early intervention is key and should be available to all who need it, when they need it. In 2021, ten years after my first episode I plan to return to Thailand to create some more positive memories.”

Source: My Story: From Psychosis to Psychology

2.11 EIP service models

There are two models for EIP service delivery: stand-alone and hub and spoke. In a stand-alone service, the team works independently from the generic community mental health teams (CMHTs) and care co-ordinators assertively outreach to people when they are experiencing first episode psychosis. There is a clear evidence base for the delivery of EIP in a stand-alone model. Research shows these teams are more clinically and cost-effective, and better able to implement NICE-recommended interventions.

The hub and spoke model is one where some EIP staff members ('spokes') are based within generic CMHTs and link to an EIP 'hub' for access to specialist skills, support and supervision. The evidence for these teams is limited as there are significant risks associated with this model, including:

- isolation of EIP workers
- limitations in clinical supervision
- lack of availability for trained therapists
- issues with travel time

- abrupt or gradual increases in caseloads.

Hub-and-spoke models may however be appropriate for very sparse, rural areas where there may be issues with providing a stand-alone EIP function.

Regardless of the locally agreed model, systems should consider how the EIP service is a key function of the new and integrated models of primary and community mental health care, as articulated in the [NHS Long Term Plan](#).

Considerations for children and young people

All children and young people, aged 14 and above, experiencing first episode psychosis should receive a comprehensive package of NICE concordant care within two weeks of referral to a specialist service. **For the purpose of calculating waiting times,** a specialist service includes any team that is identified as delivering a component of the locality's specialist EIP response which must be comprehensive across the full 14 to 65 years age range.

As set out in the [NHS Long Term Plan](#) and the [LTP Mental Health Implementation Plan 2019/20-2023/24](#), children and young people accessing EIP services should have a seamless experience of NICE concordant care; all services supporting children and young people, between the ages of 14 to 18, with first episode psychosis, should be able to support them for at least the duration of the full three years, avoiding premature transitioning to alternative services.

As services have extended their upper age range to 65 years, commissioners and providers may wish to also consider the refinement or development of EIP services. This would facilitate a focus on CYP and young adults aged 14 to 25 years, reflecting the NHS Long Term Plan ambition for a new approach to young adult mental health services for people aged 18 to 25 which will support the transition to adulthood and improve outcomes across the life course.

Table 3 below sets out key considerations for providing care to children and young people aged 14 and above. While the evidence base is limited for children and young people under the age of 14 experiencing first episode psychosis, due to the low incidence, many of the principles of care and support set out below would be relevant to their care and support within children and young people's mental health services:

Table 3: Key considerations for providing care to children and young people aged 14 and above

Area	Detail
NICE concordant care	<ul style="list-style-type: none"> • Evidence based interventions should be offered routinely: assessments and interventions should be delivered in line with NICE guidelines. • Staff should be competent in delivering interventions and working with families and carers, as well as providing support with social needs.
Workforce	<ul style="list-style-type: none"> • Practitioners working with children and young people should have necessary training, expertise and support in children and young people’s mental health, as well as the required competencies in delivering EIP interventions. • EIP services should include practitioners with expertise in identifying neurodevelopmental disorders in children and young people in the presence of psychosis⁴¹ and make reasonable adjustments to their service, including communication preferences, to facilitate vocational and educational recovery and social functioning. • Staff should also be fully competent in safeguarding procedures and working with colleagues from social care.
Collaboration	<ul style="list-style-type: none"> • There should be a strong interface and relationship between children and young people’s mental health services and EIP teams. • Expertise in working with children and young people and their families or carers is integral. • Joint working protocols are essential to support close working.

Education and training

- Access to, and participation in education and training is a crucial aspect of recovery and fulfilling children and young people's potential as adults.
- There should be a strong interface with education to support full access and participation so that the young person can fulfil their potential in education.
- A personalised educational support plan co-produced with the young person and their parent/carers including re-integration after periods of non-attendance which may include an inpatient stay should be developed.
- A named school/college representative should be identified to preserve confidentiality and the dignity of the young person's condition and as a direct communication channel to ensure the young people's needs are supported at school.
- Dedicated educational, training and employment specialists with a primary expertise in this area should be an integral aspect of service provision.

2.12 At-risk mental state

The [NHS Long Term Plan](#) and the [Long Term Plan Mental Health Implementation Plan 2019/20 – 2023/24](#) make it clear that a comprehensive EIP service should ensure that people, including children and young people, with an at-risk mental state have to access to evidence-based care and support.

The waiting time element of the EIP standard requires that anyone with a suspected first episode of psychosis should be referred for assessment. If the person is not experiencing first episode psychosis but may have an at-risk mental state, the clock will stop when:

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

Early detection which focuses on early identification and provision of preventative strategies should be a core activity for mental health services, with the aim of providing a comprehensive and timely assessment, with subsequent care and support where this need is identified.

Evidence suggests that for many people experiencing at-risk mental state, many protective social factors are still intact. For example, people are still engaged in education or work and usually have a range of social contacts and a supportive family group. For the person who develops distressing psychotic symptoms and does not have prompt access to effective treatment, deterioration in family and social life can occur very quickly.⁴²

ARMS provision can also support a reduction in the duration of untreated psychosis (DUP), which is the length of time between the onset of psychotic symptoms and the subsequent detection, diagnosis and commencement of treatment.⁴³

This can be achieved by early case finding but also being able to quickly transfer people into first episode psychosis care if they do transition to a first episode psychosis. Minimising DUP is critical for service users, their families and the team providing care and support.

ARMS provision: key aims and NICE guidance

The overall aim of ARMS provision is to delay or prevent the onset of severe mental health problems, including psychosis, as well as provide a stepped care approach for people experiencing emerging psychotic symptoms. ARMS provision should identify people who are experiencing an ARMS. This is particularly important in children and young people.

Following a comprehensive assessment, evidence-based care, support and interventions should be provided to individuals experiencing an ARMS. Practitioners should be competent in completing a thorough assessment and formulation which also considers the effects on presenting symptoms of adverse childhood experiences, including trauma and neglect, as well as potential learning difficulties and neurodevelopmental conditions.

Table 4 below provides an overview of the NICE guidance for individuals who are identified as experiencing an ARMS:

Table 4: NICE guidance for individuals experiencing ARMS

Component	Children and young people	Adults
Maximum waiting time from referral to treatment	Children and young people who are referred to a specialist mental health service with a suspected first episode of psychosis start assessment within two weeks.	Adults with a suspected first episode of psychosis start assessment within two weeks of referral.
Specialist assessment, ⁱⁱⁱ ie consultant psychiatrist or trained specialist with experience in ARMS	Children and young people’s mental health services or an EIP service provide assessment if a child or young person experiences: <ul style="list-style-type: none"> • transient or attenuated psychotic symptoms; or • other experiences or behaviours suggestive of possible psychosis. 	Suitably trained clinician to provide an assessment if a person is distressed, has a decline in social functioning and has: <ul style="list-style-type: none"> • transient or attenuated psychotic symptoms; or • other experiences or behaviours suggestive of possible psychosis; or first degree relative with psychosis or schizophrenia.
Individual CBT with or without family intervention	Individual CBT with or without family intervention delivered by a trained therapist	Individual CBT with or without family intervention delivered by a trained therapist
Interventions for co-existing mental health problems	To be offered for depression, any of the anxiety disorders, emerging personality disorder or substance misuse, along with individual CBT (with or without family intervention).	To be offered for depression, any of the anxiety disorders, emerging personality disorder or substance misuse, along with individual CBT (with or without family intervention).

ⁱⁱⁱ An example of a comprehensive assessment tool is the comprehensive assessment of at-risk mental states (CAARMS) that identifies people at risk of developing psychosis and outlines a care plan and package of care.

Individuals experiencing an ARMS will require a period of active treatment lasting up to two years. They should be monitored regularly for at least another year after treatment. This means that those with ARMS will be seen for a minimum of two years and a maximum of three years in total. Monitoring should include the use of a structured and validated assessment tool, for example the comprehensive assessment of at-risk mental states (CAARMS).

ARMS provision may also include support for people to live well and maintain their social and family links: including, education and employment support and support to maintain good physical health. Provision may also be made to provide support for carers and families. The current evidence base for providing care and support for people with ARMS is 14 to 35 years. NICE guidance also recommends that individuals with an ARMS should not be prescribed anti-psychotic medication.

Models of care

There are two options for the delivery of ARMS provision: the stand-alone or integrated ARMS model. Commissioners and service leads should work jointly to identify the most appropriate model for their local population. Figure 1 below provides an overview of the key features of different models of ARMS provision, including some of the benefits for each model. Mechanisms should be in place to monitor access rates for all people entering the service, as well the quality the quality of the care and support provided.

Figure 1: Different models of ARMS provision

	Stand-alone	Integrated ARMS pathway	
		Dedicated ARMS caseload	Clinicians with mixed caseload
Model of provision	<ul style="list-style-type: none"> Stand-alone team Require referral from other mental health services Multi-disciplinary, can provide all recommended ARMS care and support Strong links with EIP and other mental health services 	<ul style="list-style-type: none"> EIP team includes dedicated team of care co-ordinators/ clinical staff with ARMS specific cases. Management structures shared across psychosis and ARMS pathways. Access to shared resources and support staff, i.e. psychologists/ therapists and education and employment services 	<ul style="list-style-type: none"> Specific care co-ordinator or clinician has mixed cohort of ARMS and psychosis cases. Shared manager across psychosis and ARMS Access to shared resources i.e. psychologists/ therapists and education and employment support staff.
Benefits	<ul style="list-style-type: none"> ✓ Resources cannot get drawn into EIP ✓ Clarity of focus only on ARMS, including ability to provide specific ARMS provision ✓ Ability to provide input and develop expertise for a wider range of (non-psychosis) outcomes ✓ Wider impact of early detection and prevention of a range of mental health conditions ✓ Reduced potential of iatrogenic harms 	<ul style="list-style-type: none"> ✓ Improved continuity of care for people who are later suspected to have First Episode Psychosis ✓ Support of wider EIP team to manage duty system ✓ Range of skills available for bespoke interventions ✓ Efficiencies from shared tasks i.e. assessment rota 	

3. The access and waiting time standard

3.1 Requirements of the standard

By 2024, 95% of people experiencing first episode psychosis will be treated with a NICE-approved care package^{iv} within two weeks of referral. The standard is targeted at people aged 14 to 65 in line with NICE recommendations.^v

As indicated in the [NHS Mental Health Implementation Plan](#), all areas should ensure there is provision for people with an ARMS.

The standard is ‘two-pronged’ and both conditions must be met for the standard to be deemed to have been achieved:

1. a maximum wait of two weeks from referral to start of treatment, and
2. treatment delivered in accordance with NICE guidelines and quality standards for psychosis and schizophrenia – either in children and young people [CG155 \(2013\)](#) and QS102, or in adults [CG178 \(2014\)](#) and [QS180](#).

The approach to measurement of performance against the standard has been designed to ensure that both elements can be assessed and outcomes (clinician and service user reported) routinely reviewed.

^{iv} Throughout the rest of this tool the term ‘NICE-recommended’ package of care/intervention has been used at the request of NICE.

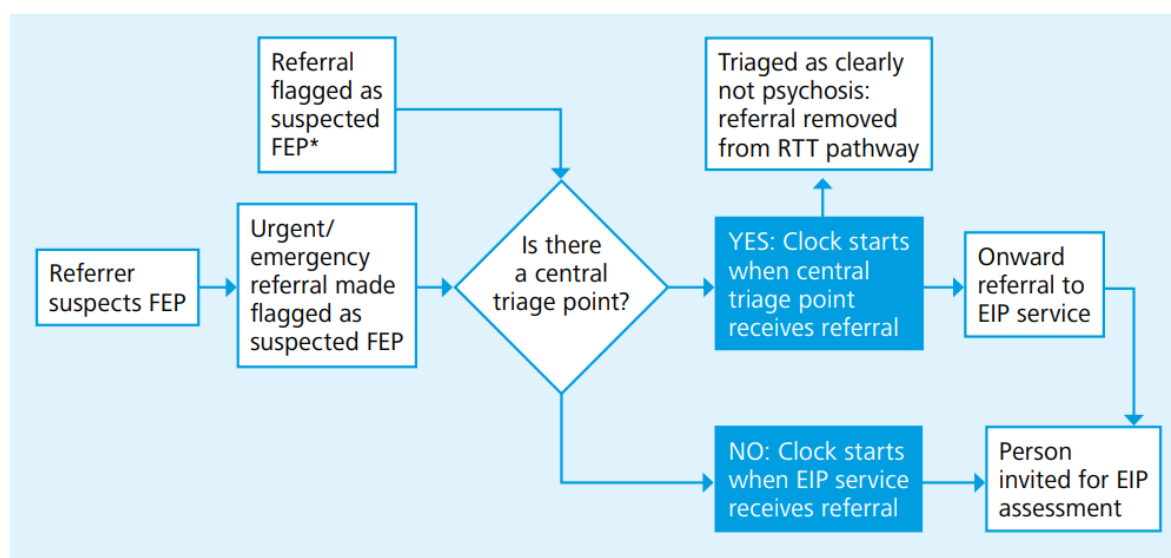
^v EIP services may also be clinically appropriate for people outside the 14-65 age group. Professionals should use their clinical judgement when considering whether people outside the 14-65 age group should be referred to / accepted by EIP services with commissioners and providers ensuring that people are not inappropriately restricted from accessing care

3.2 Measuring and reporting performance against the referral to treatment (RTT) waiting time requirement

3.2.1 Measuring the clock start: referral, recognition and initial assessment

Referral and recognition

Figure 2: Referral to 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.

Key: FEP = first episode psychosis; RTT = referral to treatment

The clock for the two-week pathway starts when a referral has been identified or flagged as ‘suspected first episode psychosis’ or is recognised as such upon receipt. Referrals would usually be made either to a central triage point (‘single point of access’) or direct to an EIP service.

Referrals may come from any source and may be internal (for example from a children and young people’s mental health service, a CMHT, an inpatient ward, prison or forensic mental health services) or external (for example from a GP, carer, school or self-referral).

The key ‘rules’ for this part of the pathway are as follows:

- if a single point of access or triage service receives a referral flagged as ‘suspected first episode psychosis’ this will start the clock

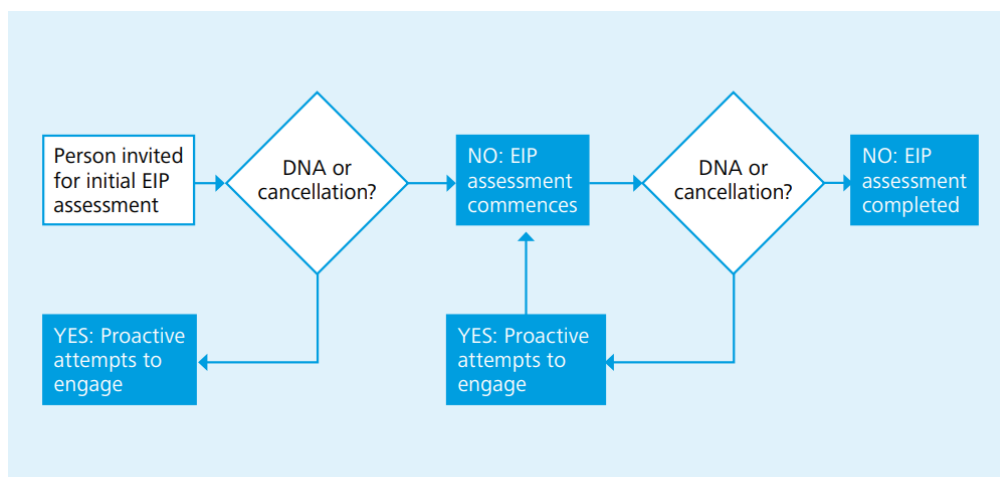
- if a single point of access or triage service receives a referral not flagged as ‘suspected first episode psychosis’, but the person is assessed or triaged as such, this should be flagged and moved on to the first episode psychosis pathway, and the clock will start on the date that the single point 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 EIP service it is triaged as clearly not psychosis, the referral should not enter the pathway or be counted against the access and waiting time standard
- if an EIP service accepts direct referrals, the clock will start from the date the referral is received by the EIP service.
- If a service user within a generic CYPMH service or adult CMHT is identified as suspected psychosis, the clock will start from identification or flagging as ‘suspected first episode psychosis’.

The clock starts regardless of referral source, the age of the person being referred or comorbidities such as learning disabilities, substance misuse, personality disorder or autism.

The only exemptions from these arrangements will be 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 or cysts.

Initial assessment

Figure 3: Initial assessment



Key: DNA = did not attend

Assessment for first episode psychosis should be completed by a competent and qualified professional (see section 3.5.1). Assessments should be completed with the support of the full multidisciplinary team, enabling a team-based formulation of the individual's needs. It is vital for services to work proactively to engage people experiencing first episode psychosis because it is often those who do not engage with services immediately who are most in need of support.

Services must ensure that they engage equally effectively with people from all cultural backgrounds. Non-attendance or cancellations will not stop or pause the clock for the access and waiting time standard.

The first assessment is a critical step in an engagement process upon which therapeutic alliances and interventions are built. However, feelings of ambivalence towards the process are common and natural on the part of service users (and sometimes families and carers too).

Where people referred do not attend or agree to an initial assessment, appropriate contact should be made with the referrer and with families or carers to gather further information and to provide support and advice to them where they have already become involved.

Where families or carers have not been involved, a decision to contact them can be made if a safety assessment of the available information warrants it.

Guidelines on capacity and information sharing should always be followed. If someone aged 16 or over is assessed as lacking mental capacity, steps may be taken in their best interests in accordance with the [Mental Capacity Act 2005](#) and its code of practice.

Attempts must continue to be made to engage the person and make an assessment, including visiting them at home or a mutually agreed location. Depending on the urgency of the situation, this should occur at least twice within the two-week period after referral and more frequently if there are safety issues, if necessary, in collaboration with the crisis resolution home treatment team.

If contact has not been possible, a care co-ordinator should be allocated within the two-week period to continue attempts to complete an assessment and liaise with carers and the referrer. This will not stop the clock but represents good practice.

In these circumstances, if there is enough suspicion about the presence of psychosis that the EIP service continues to work with the family and carers, this may include the allocated care co-ordinator undertaking therapeutic work with the family.

It is important in cases of poor engagement that services continue to make all efforts to engage the service user. This will help to prevent people from 'falling through gaps' and receiving inadequate care, and it can reduce the risk of long-term poorer outcomes and increased use of healthcare resources (and associated costs).

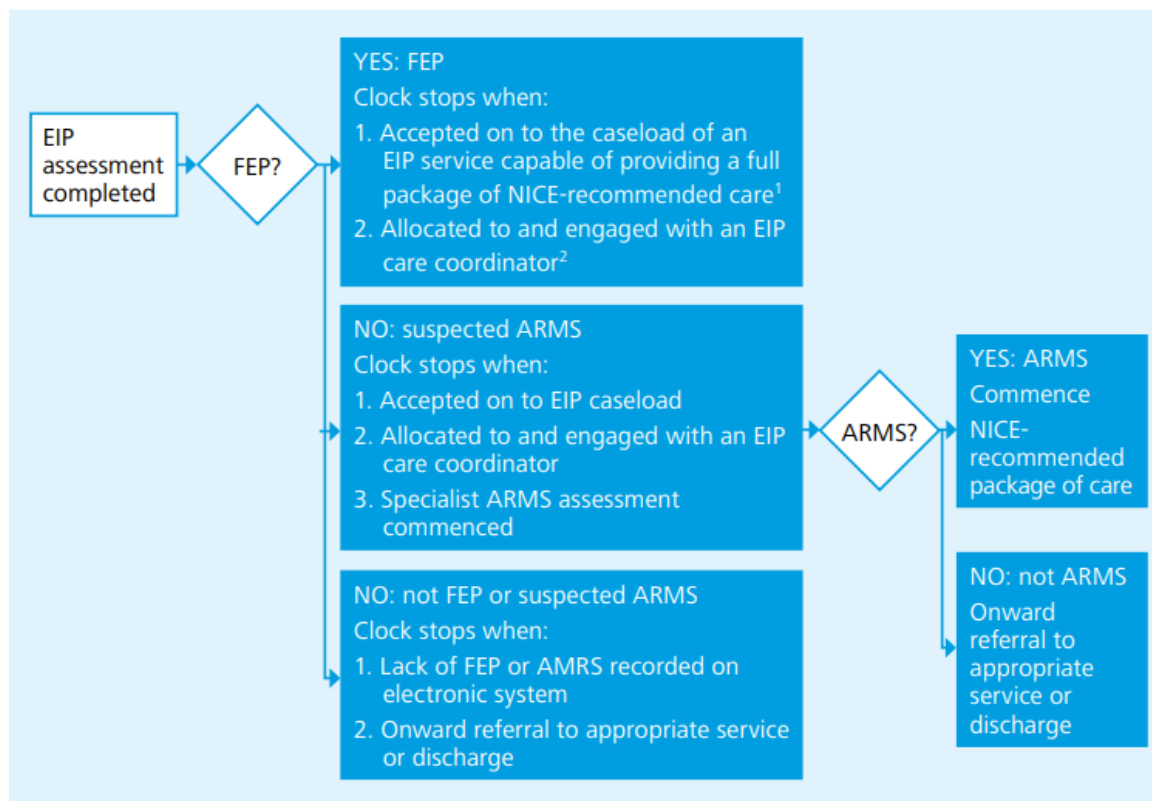
Commissioners should review cases with providers on a six-monthly basis where the service has been unable to assess someone who was referred with a possible first episode psychosis.^{vi} Where contact is not made, discharge from the pathway should only occur with prior agreement of the carer and referrer, and the clock will then stop. In such cases, details should be recorded, and information provided to enable rapid reassessment by the EIP service if necessary.

In scenarios where the individual moves areas (for example, to another county or to university), transfer of care to a local EIP service (or its equivalent) should occur unless it is more appropriate to maintain contact (for example, if the service user returns to the area periodically). In all circumstances, there should be effective communication with primary care.

^{vi} Commissioners and providers will need to work together to ensure that any review uses service user data appropriately and lawfully

3.2.2 Measuring the clock stop: start of treatment

Figure 4: Clock stop



Key: ARMS = at risk mental state; FEP = first episode psychosis; RTT = referral to treatment

Notes:

1. The [Early Intervention in Psychosis Scoring Matrix](#) contains a scoring matrix, comprising three domains and a sub-matrix of three domains. An overall score will be calculated from domains in the scoring matrix only and will not include items in the sub-matrix. Each item, each domain and an overall rating will be scored at one of four levels:
Level 4: Top performing
Level 3: Performing well
Level 2: Needs improvement
Level 1: Greatest need for improvement
2. 'Engaged with an EIP care co-ordinator' means that the care co-ordinator actively engages to form a therapeutic professional relationship with the person and offers treatment to them.

Assessment by the EIP service will ascertain whether the person:

- is experiencing first episode psychosis (see section 2.2.1)
- is not currently experiencing first episode psychosis but may have an at-risk mental state (see section 2.2.2)
- does not have evidence of first episode psychosis or of an at-risk mental state.

If there is any doubt about the presence of psychosis or an at-risk mental state, the person should remain in the EIP service until the diagnosis is clear.

Following completion of the EIP assessment, if the person is experiencing first episode psychosis the clock will stop when:

- the person is accepted on to the caseload of an EIP service assessed as capable of providing a full package of NICE-recommended care,^{vii} and
- the person is allocated to and engaged with an EIP care co-ordinator^{viii} (engagement with the care co-ordinator should begin immediately upon allocation).

If the person is not experiencing first episode psychosis but may have an at-risk mental state, the clock will stop when:

- the person is accepted on to the caseload of an EIP service, and
- the person is allocated to and engaged with an EIP care co-ordinator,^{ix} and
- an at-risk mental state assessment has commenced by an appropriately trained and qualified clinician.

If the person is assessed as not experiencing first episode psychosis or an at-risk mental state the clock will stop, but the service should still ensure that the person is supported to access any further help they need. This could involve:

- discharging the person back to primary care, with advice about next steps, for example, treatment of depression, anxiety or any other common mental health problem
- referring the person to an appropriate mental health service.

^{vii} See Figure 3, note 1.

^{viii} See Figure 3, note 2.

^{ix} See Figure 3, note 2.

If a person's condition is very severe and the risk warrants it, they may first enter an acute care service, such as a crisis resolution and home treatment team, an acute inpatient service or a psychiatric intensive care unit.

In such circumstances the person should be referred to EIP services as soon as acute care services suspect first episode psychosis, in order that (s)he has the same access to NICE-recommended care as those entering EIP services through any other route.

The clock will start at the point of recognition and referral (which should take place simultaneously), and EIP services should assess and begin treatment within two weeks. This may involve EIP services working jointly with acute care services for as long as needed.

3.2.3 Reporting performance against the referral to treatment (RTT) waiting time requirement

Submission of data via the mental health services dataset (MHSDS)

All mental health teams contributing to the EIP, NICE concordant service pathway, including those for children and young people under 18 years of age, should flow data to the MHSDS for the EIP standard and to support the national audit of EIP services.

The MHSDS is a patient-level, output-based, secondary uses data set, which delivers robust, comprehensive, nationally consistent and comparable person-based information for children, young people and adults who are in contact with mental health and learning disability services. As a 'secondary uses' data set it re-uses clinical and operational data for purposes other than direct patient care.

The MHSDS will enable collection, measurement and reporting of the EIP referral to treatment waiting time.

Technical guidance to support data submission to the MHSDS for the EIP standard has been developed and is available alongside this document via the [NHS England website](#).

3.3 Measuring and reporting performance against the requirement that the treatment accessed is in line with NICE recommendations

3.3.1 What is NICE-recommended treatment?

The second 'prong' of the EIP access and waiting time standard requires that the treatment provided is in accordance with NICE recommendations. Section 3.4 sets out the key components of the two NICE guidelines and accompanying quality standards that are directly relevant to the provision of EIP services:

- [Psychosis and Schizophrenia in Children and Young People NICE guideline](#)
- [Bipolar Disorder, Psychosis and Schizophrenia in Children and Young People NICE quality standard](#)
- [Psychosis and Schizophrenia in Adults NICE guideline](#)
- [Psychosis and Schizophrenia in Adults NICE quality standard](#)

NICE recommends that specific therapeutic interventions should be delivered in the context of a holistic and recovery-focused service model as described in section 3.3 and section 3.5. This will require an appropriate workforce with the requisite skills and competencies (see section 3.6) and an effective service model (see section 3.7). This must be fully inclusive of all people, including children and young people, between 14 to 65 years of age.

Measurement of performance will focus upon delivery of the requirements of the above guidelines and quality standards. However, section 3.4 also makes clear the expectation that EIP services should continue to offer care and treatment to people who go on to receive a diagnosis of bipolar disorder or unipolar psychotic depression.

Therefore, depending on the emerging diagnosis, other NICE guidelines and quality standards (listed in section 3.4) might also be relevant to the continuing treatment of people accessing EIP services.

3.3.2 Reporting NICE-recommended interventions using SNOMED-CT codes

The MHSDS includes a mechanism through which NICE-recommended interventions can be reported as part of routine dataset submissions: use of Systematized Nomenclature of Medicine-Clinical Terms (SNOMED-CT) codes.

To submit interventions data in this way, providers firstly need to ensure that their electronic care record systems are developed to allow EIP clinicians to record the therapeutic interventions recommended by NICE that take place during a clinical contact – eg ‘CBT for psychosis’ (see section 3.4 and appendix 3).

Providers will need to develop their electronic care record so that clinicians can record interventions using a set list of activity types (eg making these available via a drop-down menu). The relevant [interventions](#) can be found in appendix 3 and further information can be found in the [MHSDS user guidance](#) and [Recording and reporting on NICE-recommended interventions using SNOMED-CT codes](#).

3.3.3 National Clinical Audit of Psychosis

The [National Clinical Audit of Psychosis \(NCAP\)](#) has been commissioned by the Healthcare Quality Improvement Partnership (on behalf of NHS England) to conduct an annual audit of EIP services’ ability to provide timely access to NICE-approved packages of care.

An assessment framework for the ‘second prong’ of the EIP standard (ie care in accordance with NICE recommendations) and an accompanying four-point performance assessment scale has been developed.

The [Early Intervention in Psychosis Scoring Matrix](#) contains a scoring matrix, comprising three domains and a sub-matrix of three domains. An overall score will be calculated from domains in the scoring matrix only and will not include items in the sub-matrix. Each item, each domain and an overall rating will be scored at one of four levels:

- Level 4: Top performing
- Level 3: Performing well
- Level 2: Needs improvement
- Level 1: Greatest need for improvement

As specified in the NHS Long Term Plan, 95% of services should provide level three NICE concordance care by 2023/24.

3.4 Routine collection of outcomes data

Clarity on expected service user outcomes is key to measuring and monitoring the effectiveness of services. The EIP expert reference group has recommended that three outcome tools should be used in EIP services. As a minimum, these should be used:

- during initial assessment
- at six and 12 months
- annually, and
- upon discharge.

However, services should be working towards routine and regular use of these or other suitable measures. This will support care planning and ongoing monitoring of service users to determine whether shared treatment goals are being achieved, to reinforce the therapeutic alliance and to ensure full pre- and post-treatment outcome data for 100% of all cases.

The three recommended tools together provide ratings of the clinician's assessment alongside service users' views of their needs, experience and stage of recovery.

These have been chosen because they have been well researched and cover a wide range of relevant outcomes while being brief and practical to use in routine clinical settings:

- [Health of the Nation Outcome Scales \(HoNOS\)](#)
 - this clinician-rated outcome measure covers safety, substance use, physical health, symptoms and social issues.⁴⁴ It has been used regularly in services as it forms part of the clustering tool and therefore is familiar to clinicians. The child and adolescent version (HoNOSCA) should be used for under 18s.
- DIALOG
 - a service user-rated outcome and experience measure, which focuses on quality of life, care needs and treatment satisfaction.⁴⁵

- the Process of Recovery Questionnaire (QPR)
 - developed in collaboration with service users,⁴⁶ the QPR asks about key aspects of personal recovery including connectedness, hope, identity, meaning to life and empowerment.

Both DIALOG and the QPR were developed for people aged over 18, although they may be suitable for some young people. The decision about which measure to use should be taken on a case by case basis in collaboration with the young person. If DIALOG and/or QPR are deemed inappropriate a general functioning tool should be used as a measure of outcome including the suite of outcome measures in routine use in children and young people's mental health services.

The Goal Based Outcome measure (GBO) is a clinically relevant tool which is readily integrated within clinical practice while the Strengths and Difficulties Questionnaire (SDQ) and Experience of Service Questionnaire (ESQ) are generic outcomes and experience measures respectively – all of which are available within MHSDS.

Within the Community Mental Health transformation, services outside of EIP are recommended to use and flow data from three Patient Reported Outcome Measures (PROMs) by the end of 23/24. These three measures are:

- DIALOG
 - as above.
- Goal Based Outcomes (GBO)
 - a measure that focuses on an individual's personal goals.
- ReQoL-10
 - a 10 item PROM that measures the factors associated with personal recovery, plus there is an additional question that asks about physical health. ReQoL has been developed for people aged 16 and up.

To allow for outcomes to be measured consistently throughout a person's care journey, it would be beneficial for EIP to use the same outcome measures as other community services. To ensure existing service users are not impacted by the introduction of new PROMs during their time in EIP services, changes will be implemented incrementally.

In 2023/24 the national standard for service users to have paired scores from at least two outcome measures will remain; however, the choice of outcome measure will increase to include GBO and ReQoL in addition to HoNOS, QPR and DIALOG.

4. Key commissioning and service development considerations

All areas will have an existing EIP service, but it is likely that services will require investment and significant development in order to meet the two key conditions of the access and waiting time standard and that this can be met equally for children and young people and the relevant data flowed.

This section provides a step-by-step process that local commissioners and providers can follow. Commissioning and service development plans should be co-produced with a range of stakeholders, including service users and their families or carers, partner organisations and relevant voluntary sector organisations.

Step 1: Understand local demand

Commissioners should develop a good understanding of local demand, drawing upon local provider intelligence. To achieve this, they should:

- Use the National Mental Health Intelligence Network's [Fingertips tool](#) to establish the estimated psychosis incidence rate per 100,000.
 - While the access and waiting time standard is applicable to people aged 14-65 it should be noted that the incidence rate defined by the Fingertips tool is for people aged 16 to 65 years. The incidence rate can be multiplied by the population of 16 to 65-year olds in the local system catchment area to understand the expected number of new cases of first episode psychosis expected per year. **EIP is typically a 3-year service.**
 - Further estimations should be put in place for young people aged 14 and 15 years old. Fingertips uses the predictions tool, [PsyMaptic](#), which provides predicted incidence rates for local authority areas.
 - Commissioners should familiarise themselves with the methodology used to produce these predictions, including the confidence levels and caveats that apply.
- Work with providers to understand the current referral rate:
 - This will be higher than the incidence rate because a number of people are referred who do not go on to develop first episode psychosis – this may mean additional referrals totalling up to double the incidence rate.

- Systems will need a clear understanding of referrals for EIP and ARMS for the full age-range, ie 14 to 65-year olds.
- This should also include ensuring the referral demand of children and young people in the 14 to 18 and under 14 age group is captured, especially if these referrals have previously been directed to children and young people’s mental health services.
- Arrive at a local referral estimate. Combine the two factors above with any specific local factors that may impact on the referral rate.
- Understand the demographic profile. Beneath an overall incidence rate for an area, incidence rates vary across age, gender and ethnicity.

Step 2: Develop an outline service model

Commissioners and providers should work together, using the staffing models, service examples and pathways provided in this tool to:

- Apply the understanding of local need to identify the staffing complement and competencies required. The workforce planning tool can be used to help with this.
- Consider any reasons why the use of a standalone team would not be the appropriate model, such as geography. If using a hub and spoke model, consider how the service will overcome the inherent risks of this approach and deliver the same benefits as the evidence-based stand-alone model.
- Consider the age-appropriateness of the service offered. This should be informed by the age profile of the **ICB** area and the impact it has on incidence, and arrangements for those under 18.
- Outline the service model, including consideration of the number of teams, management, clinical leadership, and any specific characteristics the team will need to address demographic considerations identified in step 1.
- Identify and understand current referral pathways, including external and internal referral sources (for example, self-referrals, GPs, inpatient wards, assessment teams, crisis resolution and home treatment teams, drug and alcohol services, schools, colleges and universities, and the police), partners in service delivery or identification of referrals (for example,

voluntary and community organisations and social services) and discharge pathways (for example, into CMHTs, primary care).

- Commission ARMS pathway, this includes working to identify estimated demand for ARMS provision in the local population to develop provision for people experiencing an ARMS.

Step 3: Obtain baseline current service provision and identify gaps

Once an outline service model has been developed, a plan should be produced that sets out how to progress from current service provision to the new model.

Commissioners should work with their providers to:

- Compare staffing numbers, skill-mix and competencies in the new model with current provision.
 - As well as current staffing of EIP services, this should consider the resources currently being used for those aged over 35 and under 18 (if not currently supported by an EIP service).
 - Consideration also needs to be given to the qualifications, competencies and supervision arrangements of those providing CBT for psychosis and family intervention, prescribing, and those providing employment support and physical health interventions.
- The pathway should include staff who have specific training, experience and skills in both EIP and CYP MH.
 - This should also include competencies in relation to atypical neuro-development, safeguarding and education settings, for further information see the University College London competence framework for [Child and Adolescent Mental Health Services](#).
- Identify gaps in provision. This should enable development of recruitment and training plans.

This work should be informed by the findings of the EIP national clinical audit (see section 4.3.3).

Step 4: Agree service redesign, recruitment and training plans

Once assessment of workforce requirements has been made, the implications for service reconfiguration, recruitment and workforce development will need to be

considered jointly with providers. A task and finish design and implementation group will need to be established to ensure the necessary changes are made.

Commissioners should:

- agree service redesign plans with providers. This may involve major or minor redesign, but should include arrangements to ensure:
 - the EIP service can routinely provide NICE-recommended interventions to people with or at high risk of developing first episode psychosis aged 14-65
 - interventions are provided by suitably qualified staff who are properly supervised
 - clinician and service-user reported outcomes are routinely collected and used effectively to improve care.
- agree recruitment plans with providers, including how they will address any specific demographic issues. All areas should ensure that the workforce is reflective of the population it serves, with due regard for all protected characteristics.
- agree training plans with providers, engaging local education and training boards as necessary, and ensuring that:
 - there are sufficient numbers of people trained in CBT for psychosis
 - staff delivering family intervention are suitably trained
 - staff delivering educational and employment support are suitably trained
 - all staff have a good knowledge of the importance of physical health interventions for people with psychosis, and how they will deliver these.

Step 5: Design local referral to treatment pathways and accompanying protocols and guidance

Having identified referral pathways in step 2, local services and commissioners will need to develop protocols and guidance consistent with their current referral practices, for example single point of access or referral directly to EIP services, and electronic care record systems.

They should:

- Compile a list of external and internal referral sources
 - consulting with stakeholders to ensure the list is comprehensive.

- Ensure that protocols and guidance are in place for the pathway
 - These should make it clear who should be referred and when in order to ensure that the access and waiting time standard can be met. There should also be protocols to ensure children and young people’s mental health services and adult services work together as described in section 3.7.4.
- Provide education and training programme for referrers
 - to ensure that people with suspected first episode psychosis or an at-risk mental state are picked up in primary care, or in other non-specialist settings, including education, youth justice and third sector services counselling, and promptly referred.
- Consider a public awareness campaign
 - working with local authorities and other partners to raise the overall levels of awareness in the population about psychosis, in order to increase early help seeking and improve the likelihood of signs or symptoms of psychosis being recognised and reducing the stigma associated with it.

Step 6: Ensure the necessary changes have been made to provider electronic care records and information systems to enable monitoring of performance against the standard

The electronic care record system should enable collection and submission of data in three key areas:

- Referral to treatment waiting time performance
- Performance against the requirement that the treatment accessed is in line with NICE recommendations
- Routine measurement of outcomes

Step 7: Agree data quality improvement and performance monitoring plans

Commissioners should:

- agree a data quality improvement plan with their provider to ensure full reporting against the standards (as per step 7 above), including timescales and milestones.
- agree a schedule for performance reporting - this may be worked into existing performance reporting and management arrangements.

Step 8: Agree benefits realisation plan

This should identify key benefits and set out how they will be delivered, measured and reported, in the context of a multi-year development trajectory. Key benefits of providing an EIP service should include:

- reduced waiting times for people accessing services through meeting the two- week maximum RTT waiting time standard
- improved care for individuals, families and carers through routine access to the full range of NICE-recommended interventions delivered by suitably qualified and supervised staff
- improved mental health, physical health and social outcomes for service users
- improved experience of services for people in need of mental health care and their families
- potential for reduced costs, through reduced use of crisis and acute services, including use of the Mental Health Act 1983
- improved awareness and satisfaction among referrers.

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Appendix 3: Essential components of a NICE-approved care package

This appendix provides a summary of NICE-recommended interventions from:

- [Psychosis and Schizophrenia in Children and Young People NICE guideline](#)
- [Psychosis and Schizophrenia in Adults NICE guideline](#)
- [Psychosis and Schizophrenia in Adults NICE quality standard](#).

Table 5: NICE-recommended interventions for children and young people with psychosis

Intervention	Delivery of the interventions	Provider	Outcome
Assessment	To address psychiatric, medical, physical health and wellbeing, psychological and psychosocial, developmental, social, occupational, and economic domains, and to routinely monitor coexisting conditions, for all children and young people with first episode psychosis.	Specialist EIP service, whether situated in a children and young people's mental health service or an adult EIP service with input from consultants from children and young people's mental health services.	Comprehensive co-produced biopsychosocial formulation inclusive of trauma and adversity

Intervention	Delivery of the interventions	Provider	Outcome
Family intervention	<p>To be offered in conjunction with CBT for psychosis and antipsychotic medication. Advice that they are more effective in combination should be provided. If the child or young person has a psychological intervention without antipsychotics, a time limit of 1 month for reviewing treatment options should be agreed.</p> <p>To be delivered between three months and one year over at least 10 planned sessions; the child or young person with psychosis should be included if practical; and the family's preference for single- or multi-family group intervention and the relationship between the main carer and the child or young person with psychosis should be taken into account.</p>	A therapist or care co-ordinator, who is trained in family intervention	Reduced hospitalisation and relapse, and improved social functioning
Antipsychotic medication	To be offered in conjunction with CBT for psychosis and family intervention. Advice that they are more effective in combination should be provided. A baseline investigation and regular and systematic monitoring of symptoms and side effects should be conducted.	Psychiatrist	Reduced symptom severity and associated distress, improved rates of recovery, decreased relapse rates
Monitoring of physical health	To be monitored at least once a year. Children and young people who smoke or who have high blood pressure, raised lipid levels or increased waist measurement should be identified and cardiovascular disease and diabetes monitored for.	Mental healthcare provider maintains responsibility for monitoring physical health and the effects of antipsychotic medication for at least the first 12 months or until the child or young person's condition has stabilised; thereafter, the responsibility for this monitoring may be transferred to primary care (the GP or practice nurse) under shared care arrangements	To reduce the trajectory towards weight gain, minimise adverse change in glucose and lipid metabolism, improved quality of life and improved rate of smoking cessation

Table 6: NICE-recommended interventions for children and young people with an at-risk mental state

Intervention	Delivery of the interventions	Provider	Outcome
Assessment	<p>To be carried out if a child or young person experiences either:</p> <ul style="list-style-type: none"> • transient or attenuated psychotic symptoms • other experiences or behaviours suggestive of possible psychosis. <p>If no clear diagnosis can be made, monitor for changes in symptoms and functioning for up to 3 years</p>	Children and young people’s mental health services or an EIP service; assessments in children and young people’s mental health services should include a consultant psychiatrist; assessments in EIP services should be multidisciplinary	To identify whether a child or young person may be at risk of developing psychosis
Individual CBT with or without family intervention	<p>To be offered along with interventions recommended in NICE guidelines for coexisting mental health problems (see row below).</p> <p>CBT: Deliver on a one- to-one basis over at least 16 planned sessions.</p> <p>For the number of sessions of family intervention see Table 4.</p>	<p>Clinical psychologists or CBT therapists, who have undertaken training on a course meeting competency standards for NICE-recommended therapy.</p> <p>A therapist or care coordinator, who is trained in family intervention.</p>	To prevent transition to psychosis
Interventions for co-existing mental health problems	To be offered for depression, any of the anxiety disorders, emerging personality disorder or substance misuse, along with individual CBT (with or without family intervention).	Primary care, children and young people’s mental health services, substance misuse services	To treat coexisting mental health problems
Antipsychotic medication	NOT to be offered to children and young people for psychotic symptoms or mental state changes not sufficient for a diagnosis of psychosis or schizophrenia OR with the aim of decreasing the risk or preventing psychosis.	n/a	n/a

Table 7: NICE-recommended interventions for adults with psychosis

Intervention	Delivery of the interventions	Provider	Outcome
Comprehensive multidisciplinary assessment	To address psychiatric, medical, physical health and wellbeing, psychological and psychosocial, developmental, social, occupational, and economic domains, and to routinely monitor coexisting conditions, for all people with first episode psychosis.	Psychiatrist, a psychologist or a professional with expertise in the psychological treatment of people with psychosis or schizophrenia	Comprehensive co-produced biopsychosocial formulation inclusive of trauma and adversity
Antipsychotic medication	<p>To be offered in combination with family intervention and individual CBT for psychosis for first episode psychosis and subsequent episodes.</p> <p>The choice of drug should be made by the service user and healthcare professional together, after provision of information and discussion about the likely benefits and possible side effects of each drug. Adults with schizophrenia whose symptoms have not responded adequately to treatment with at least two antipsychotic drugs used sequentially should be offered clozapine.</p> <p>Antipsychotic medication should not be offered to people considered to be at increased risk of developing psychosis or with the aim of decreasing the risk of or preventing psychosis.</p>	Psychiatrist	Reduced symptom severity, and associated distress, improved rates of recovery.
CBT for psychosis	<p>To be offered in combination with family intervention and antipsychotic medication for first episode psychosis and subsequent episodes.</p> <p>CBT for psychosis should be delivered on a one-to-one basis over at least 16 planned sessions.</p>	Clinical psychologists or CBT therapists who have undertaken specific training in CBT for psychosis on a course meeting competency standards for NICE-recommended therapy.	Reduced distress and severity of symptoms, improved social functioning and reduced hospital rates

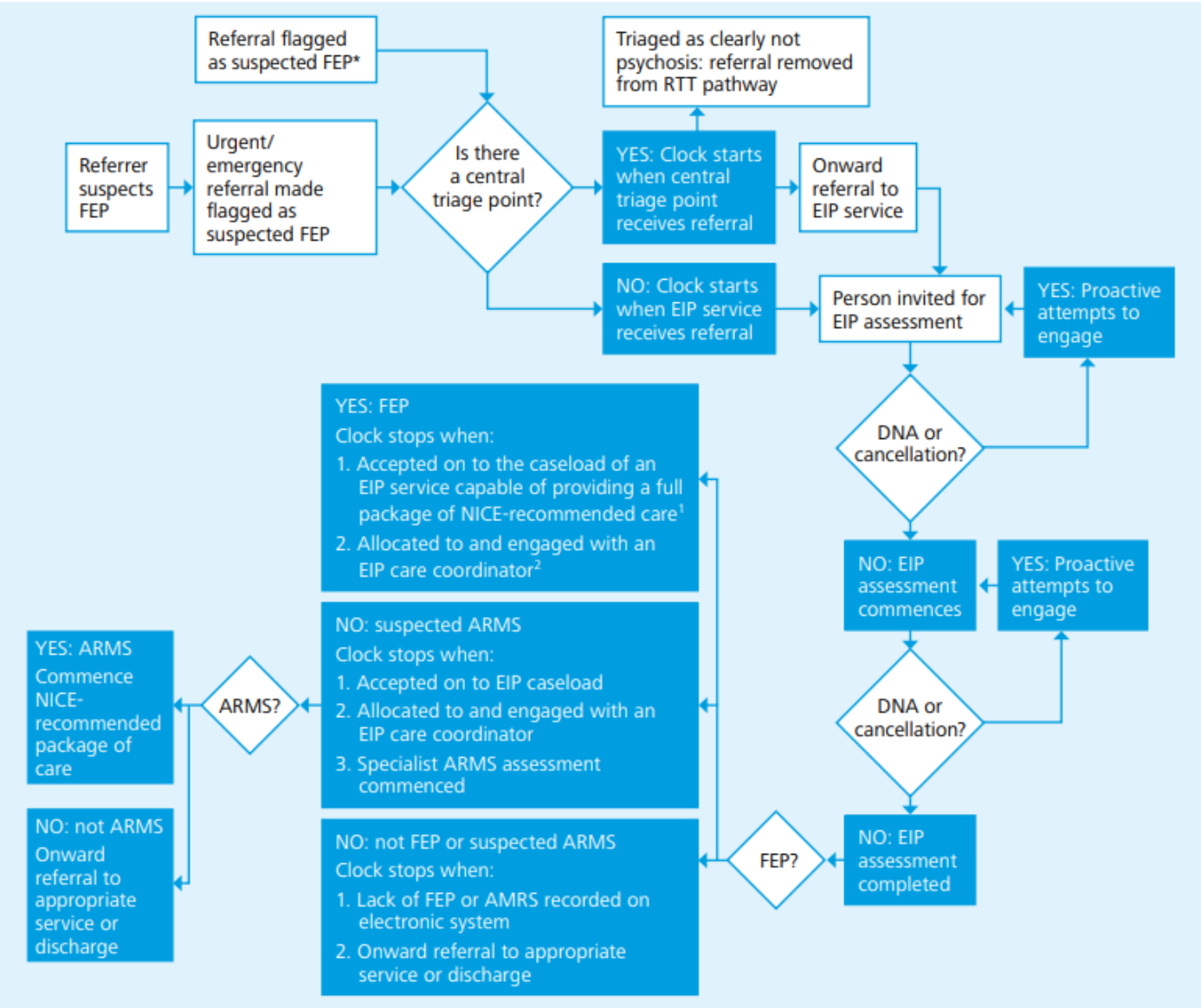
Intervention	Delivery of the interventions	Provider	Outcome
Family intervention	<p>To be offered in combination with individual CBT for psychosis and antipsychotic medication for first episode psychosis and subsequent episodes.</p> <p>Family intervention should be delivered for between three months and one year over at least 10 planned sessions; the person with psychosis should be included if practical; and the family's preference for single- or multi-family group intervention and the relationship between the main carer and the person with psychosis should be taken into account.</p>	A therapist or care co-ordinator who is trained in family intervention	Reduced hospitalisation and relapse, increased medication adherence and improvement in social functioning
Supported employment programmes and vocational rehabilitation	<p>To be offered to people with psychosis who wish to return to work. Other occupational or educational activities, including pre-vocational training, can be considered for people who are unable to work or are unsuccessful in finding employment.</p>	Trained vocational workers or employment specialists, who are aware of the specific needs of people with psychosis.	Higher rates of competitive employment, longer duration of employment and number of hours worked.
Carer-focused education and support programmes	<p>To be offered as early as possible to all carers.</p> <p>These programmes, which may be part of a family intervention, should be available as needed and provide a message about recovery.</p>	Any EIP team member	Reduced carer burden, reduced long-term distress and improved experience of caregiving.

Intervention	Delivery of the interventions	Provider	Outcome
Physical health interventions and monitoring	<p>A combined healthy eating and physical activity programme should be offered to people with psychosis, especially those taking antipsychotics.</p> <p>Weight and cardiovascular and metabolic indicators of morbidity should be monitored.</p> <p>If a person has rapid or excessive weight gain, abnormal lipid levels or problems with blood glucose management, interventions in line with relevant NICE guidance should be offered.</p> <p>Help to stop smoking should be offered.</p>	Mental healthcare provider maintains responsibility for monitoring physical health and the effects of antipsychotic medication for at least the first 12 months or until the person's condition has stabilised; thereafter, the responsibility for this monitoring may be transferred to primary care (the GP or practice nurse) under shared care arrangements	To reduce the trajectory towards weight gain, minimise adverse change in glucose and lipid metabolism, improved quality of life and improved rate of smoking cessation

Table 8: NICE-recommended interventions for adults with an at-risk mental state

Intervention	Delivery of the interventions	Provider	Outcome
Assessment	To be carried out if a person is distressed, has a decline in social functioning and has any of the following: <ul style="list-style-type: none"> • transient or attenuated psychotic symptoms • other experiences or behaviours suggestive of possible psychosis • a first degree relative with psychosis or schizophrenia. 	A consultant psychiatrist or mental health practitioner in an EIP service or specialist mental health service with training in identifying at-risk mental states.	To identify whether or not a person may be at-risk of developing psychosis
Individual CBT with or without family intervention	To be offered along with interventions recommended in NICE guidelines for coexisting mental health problems (see row below). CBT: Deliver on a one-to-one basis over at least 16 planned sessions. For the number of sessions of family intervention see Table 7.	Clinical psychologists or CBT therapists, who have undertaken training on a course meeting competency standards for NICE-recommended therapy. A therapist or care coordinator who is trained in family intervention.	To prevent transition to psychosis
Interventions for coexisting mental health problems	To be offered for depression, any of the anxiety disorders, emerging personality disorder or substance misuse, along with individual CBT (with or without family intervention).	Primary care, secondary care mental health services, substance misuse services	To treat coexisting mental health problems
Antipsychotic medication	NOT to be offered for people considered to be at increased risk of developing psychosis OR with the aim of decreasing the risk or preventing psychosis.	n/a	n/a

Appendix 4: The full referral to treatment pathway



- 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.

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