



*National Institute for
Mental Health in England*

NIMHE National Early Intervention Programme

Early Intervention (EI) Acceptance Criteria Guidance

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1. Introduction

EI services support individuals experiencing a first episode of psychosis (FEP) who typically are presenting for the first time to mental health services and who have either not yet received any antipsychotic treatment or have been treated for less than one year. EI services should be designed to encourage access and provide treatment to what is by its very nature a young client group when a FEP develops. This must embrace a culturally sensitive approach.

A first episode psychosis is important as a marker for the possible later development of schizophrenia and other related long term functional psychoses, allowing early identification and preventive interventions to mitigate longer term outcomes. An EI team composition adopting a bio/psycho/social approach and assertive outreach style is suited to this target group. Viewing EI as primarily and most importantly for the early treatment of certain long term psychoses rather than the treatment of all psychoses in a particular age group may help to explain the rationale embodied within this guidance for prioritising or in some cases, excluding disorders which cause transient and fleeting psychotic symptoms such as bereavement reactions, neurological conditions and borderline personality disorder.

Diagnostic uncertainty characterises the early phase of a psychosis and thorough clinical assessment is crucial and a key function of EI services. No confirmatory psychological, neurological, laboratory or radiological tests are currently available to assist this process beyond ruling out possible organic causes for psychotic symptoms. Inevitably, because it is difficult to predict which psychotic presentation is schizophrenia or another related long term psychosis, EI services can appear over inclusive and even include individuals for whom EI services may be inappropriate or potentially damaging. Psychotic experiences are common in community populations (Johns & Van Os, 2001) and not necessarily indicative of either emerging mental health difficulties or specific to FEP (Cougard et al., 2007; Rossler et al., 2007). Thus psychotic symptoms can be viewed as a continuum (Verdoux et al., 1998), and that acceptance into services should occur above a level of severity where an individual is in distress, help seeking or when serious risk may be anticipated if left untreated.

Some assessment tools such as the PANSS and CAARMS set explicit criteria to assist clinical judgements in relation to severity of symptoms and define an arbitrary cut-off for the presence of psychosis along three dimensions which include intensity, frequency and duration of positive symptoms (although they ignore negative symptoms and catatonia). Although these criteria can help in defining the boundary between an 'At Risk Mental State' (ARMS) prodromal case and psychosis we still need to ensure that individuals do not fall through a gap between the phase of ARMS and a definite psychosis. Similarly, where separate early detection and EI teams exist, individuals can fall between services ('too psychotic' for the early detection team but 'not psychotic enough' for the EI team). This is why EI teams can legitimately offer a monitoring function for suspected psychosis cases, particularly in the absence of an early detection arm or a separate early detection team, to prevent very early cases having to considerably worsen before they can access EI support and treatment.

2. Aims

Now established, a feature of EI teams is their willingness to overcome service boundaries for the benefits of users and to work in a style which is outreaching, destigmatising, proactive and avoids rigid eligibility criteria. However there continues ongoing debate both within and outside the EI community as to where lines should appropriately be drawn in terms of acceptance criteria for EI services.

With this in mind this discussion paper is intended to:

- Respond to common questions that have arisen from EI services around acceptance criteria in relation to age cut-offs, bipolar disorder and drug induced psychosis.
- Inform EI screening assessment decisions and ensure that individuals with FEP receive appropriate support and care.
- Help EI services who may be struggling to meet caseload trajectory targets to question whether their current acceptance criteria may be inadvertently excluding some groups of individuals with psychosis. Challenge EI teams to

avoid excessively narrow criteria and encourage a more consistent application of eligibility criteria to achieve the intended caseload trajectory

- Conversely EI services who adopt very broad acceptance criteria should challenge themselves to ensure that they are not inappropriately drawing in some individuals who may be reporting psychotic phenomena where their experiences are not underpinned by a psychotic disorder and whose needs may not be best served by spending three years with an EI service.
- Respond to performance management queries about the numbers of cases discharged earlier from EI services than their intended 3 years of intervention by highlighting those instances where earlier discharge may be appropriate following extended assessment or with certain types of psychotic disorder.

3. What conditions may present with psychotic symptoms?

Psychotic symptoms occur with :

- individuals with **acute and transient psychotic disorder** (no prodrome and short duration of psychotic symptoms for less than 2 weeks with a clear stressful precipitant),
- **schizophrenia**,
- **other non affective psychoses such as delusional disorder** (without hallucinatory phenomena or negative symptoms)
- **drug induced psychosis**.

Psychotic symptoms can also occur:

- in the context of major alterations in mood including **bipolar disorder and schizoaffective disorder**. In bipolar affective disorder, psychotic symptoms can occur during either a high (manic) or low (depressive) episode.
- with **psychotic depression** (severe depressive episode with psychotic features) where some people who become severely depressed may also develop psychotic hallucinations and delusions related to and congruent (in content) with their low mood.
- In post partum mothers experiencing a **puerperal psychosis**

Psychotic symptoms can also occur:

- in the context of a **lifelong disorders such as autism, Asperger's Syndrome and learning difficulties**
- where there may be an underlying organic condition such as **epilepsy or head injury**
- with **Borderline Personality Disorder**, when in a decompensated state psychotic symptoms may often emerge.

4. What counts as a FEP?: the two extremes

Case 1: EI services adopting a purely phenomenological approach (taking anyone experiencing any kind of psychotic phenomena)

EI services taking this approach are likely to be over inclusive. This may potentially lead to individuals with post traumatic stress disorder (PTSD) experiencing dissociative phenomena, individuals with obsessional difficulties or with complex bereavement reactions (where symptoms are driven by non-psychotic processes) or individuals with schizotypal or paranoid personality disorder being drawn into EI services inappropriately. We need to be cautious in inadvertently pathologising all psychotic experiences as indicative of emerging FEP; this could potentially draw individuals into a 3 year intervention programme with associated risks of labelling, stigma and unnecessary exposure to potentially harmful treatments (such as anti-psychotic medications); whilst this may be beneficial in managing psychotic symptoms it can also create harmful short and long term health risks and added costs.

Case 2: EI services adopting excessively conservative acceptance criteria to target Schizophrenia and the non affective psychoses

EI services taking this stance are likely to be too narrow and may miss many individuals who have a genuine FEP. By accepting only individuals with a clear diagnosis, this conflicts with the key EI principle of working with diagnostic uncertainty. This is even more likely where traditional diagnostic criteria are employed to make a diagnosis of FEP, perversely requiring symptoms to have been

present and persistent for a certain minimum period. Such a narrow eligibility misses the whole point of EI, and will result inevitably in longer DUP

Another consequence of adopting very narrow criteria is that individuals with an FEP whose diagnosis is unclear or complex, for example with co-morbid difficulties such as depression or substance use or where psychosis occurs alongside a lifelong disorders such as autism, Asperger's Syndrome and learning difficulties may end up being screened out and falling 'between service stools' because their presentation is clouded or complex. Indeed these individuals, thus rejected by services, may suffer the damaging long-term consequences of an untreated psychosis.

5. Who do EI services definitely not take?

This is a more difficult question than it first appears. It is best illustrated by considering organic psychosis which most EI services might initially consider would not meet eligibility criteria for their service:

- a. Psychotic symptoms occur not infrequently with neurological disorders such as epilepsy, head injury, haemorrhage, infarction, tumours delirium and all forms of dementia. In some cases, this can be extremely tricky as some individuals following a head injury can develop what looks very like schizophrenia. EI services, often in conjunction with the individuals GP, will routinely screen using urine and blood tests, electrophysiological (EEG, ECG) and radiological investigations (CAT scan, MRI) to establish an underlying organic cause and offer appropriate treatment of that physical health condition. However, while the identified physical cause may be best treated by a 'physical' specialist, there may also be for a need for symptomatic short term treatment of and support for the acute psychotic symptoms from an EI service in collaboration with the 'physical' treatment provision.
- b. In other cases, an underlying organic condition such as epilepsy or head injury may co-exist with FEP as co-morbid problems. Here a collaborative 'shared care' approach is desirable where EI services target the FEP over a 3 year intervention period but longer term support for the underlying organic

condition is secured from neurology or neuropsychiatry services alongside EI involvement.

6. To treat or not to treat?

The majority of arguments about whether to treat or not to treat within an EI service arise with three particular groups of FEP cases: those with **drug induced psychosis**, those with **bipolar disorder** and those with **Borderline Personality Disorder**

6.1 Drug induced psychosis

The biggest assessment debate within EI services is whether early intervention teams should take everyone who is using substances and experiencing psychotic symptoms. This is a complex area of conceptual confusion and one that often blurs considerations of co-incidence with causality. The debate centres on whether individuals who experience psychotic symptoms when intoxicated have an underlying vulnerability to psychosis which is triggered by drug use (a 'drug induced psychosis') and therefore, requiring full EI intervention or whether their psychotic symptoms are purely 'drug driven' requiring interventions simply to tackle their drug taking behaviour.

The concept of 'drug induced psychosis' is in common parlance but is actually of rather uncertain standing. Where there is coincidence it is often taken as a given that there is a causal relationship.. However, 'drug induced psychosis' does not appear as a diagnosis in ICD10 or at least, not in the 'psychosis' section. 'Psychosis' does appear in the 'substance misuse' section of ICD10 as a complicating factor which describes psychotic reactions to intoxication that are resolved usually within a month but sometimes up to 6 months following abstinence. When psychosis persists for longer periods it is then that a psychosis is likely to be diagnosed where drug use may have served as a trigger or indeed may still be coincidental. This is a bit like puerperal psychosis, where there is a peri-event form of psychosis which is regarded as related to childbirth but if it continues, is then reconsidered to be a psychotic illness precipitated by childbirth and therefore, treated as such.

With drug use and psychotic symptoms the relationship is even more complex and the potential scenarios include intoxication psychoses, withdrawal psychoses persisting up to 6 months, psychotic reactions to drugs use/misuse, brief psychotic reactions (Brief Limited Intermittent Psychotic states - 'BLIPS' ('Glastonbury psychosis') which may be harbingers of later psychotic disorder, drug precipitated psychosis where use of street drugs triggers an ongoing psychotic illness and acts as a biological trauma / stressor and drug sustained psychosis, where continuing drug use is an ongoing precipitant of a psychotic disorder which has arisen from another causation, including 'endogenous vulnerability'.

It is therefore important that EI teams have the capacity and time to unpack these interrelationships which can range from a 'bad trip' to primary drug misuse problem with complicating psychotic features to co-morbidity (dual diagnosis) to drug complicated psychosis, to coincident use, to perpetuation, each of which may carry quite different implications for treatment.

Clearly, it is difficult to predict what is going on without sufficient time to assess whether an individual might become symptom free if they stopped using substances (particularly if they continue to use them) and even if the individual does stop using drugs completely, having to allow for the fact that some psychotic reactions to drug use can persist for up to 6 months. We can also not be absolutely certain that there is no underlying vulnerability to psychosis which may have been triggered by drug use or that chronic substance use has had a 'priming' effect making an individual susceptible to further psychotic episodes with or without continued drug use. If we are too hasty in our assessment judgements, such individuals may end up being inappropriately excluded from EI services and then subsequently re-referred or 'falling between stools' ending up being passed between EI and drug services and not receiving appropriate treatment and support for either their psychotic symptoms or their drug use.

One approach to this conundrum is for EI services to accept these individuals onto caseload for a period of 'extended assessment' (typically between 6 months to one year). This allows assessment over a longer time period where the individual can be supported to try to stop or reduce their substance use and gives more opportunity to observe links between symptom exacerbations and increased drug use, potentially clarifying whether substance use is an explanatory or contributory factor and whether a FEP may indeed be present. From a very early stage, the individual should be

encouraged to seek additional support from substance misuse services to establish a service link with specialist support for their substance use particularly if it is then subsequently felt that treatment within an EI service may be inappropriate.

Where an FEP is confirmed, if there is no dual diagnosis specialist expertise within EI, a 'shared care' approach with substance misuse services may be appropriate. In this scenario, EI services target the FEP over a 3 year intervention period while specialist support for the management of substance difficulties is provided from substance use services in a shared care model.

Where psychotic symptoms are purely drug driven, the substance use may be more appropriately treated by substance use services, using a similar argument to that suggested in 5a above with physical conditions, and the symptomatic short term treatment of acute psychotic symptoms by EI services. In these cases, the substance misuse practitioner is supported by the EI service in the management of acute psychotic symptoms but longer term support is provided by substance use services beyond EI involvement. This may be another group of individuals who may be supported by EI services over a limited period of time but who following intervention may warrant earlier discharge.

Clearly, the issue of drug psychoses is very complex. Although this guidance paper supports the use of extended assessment and brief treatment interventions to try to sort out questions about aetiology and whether psychotic symptoms are 'purely drug driven', it is acknowledged that sometimes the picture can remain unclear even in the longer term and it is then a case of deciding which service best meets the needs of a given individual and relies on a mature and supportive relationship between substance misuse and EI services.

6.2 Bipolar Disorder

Bipolar I disorder is defined by the occurrence of manic rather than psychotic symptoms in DSM1V. However, most EI services agree that individuals with Bipolar I disorder who experience psychotic symptoms should be a target group for early intervention services. In these cases, the presence of psychotic symptoms raises the possibility of later development of schizophrenia including schizoaffective disorder. There is less agreement about whether or not Bipolar II individuals with

hypomania (elevated mood without psychotic symptoms) should also be offered EI services. Recent NICE Bipolar guidance recommended that ‘all individuals with a first episode of Bipolar Disorder should be offered early intervention services’ (NICE 2006) but this blanket acceptance of all cases is problematic when EIP services have been developed and predicated on the presence of psychotic symptoms and where some individuals with Bipolar disorder may never experience psychotic symptoms. This arbitrary divide based on presence of psychotic symptoms can be particularly problematic in adolescent cases, where a bipolar affective disorder may be emerging and the presence of psychotic symptoms may not immediately be clear. This issue has not been fully resolved and often leads to hot debate both within and between EI services, particularly with Child and Adolescent Mental Health Service (CAMHS) partners. While acknowledging that all individuals with bipolar disorder may well benefit from the interventions offered by EI services and the laudable intentions of NICE in advocating an early approach to symptom management in bipolar disorder as well as psychosis, there is a danger if EI services start to take bipolar disorder without psychotic symptoms that they then become a ‘catch all’ for all affective disorders thereby diluting the EI evidence base and capacity to intervene with those groups that EI was primarily designed and funded to intervene with. It should also be recognised that the funding for EI services and incidence estimates on which national caseload targets have been based did not take into account this population and these would need to be reviewed and separately commissioned and funded. Typically, we would encourage EI services to continue to take a conservative stance on this issue accepting individuals with Bipolar I disorder and, while acknowledging that individuals with Bipolar II might well benefit from EI interventions, accepting only those cases of bipolar disorder where the individual is also experiencing definite psychotic symptoms.

6.3 Borderline Personality Disorder

These are often amongst the most difficult and contentious of referrals to EI services, particularly where the predominant need is for the personality issues, but where there are also transient psychotic symptoms. A period of extended assessment may be helpful in assessing suitability and potential to benefit from EI services. However

there is a risk of being *swamped* if a service is too flexible with this client group as the expertise required to effectively treat these cases is quite different to EIP (where one typically aims to engage the ‘under engaged’) contrasting with personality disorder who more typically may be ‘over engaged’ and where Dialectical Behaviour Therapy (DBT) or DBT-lite may be a more appropriate service intervention.

7. The case for early discharge

There are a number of case scenarios (independent of caseload capacity or funding restrictions) that might lead EI services to discharge earlier than the intended three years of intervention:

- When diagnosis is still unclear following initial assessment, one approach is to accept individuals onto caseload for a period of ‘extended assessment’ (typically between 6 months to one year) to allow time to assess the individual over a longer period of time. This is a commonly adopted approach by many EI services to address diagnostic uncertainty recognising the importance of not denying individuals a service where it ultimately may turn out to have been appropriate. During this period individuals may be offered targeted interventions to address their presenting difficulties such as trying to reduce their substance use or treating an underlying depression to assist in clarifying potential contributory factors and deciding if an FEP may be present. At a 6 or 12 month review as appropriate, the benefit of more time and involvement for a more thorough assessment allows a more confident decision as to whether an individual does have an FEP which would benefit from continued intervention over 3 years. If not thought to have an FEP after all, the individual can be appropriately discharged earlier following this period of extended assessment and focussed treatment intervention.
- Different types of psychosis may have different prognoses. Some types such as psychotic depression, puerperal psychosis or acute transient psychotic disorder are typically associated with a uniformly good and relatively quick recovery. This may have implications for choice of treatment intervention

particularly whether antipsychotic medication may be required or in some cases, whether cognitive behavioural intervention targeting stress precipitants may be more appropriate. Dependent on response to intervention, some individuals may recover swiftly to pre-morbid levels of functioning when they will not need a 3 year period of intervention; it may be considered appropriate to offer such individuals earlier discharge or a move from active case management to 'monitoring' status.

This guidance paper discusses criteria for early discharge based on diagnosis but clearly there may be other reasons for early discharge, for example, where EI services have failed to engage an individual despite continued and repeated attempts to engage them or where an individual who has been engaged for some time perceives that they are recovered and no longer requires continued EI support. In both cases, there is a narrow line between 'assertive engagement' and 'harassment' if an individual repeatedly declines services offered and EI services may have to respect an individual's right not to engage or to disengage especially when there are no risk issues that may necessitate considerations around compulsory treatment. Equally, young people can typically be a very mobile group who may move frequently, go travelling or go to college which may also lead to discharge from an EI service (although in the majority of cases, with sufficient notice, EI services will endeavour to organise a transfer of care to another EI service where these exist so that early intervention support may continue with a different EI service in the area to which the young person has moved).

While acknowledging that a small minority of cases may be considered for earlier discharge from EI services, for the majority of EI cases, a 3 year model is essential, particularly for social and developmental interventions for people that have recovered. Generally speaking, all FEP cases should be held on caseload for continued monitoring over the three year period given the high risk of relapse and the significant risk of suicide in the first few years of a psychotic illness.

8. Co-morbidities and complex cases

Co- morbidities are common with FEP and should not be used as a reason for exclusion from EI services. Individuals may present with an FEP in the context of a co-morbid lifelong disorder such as autism, Asperger's Syndrome, a learning disability or an underlying physical health condition such as epilepsy or a head injury. Care needs may be more complex requiring involvement of other specialist services to support and manage residual difficulties arising from the underlying lifelong disorder in addition to EI. Deciding which service leads the care management requires careful consideration and negotiation based on presenting needs at the time and taking into account residual difficulties likely to persist beyond the current psychotic episode; EI services generally should contribute to an agreed care package rather than take the lead on care management and support.

Similarly, there are other cases of FEP where the needs of individuals may be complex and require specialist input beyond the expertise provided by an EI service. A good example may be puerperal psychosis where specialist input or possibly specialist admission to a mother and baby unit may be required arising from the need to care for and protect both the mother with psychosis and the newborn child. This should not be a reason for exclusion from EI service but again may require multi agency collaboration where EI is a contributor to an overall care package involving a complex range of agencies and services to support and protect the well being of both mother and baby.

9. Age criteria

9.1 Age is an important risk indicator when considering whether a psychosis is present or not. Epidemiological data show that most new cases of psychosis arise in men under 30 years and women under 35 years. Age acceptance criteria of 14-35years will *capture* the majority of individuals with FEP (a second peak occurs in people

over 60 years but is more likely to have an organic basis). A service which sets their age criteria more narrowly (typically at 16-25 years) will exclude

- a. early onset cases which tend to have poorer long-term outcomes (reference) and deny a group which should indeed be prioritised to receive EI services (even though their care arrangements may be more complex and require skilful negotiation across the CAMHS/adult transition to provide a seamless service).
- b. individuals aged over 25 years and as a consequence will miss 50% of women with FEP who typically present for the first time in their early thirties This may, in part, explain the low numbers of female cases reported by some EI services. Such EI services could be accused of discriminating against females.

9.2 How tight do you draw the line if someone presents age 12 with a psychosis or age 36 years? Most services recognise the need for some flexibility so there is capacity to take very early onset cases rather than denying access to EI until they reach the age threshold of 14 years. This will avoid an unnecessarily long DUP and the likelihood of adverse developmental impact for one of the most vulnerable groups where predicted outcome is often considered poor.

Similarly, with those presenting over 35 years most services will accept in EI up to 36th birthday so may have individuals on EI caseload who within first 3 years of FEP may be aged 35-38 years. Typically, with this group one tends to anticipate better outcomes as often good pre-morbid functioning for many years where settled in employment, relationships etc prior to onset of psychosis.

With these exceptions, it is important to hold age boundary entry criteria as, otherwise, EI services may be inappropriately expected to treat cases who have psychotic symptoms for other reasons than an FEP (typically organic). A clear distinction also needs to be drawn between providing a general 'psychosis service' to anyone presenting at any point with a psychosis in contrast to an EIP service which is positively targeting young people experiencing an FEP.

10. Catchment population

Most services define their catchment population by either residential post code, County boundary or whether registered with a local GP within the defined catchment area. Problems arise when individuals are registered with a local GP but live outside the catchment area or where they live within the catchment area but are registered with a GP elsewhere (common with student populations, travellers, temporary and overseas NFA and homeless individuals, asylum seekers, prisoners and young offenders housed out of area). EI services get around this in different ways; by ensuring agreement over responsibility for follow up before providing temporary input while the individual remains in the catchment area, requiring the individual to re-register with a local GP or, in some cases, crossing county boundaries to provide support to a patient who is registered with a local GP and yet living out of area although this can sometimes throw up enormous logistical and liaison difficulties. Difficulties can also arise where Health and Social Care boundaries are not continuous and can disadvantage individuals caught between boundaries eg in relation to social services and housing provision unless an individual is eligible to section 117 aftercare from inpatient services or from NASS if asylum seekers. Some EI services will negotiate on who is best placed to meet the needs of client falling on County boundaries or will negotiate a shared care arrangement with another EI service, for example across term time and holidays with student populations or for gap students, seasonal workers (eg fruit pickers) and travellers to ensure their needs are met. In the case of travellers abroad, this can involve negotiations with international EI services. Clearly, this picture may become even more complex with the development of Foundation Trusts where the care provider may not necessarily be based locally. You can seek information about availability of other regional, national or international EI services through your NIMHE RDC EI regional Lead who has access to a national EI service database and can seek assistance with international contacts through the IEPA (www.iepa.org.au) and ISPS international (ISPS-INT@yahoo.com) networks.

11. Critical period

Funding and policy guidance for UK EI services has been based upon intervention over the first three years of a psychosis. This is in line with research evidence indicating a 'critical period' of the first 3-5 years for intervention if we are to influence longer term outcomes. Some services have queried why there is a 3 year limit when emerging, albeit currently limited, international research evidence suggests that this may not be sufficient to ensure that the beneficial outcomes achieved by EI services are sustained in the longer term. This is also particularly pertinent when treating a very young person with FEP where their psychosis starts in very early adolescence who may still be very young, vulnerable and with difficult developmental transitions to achieve when they complete their 3 years with an EI service. The question therefore arises as to whether, just as EI services may legitimately have criteria for early discharge whether they should also have criteria for prolonged EIS involvement? Clearly, this has both funding and capacity implications and needs to be specifically commissioned if EI services are to successfully maintain a throughput of cases. It also may not be necessary for the majority of individuals within EI services if we can ensure that individuals do get three years of sustained intervention which includes specific support to address social, educational and vocational recovery outcomes as well as symptomatic improvement.

Another common scenario which raises discussion about the critical period for early intervention is when individuals delay help seeking or their psychotic symptoms are not identified early so that they incur long delays and may end up being in the second or third year of the critical period before accessing EI treatment. This can raise issues for EI services as to whether intervention at this stage may be futile in altering longer term trajectories because of the long DUP that the delay has incurred. Similar arguments may be voiced for individuals being referred to EI with a second or third episode but still within the first year of an as yet untreated psychosis (high relapsers) or where an individual has already been partially treated in another service or in some cases, another country. The line that we suggest is that EI services should take on these cases wherever possible, the rationale being that they are still within the critical period and although a longer DUP or relapse history may predict poorer outcome it is not inevitable and these are the very cases we should be prioritising in EI rather than excluding from intervention. Clearly, there has to be a cut off so that we retain an

early intervention focus and avoid being inadvertently drawn into treating all psychoses independent of age, duration of psychosis, treatment history and number of episodes. Decisions about what these specific cut offs will be may vary between services and may, in part, be dictated by available resources but we would encourage EI services to be inclusive and to avoid ‘cherry picking’ good outcome cases and discriminating against those for whom EI may be critical in altering a potentially poor outcome trajectory.

12. At Risk Mental States

Now that EI services are more established in delivering a service to a FEP population, more interest is being developed in providing interventions with a population who are considered to be experiencing an ‘At Risk Mental State’ (ARMS cases). However, ARMS activity is not currently directly recognized either in the EI Policy Implementation Guidance (DH 2001) which emphasizes working with people in a first episode of psychosis or more significantly, able to be counted in the numbers of cases associated with line 5319 of the LDPR guidance (Line descriptor: Number of people receiving early intervention services) which is this count which attracts most attention. However, the Department of Health has recognized the importance of this activity for EIP teams, influenced by recent international research evidence, and have added line 5379 to the LDPR guidance (Line descriptor: Cases who are suspected of having a psychosis and are being monitored by EI teams). The detailed guidance clearly emphasizes this activity: *“Cases who are suspected of having a psychosis or who are at high risk of developing a psychosis and are being monitored by EI teams in case they develop a First Episode of Psychosis. These patients are also described as being ‘Prodromal’. The count is the number of ‘prodromal’ cases being monitored as at the end of each quarter irrespective of the date at which monitoring started”*. Therefore, as part of the LDPR, early intervention teams are meant to report on the number of cases their team are monitoring who meet the LDPR guidance criteria.

With the paradigm of early intervention moving up stream towards the idea of prevention, monitoring and intervening with ARMS cases fits with emerging mental health priorities. Transition to psychosis has been a key factor associated with this

group and interventions so far have been focussed on reducing transition to a full expression of psychosis. However, it is clear that whilst only a proportion of this group may go on to develop psychosis (between 15 – 40%) all of them will be experiencing high levels of distress and dysfunction and high levels of self harm and suicidality. Therefore, this is a population who have multiple and complex needs.

It is important to recognise that although the original EI funding model did not take this activity into account when the PIG was established some years ago, working with ARMS cases is a new research and clinical opportunity that has established itself subsequent to the PIG. If teams are to incorporate this work into their routine clinical activities this will have funding implications. However, as with the evidence for the cost economic value of early intervention for FEP, a similar cost economic argument has emerged which indicates that significant costs savings can be achieved through ARMS intervention.

As with FEP, it is important to clarify some common assessment and treatment questions that arise in relation to identifying and working with ARMS cases. In relation to assessment, there are now reliable criteria that allow identification of this high-risk population and there are measures which allow for accurate identification of this group. The standard criteria are based around the PACE criteria which combines attenuated symptom profiles, brief limited intermittent psychotic symptoms and family history criteria into a core set of criteria which accurately identify ARMS cases. Teams are encouraged to utilise these measures to facilitate their judgment making. Recommended measures would be either the Comprehensive Assessment of At Risk mental States (CAARMS) or the Structured Interview for Psychotic Symptoms (SIPS) and the Scale of Psychotic Symptoms (SOPS).

At the present time there is no evidence to suggest the use of antipsychotic medication as a first line treatment for ARMS clients. Guidance from the International Early Psychosis Association (IEPA) suggest that first line treatments should comprise less intrusive forms of treatment including psychological interventions or medications which target presenting problems such as sleep, anxiety and depression. This has been further developed in a recent paper by McGorry ((McGorry, Hickie, Yung, Pantelis, & Jackson, 2006) which utilised the idea of clinical staging, borrowed from work with complex and enduring physical illness presentations and adapted its use for working with an early psychosis population. A first stage intervention may well be monitoring

of difficulties. If symptoms and distress continue, then targeting presenting problems with psychological interventions and or pharmacological interventions would be the next option. If distress continues and the individual continues to move towards a full expression of psychosis, despite these interventions, antipsychotic medication should then be considered.

13. Summary and Conclusion

Acceptance into an EI service requires clinical judgement, without any reliable confirmatory test. Many of these judgements are complex due to various factors including limitations of diagnostic classifications, the continuum of symptoms and co morbidity. This paper highlights and explores some of the key clinical decisions EI services have to make. Decisions about acceptance into EI services may be helpfully guided by several key principles. These include:

- EI should be offered to service users whose needs justify the resources and pertinent expertise allocated.
- Provision of an extended assessment to improve decision making is good practice
- An inclusive approach (particularly for disadvantaged groups) is essential
- Willingness to engage in partnership working if key expertise is held by other services.
- The predominant clinical needs of the service user should be at the heart of any decision on eligibility for EI services.
- EI services should be willing to offer their expertise and support in all FEP cases when psychotic symptoms are present, however, where the predominant need is not psychosis but another co-morbid difficulty or long term condition, overall responsibility for care may be more appropriately led by the service which is providing support for the primary difficulty.

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