SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service name	**Early Intervention in Psychosis (EIP) At Risk Mental State (ARMS)** (previously called Early Intervention in Psychosis)
Service specification number	**05/MHLD/0011 v3** (from 01 April 2023) *(v2 01/April 2016 – 31 March 2023)*
Population and/or geography to be served	The service is aimed at children and adults experiencing a first episode of psychosis in line with NICE guidelines (CG155 & CG178). Suspected cases of ARMS for developing psychosis, or Service Users who are in the first three years of an untreated diagnosis will also be accepted by the service. The service will accept referrals of Service Users registered with a GP within Dorset ARMS - Service Users will be accepted with suspected cases of psychosis where the diagnosis remains unclear. This includes those Service Users with the early signs of an emerging psychosis (prodromal phase). Where the primary need is identified not to be a psychotic illness, the Service User's needs will be best met outside the Early Intervention Team. Service Users experiencing psychotic symptoms with more complex needs such as a co-morbid learning disability, autistic spectrum condition or emerging Personality Disorder are also accepted into the service but will be worked with in collaboration with the appropriate service/team to ensure their range of needs are met by appropriately skilled practitioners. Where Service Users with complex needs or deemed to be high risk are jointly worked across services, a lead team with clearly defined roles and responsibilities will be identified. The service will accept referrals from • Education services • Social care • Schools • Dorset HealthCare – CMHTS, CAMHS, perinatal, eating disorder, criminal justice liaison & diversion team, psychiatric liaison, retreats and community front rooms, home treatment service • Self-referral The service operation 9-5 Mon Friday excluding bank holidays and weekends
Service aims and desired outcomes	Improve care for Service Users, families and carers through routine access to the full range of NICE-recommended interventions delivered by suitably qualified and supervised Staff Improve mental health, physical health and social outcomes for Service Users

	Improve experience of services for people in need of mental health care and their families Reduce relapse rates by providing family intervention support Improve quality of life and employment outcomes by supported employment ARMS service length of treatment is shorter (than for those with First Episode Psychosis) to avoid creating unwarranted dependency on specialist mental health services The impact of ARMS is measured by monitoring the number who recover and are prevented from transitioning into psychosis
Service description and location(s) from which it will be delivered	**Access** The service will promote early detection and prompt referral by community agencies by operating clear referral routes and maintaining effective working relationships with primary care, secondary care, youth agencies including schools, third sector agencies and offender services. This includes symptom awareness programmes for all relevant agencies. The service will encourage help seeking and engagement through a youth friendly and culturally sensitive approach which offers prompt access to assessment and treatment. This will include a tolerance of diagnostic uncertainty and an offer of extended assessment where necessary. **Assessment** The service will offer a person-centred approach incorporating a holistic, multidisciplinary assessment which takes account of a Service User's social circumstances, physical and mental wellbeing and psychological mindedness. Family members' perspectives will also be included specifically around the development of the mental illness. Comprehensive risk assessment will form an integral part of assessment and treatment planning. Once a Service User is taken onto caseload they will be offered a medical review to form a diagnosis and appropriate prescribing. **Service User Engagement** The service will be based on assertive outreach principles applied flexibly to meet the Service User's need with each Service User having an allocated named care coordinator. This incorporates an approach that manages symptoms as opposed to solely focusing on diagnosis and is guided by the principle that failure to engage does not lead to case closure. Where Service Users are ambivalent or resistant to service support and clinical improvement lacking, the team will work assertively to maintain contact, for example by supporting family members while trying repeatedly to engage the Service User. The service will also recognise the value and contribution that peer support offers in relation to effective engagement and improving motivation. **Family Engagement** The service will be family orientated with families/carers included in all aspects of assessment, treatment planning and review subject to consent. Particular emphasis will be placed on ensuring all carers are aware of contacts in the event of a crisis. Family members will be provided with information, support and guidance to optimise coping strategies in addition to routinely being offered a carer's assessment and provision of information regarding self-help support. This is either face to face or via a digital platform.

	Service User Interventions The service will provide a range of evidence based biological, psychological and social interventions suited to age and phase of illness (as per NICE guidelines). Interventions will be tailored to individual Service User's need. Interventions will aim to support the Service User to make sense of their experience. Co-morbid presentations for EIP including drug and alcohol use, depression, and suicidal ideation will also be addressed within the range of interventions offered. ARMS co-morbid presentations can include depression, anxiety, substance misuse personality traits ASC and ADHD. **Family Interventions** The service will offer a range of family interventions as indicated by NICE which are tailored to an individual family's presenting needs. Interventions will be offered irrespective of the level of engagement of family members. **Support roles** The service will place an emphasis on usual social roles and the Service Users development needs particularly in relation to accessing education, achieving employment, maintaining suitable accommodation and promoting social inclusion. The service will work to develop networks with relevant statutory and non-statutory organisations including the third sector. **Physical Health** The service will actively promote physical wellbeing and a healthy lifestyle. All Service Users are offered physical health screening and appropriate levels of intervention where required. The service will work closely with primary care to ensure physical health risks are addressed appropriately. **Discharge** Most Service Users will require support from the service for a period of three years. It is recognised that in some instances the duration of care may be less than 3 years or very occasionally more than 3 years where clinically indicated. Planning for discharge will occur early during the treatment episode to ensure that recovery gains achieved through the intervention of the service are maintained post discharge. Relapse prevention plans and clear pathways back to care will be provided should they be required. Each Service User will have a robust transition plan built around their needs to ensure on-going needs are met and this will be communicated to all concerned. People who are discharged earlier than the anticipated 3 years will receive a follow up telephone call. People within the ARMS service will require support from the service for a one year period.