The Development of Early Intervention in Psychosis services.

The presentation and discussion will look at the development from the original programmes in the United Kingdom and Australia, based on the work of Patrick McGorry and his team, to the development of newer models and whether deviation from the fidelity of the original model has reduced the ongoing benefits/impact for both for the individuals, their families and health care services; ultimately, is the model for Early Intervention in Psychosis applicable for mental health services beyond the United Kingdom, Australia, New Zealand, North America and Scandinavia

The Development of Early Intervention in Psychosis services.

A little bit about me.

This is the dull bit, you can drift off for a bit, I will click my fingers or whistle when you can wake up.

The development of Early Intervention in Psychosis.

The initial focus

Early intervention in psychosis is a clinical approach to those experiencing symptoms of psychosis for the first time. It forms part of a new prevention paradigm for psychiatry[and is leading to reform of mental health services,[3] especially in the United Kingdom and Australia.
This approach centers on the early detection and treatment of early symptoms of psychosis during the formative years of the psychotic condition. The first three to five years are believed by some to be a critical period.[6] The aim is to reduce the usual delays to treatment for those in their first episode of psychosis. The provision of optimal treatments in these early years is thought to prevent relapses and reduce the long-term impact of the condition. It is considered a secondary prevention strategy.
The duration of untreated psychosis (DUP) has been shown as an indicator of prognosis, with a longer DUP associated with more long term disability

Early psychosis treatment teams[edit]

Multidisciplinary clinical teams providing an intensive case management approach for the first three to five years. The approach is similar to assertive outreach teams, but with an increased focus on the engagement and treatment of this previously untreated population and the provision of evidence based, optimal interventions for clients in their first episode of psychosis. For example, the use of low-dose antipsychotic medication is promoted ("start low, go slow"), with a need for monitoring of side effects and an intensive and deliberate period of psycho-education for patients and families that are new to the mental health system. Interventions to prevent a further episodes of psychosis (a "relapse") and strategies that encourage a return to normal vocation and social activity are a priority. There is a concept of phase specific treatment for acute, early recovery and late recovery periods in the first episode of psychosis.

Early detection function

Interventions aimed at improving the detection and engagement of those early in the course of their psychotic conditions. Key tasks include being aware of early signs of psychosis and improving pathways into treatment.[12] Teams provide information and education to the general public and assist GPs with recognition and response to those with suspected signs

The work of Prof Patrick McGorry

McGorry is Professor of Youth Mental Health at the University of Melbourne. He has written a number of articles and studies, published in journals including *The Lancet*, the *British Journal of Psychiatry*, the *American Journal of Psychiatry* and the *Medical Journal of Australia*[3]. He is executive director of Orygen, The National Centre of Excellence in Youth Mental Health and founding editor of *Early Intervention in Psychiatry* published by the International Early Psychosis Association. McGorry also advocated strongly for the establishment of the Australian government funded National Youth Mental Health Foundation, which became headspace, and is a founding board member of that organisation. McGorry played a key role in leading the design, advocacy and scaling up of headspace services.

Early intervention in psychosis

McGorry and his colleagues developed an approach for young people who have symptoms of psychosis for the first time, based at the EPPIC clinic in Melbourne. This EPPIC clinic has played a key part in an early psychosis treatment paradigm for psychiatry and has led to significant reform of mental health services,[10] especially in the United Kingdom.

The EPPIC program's approach is best represented by the catch phrase "A stitch in time". A linked development is the PACE clinic: a service for young people with sub-threshold symptoms who are at risk of developing psychosis.

Initial evaluations of EPPIC showed that it was not only effective compared to the previous traditional model of care but that it was also cost effective.

McGorry has also led research and new models of care for early intervention with young people who seek help for symptoms and impairment, and are known to be at risk or more severe psychosis, but whose psychotic symptoms are less intense, including the use of safer interventions than antipsychotic medication. He has generated a body of research to determine the correct sequence of treatment, that includes psychosocial interventions.

McGorry has advocated to the Australian government to create a national network of early psychosis intervention centres, based on evidence that early treatment may improve long-term outcomes. He has worked with all sides of politics in Australia to establish and improve early psychosis services. The early psychosis model of care has garnered bipartisan support, and was originally funded under the Gillard Labor government in 2011.

The projects in Australia and New Zealand

In Australia the EPPIC initiative provides early intervention services. In the Australian government's 2011 budget, $222.4 million was provided to fund 12 new EPPIC centres in collaboration with the states and territories. However, there have been criticisms of the evidence base for this expansion and of the claimed cost savings.
On August 19, 2011, McGorry, South Australian Social Inclusion Commissioner David Cappo AO and Frank Quinlan, CEO of the Mental Health Council of Australia, addressed a meeting of the Council of Australian Governments (COAG), chaired by Prime Minister Julia Gillard, on the future direction of mental health policy and the need for priority funding for early intervention. The invitation, an initiative of South Australian Premier Mike Rann, followed the release of Cappo's "Stepping Up" report, supported by the Rann Government, which recommended a major overhaul of mental health in South Australia, including stepped levels of care and early intervention.

New Zealand has operated significant early psychosis teams for more than 20 years, following the inclusion of early psychosis in a mental health policy document in 1997. There is a national early psychosis professional group, New Zealand Early Intervention for Psychosis Society (NZEIPS), organising a biannual training event, advocating for evidenced based service reform and supporting production of local resources.

North American Early Intervention in Psychosis projects

Canada has extensive coverage across most provinces, including established clinical services and comprehensive academic research in British Columbia and Alberta(EPT in Calgary), Quebec (PEPP-Montreal), and Ontario (PEPP, FEPP).

In the United States, the Early Assessment Support Alliance (EASA) is implementing early psychosis intervention throughout the state of Oregon.

In the United States, the implementation of Coordinated Specialty Care (CSC), as a recovery-oriented treatment program for people with first episode psychosis (FEP), has become a US health policy priority. CSC promotes shared decision making and uses a team of specialists who work with the client to create a personal treatment plan. The specialists offer psychotherapy, medication management geared to individuals with FEP, family education and support, case management, and work or education support, depending on the individual's needs and preferences. The client and the team work together to make treatment decisions, involving family members as much as possible. The goal is to link the individual with a CSC team as soon as possible after psychotic symptoms begin because a longer period of unchecked and untreated illness might be associated with poorer outcomes.

The United Kingdom projects.

Initially, the United Kingdom has probably made the most significant service reform with their adoption of early psychosis teams, with early psychosis now considered as an integral part of comprehensive community mental health services. *The Mental Health Policy Implementation Guide* outlines service specifications and forms the basis of a newly developed fidelity tool. There is a requirement for services to reduce the duration of untreated psychosis, as this has been shown to be associated with better long-term outcome. The implementation guideline recommends:

- Age independent entry criteria
- First three years of psychotic illness
- Aim to reduce the duration of untreated psychosis to less than 3 months
- Maximum caseload ratio of 1 care coordinator to 10–15 clients
- For every 250,000 (depending on population characteristics), one team
    - Total caseload 120 to 150
    - 1.5 doctors per team
    - Other specialist staff to provide specific evidence based interventions

The main tenets of EIP services:

Early intervention in Psychosis services work with in certain guidelines as “prescribed” by National Institute of Clinical Evidence (NICE)

All Early Intervention in Psychosis services should be providing services around the following guidelines.

Quality statement 1: Referral to early intervention in psychosis services

Quality statement

Adults with a first episode of psychosis start treatment in early intervention in psychosis services within 2 weeks of referral.

Rationale

Early intervention in psychosis services can improve clinical outcomes, such as admission rates, symptoms and relapse, for people with a first episode of psychosis. They do this by providing a full range of evidence-based treatment including pharmacological, psychological, social, occupation and educational interventions. Treatment from these services should be accessed as soon as possible to reduce the duration of untreated psychosis.

There can be issues with managing the Referral To Treatment (RTT) timescale of 2 weeks, especially with established caseloads and limited resources in teams

Quality statement 2: Cognitive behavioural therapy

Quality statement

Adults with psychosis or schizophrenia are offered cognitive behavioural therapy for psychosis (CBTp).

Rationale

CBTp in conjunction with antipsychotic medication, or on its own if medication is declined, can improve outcomes such as psychotic symptoms. It should form part of a broad-based approach that combines different treatment options tailored to the needs of individual service users.

There is a higher ratio of psychology input within EIP teams, compared to “conventional” community mental health teams.

Quality statement 3: Family intervention

Quality statement

Family members of adults with psychosis or schizophrenia are offered family intervention.

Rationale

Family intervention can improve coping skills and relapse rates of adults with psychosis and schizophrenia. Family intervention should involve the person with psychosis or schizophrenia if practical, and form part of a broad-based approach that combines different treatment options tailored to the needs of individual service users.

There is impetus, within EIP teams to have all care coordinators trained on Family Intervention Programmes.

Quality statement 4: Treatment with clozapine

Quality statement

Adults with schizophrenia that has not responded adequately to treatment with at least 2 antipsychotic drugs are offered clozapine.

Rationale

Clozapine is the only drug with established efficacy in reducing symptoms and the risk of relapse for adults with treatment-resistant schizophrenia. It is licensed only for use in service users whose schizophrenia has not responded to, or who are intolerant of, conventional antipsychotic drugs.

Concordance remains an issue, with all antipsychotic treatments and Clozapine treatment, with the need for regular blood tests, can prove difficult to implement.

Quality statement 5: Supported employment programmes

Quality statement

Adults with psychosis or schizophrenia who wish to find or return to work are offered supported employment programmes.

Rationale

Supported employment programmes can increase employment rates in adults with psychosis or schizophrenia. It is estimated that just 5–15% of people with schizophrenia are in employment, and people with severe mental illness (including psychosis and schizophrenia) are 6 to 7 times more likely to be unemployed than the general population. Unemployment can have a negative effect on the mental and physical health of adults with psychosis or schizophrenia.

All teams should have Individual Placement Support services, that support clients with gaining and sustaining employment and/or further education

Quality statement 6: Assessing physical health

Quality statement

Adults with psychosis or schizophrenia have specific comprehensive physical health assessments.

Rationale

Life expectancy for adults with psychosis or schizophrenia is between 15 and 20 years less than for people in the general population. This may be because people with psychosis or schizophrenia often have physical health problems, including cardiovascular and metabolic disorders, such as type 2 diabetes, that can be exacerbated by the use of antipsychotics. Comprehensively assessing physical health will enable health and social care practitioners to offer physical health interventions if necessary.

There is a national drive, through Commissioning for Quality and Innovations (CQUIN) to monitor physical health, for those with severe and enduring mental health diagnoses)

Quality statement 7: Promoting healthy eating, physical activity and smoking cessation

Quality statement

Adults with psychosis or schizophrenia are offered combined healthy eating and physical activity programmes, and help to stop smoking.

Rationale

Rates of obesity and type 2 diabetes in adults with psychosis or schizophrenia are higher than those for the general population. Rates of tobacco smoking are also high in people with psychosis or schizophrenia. These factors contribute to premature mortality. Offering combined healthy eating and physical activity programmes and help to stop smoking can reduce these rates and improve physical and mental health.

EIP teams continue to promote healthy living and the team at the Zone have programmes dedicated to this

Quality statement 8: Carer-focused education and support

Quality statement

Carers of adults with psychosis or schizophrenia are offered carer-focused education and support programmes.

Rationale

Providing carer-focused education and support reduces carer burden and psychological distress, and may improve the carer's quality of life. As part of the initial process of assessment and engagement, carer-focused education and support programmes can also help carers of adults with psychosis or schizophrenia to be able to identify symptoms of concern.

As well as Family Intervention/Therapy sessions, there are also carers' groups, designed to provide informal input and peer support.

Moving forward

Age independent services:

From earlier this decade the age limit EIP services was raised from 14-35 to 14-65. People aged between 36 and 65 represented 30% of all referrals to the service. There were high levels of recorded past trauma in the sample, half had dependent children and just under half physical comorbidity. Duration of untreated psychosis was less than a year for the majority. At 1-year follow up, inpatient admission rates were lower than in previously studied younger EI populations, but only 15% experienced a single episode with full remission.

Conclusions:
These findings indicate that admitting over 35-year-olds to EI results in a substantial increase in workload. A large proportion had become unwell relatively recently, indicating that the concept of EI may not be redundant in this age range.
At Risk Mental State (ARMS)/Early Detection and Intervention Teams

At Risk Mental State/EDIT

What is an At Risk Mental State (ARMS)?

At risk mental state (ARMS) is a term which is used by health professionals to describe young people, aged 14 – 35 years, who are experiencing perceptual changes that may be early, low level, signs of psychosis. It is unusual for psychosis to just happen. There are more likely to be some early signs weeks or months beforehand. So, Mental Health Services are now trying to work with young people when they are at risk. The idea is to delay the onset of psychosis, or even stop the experience of a first episode of psychosis altogether.
There are three groups of people who may be said to have an ARMS:
1. People with short-lived or milder symptoms of psychosis within the last 3 months.
2. People who have been functioning less well over the last 12 months. For example withdrawing from school, college or work or not being able to spend time with family or friends. On its own not functioning so well may be due to something else. But if you also have a brother or sister or a parent who has experienced psychosis this could mean you are having an ARMS.
3. People who experience brief limited intermittent psychotic symptoms (BLIPs). These are psychotic level symptoms that have naturally stopped within 7 days.
They may start to have more unusual experiences; perhaps seeing things that other people don't or hearing sounds which aren't really there. These experiences may become frightening and distressing.

What causes someone to have an ARMS?

There is no one single cause. Generally people become at risk of psychosis due a mixture of stress factors and vulnerability. Like many mental health difficulties there are biological influences (genetics, chemicals in the brain), social influences (relationships, family) and psychological factors (beliefs about self and others). Currently, research suggests that about 1 in 3 people who are at risk may become more unwell in the future and experience a first episode of psychosis.

Other risk factors include:

•Higher levels of stress
•Feeling increasingly worried or anxious
•Major life events e.g. changing school, starting college, break up of a relationship, family problems, bereavement etc.
•Using substances e.g. cannabis, ecstasy, LSD, MCAT, amphetamine, cocaine.
•Childhood abuse or neglect.

The move to work with "third sector" services.

As stated earlier, I work with the Insight team in Plymouth. This is a team whose care coordinators are employed by two organisations, Livewell Southwest and the Zone.

Livewell Southwest is a Community Interest Company, which is in essence part of the NHS and whose employees are subject to agenda for change. The Zone is a charity, which provides a number of services for young people in Plymouth. The Zone staff group often have no clinical background, but are employed as care coordinators and support staff. The model, of two organisations providing staff to one team, is unusual, but not unique. It provides challenges in terms of a cohesive approach to care-planning and input, but is integral to the multi-disciplinary approach for EIP and, as such, will possibly provide the template for EIP services going forward.

The evidence: Early Intervention in Psychosis services are here to stay

There have been and there will continue to be studies in to the efficacy of Early Intervention in Psychosis programmes, with often mixed results and divided opinions. There is a programme of on-going data collection from all EI teams and services in England and Wales. NHS England and the Department of Health are committed to providing an Early Intervention in Psychosis service. The service will continue to evolve from the initial models developed in the early 1990s.

The future is bright, the future is EI