

Early Intervention: An Idea Whose Time Has Come?

Helen Lester, Department of Primary Care, University of Birmingham

Abstract

This article describes the policy background for developing early intervention services across England for young people with a first episode of psychosis. It also critically reviews the evidence base and professional consensus-led arguments for and against the development of early intervention services.

Keywords: early intervention, mental health, health policy

'There is one thing stronger than all the armies in the world; and that it is an idea whose time has come.'

(Victor Hugo 1862)

Introduction

Early intervention is now a 'hot topic' not only in mental health care but throughout the British National Health Service (NHS). However notions of prevention or at least early detection are concepts more likely to be discussed in the context of screening for physical illness than mental health. In this paper, I will discuss the epidemiology of first episode psychosis and common ways in which young people may present, the policy context of early intervention and critically discuss the arguments both for and against the development of early intervention services (EIS).

Background

Four per 1,000 adults aged between 16–64 years of age, or approximately 190,000 people have a functional psychosis in the United Kingdom (UK) (Meltzer et al, 1995, 1996). Most General Practitioners (GPs) will see one new person with a first episode psychotic illness each year, and will have approximately 12 patients on their list with a diagnosis of psychosis.

Knapp (1997) suggests that the annual identifiable direct and indirect financial consequences of schizophrenia are £2.6 billion. This figure is derived from costs falling on the NHS, local authorities, charities and the criminal justice system and does not include the personal costs to the individual and their carers. More recent figures from the Sainsbury Centre for Mental Health that do include these figures estimate the total annual cost of both common mental health problems and serious mental illness in England at £77.4 billion (The Sainsbury Centre for Mental Health, 2003).

The term 'psychosis' covers a range of mental illnesses, the most common of which is schizophrenia. The mean age of onset of psychotic symptoms is 22 years for women and 19 years for men, with 80 per cent of first episodes occurring between the ages 16 and 30 years.

First episode psychosis is usually preceded by months or sometimes years of 'prodromal symptoms.' These are often non-specific, particularly in the early stages, and are commonly mistaken as part of normal adolescent behaviour. Prodromal symptoms include attenuated positive symptoms such as illusions, ideas of reference and magical thinking; mood symptoms such as anxiety, mood lability and irritability; cognitive symptoms such as difficulty in concentrating; social withdrawal, sleep disturbance and obsessive behaviours (Yung and McGorry, 1996).

Patients who go on to develop a first episode of psychosis may experience a number of 'positive' and/or 'negative' symptoms including hallucinations particularly hearing voices, delusions (that is, firmly held ideas that are usually false and not shared by others in the patient's social, cultural or ethnic group), loss of motivation, depression or blunting of emotions. Suicide is also a significant risk. One in ten people with psychosis commit suicide, with two thirds of deaths occurring within the first five years of diagnosis.

Early Intervention: The Policy Context

Priority setting is a concern for Governments throughout the world. The development of EIS has become a priority in the UK for a number of different and inter-related reasons, including the rise of community care, the move towards control as well as care in the community, user and carer concerns, the increasing evidence of unacceptably long durations of untreated psychosis (DUP) and the benefits of early diagnosis and treatment.

Modern psychiatric care has evolved largely out of the context of the psychiatric hospitals built in the

nineteenth century to protect and care for 'poor communities' (Weller and Muijen, 1993). However from the 1950s onwards, the development of neuroleptic medication, the cost inflation of mental hospitals (Scull, 1977) and new ways of thinking about healthcare including the growing importance of social networks (Prior, 1991), led to an increasing move away from hospital based care towards community care (Rogers and Pilgrim, 2001). In 1954, there were 154,000 residents in UK mental hospitals. By 1982, this figure had fallen to 100,000 and by 1998 to 40,000.

72

In the later part of the 1980s and early 1990s there was also significant media coverage of a small number of untoward incidents involving people with severe mental illness, for example the killing of Jonathan Zito by Christopher Clunis. Although much of this was alarmist, the net result was a growing public concern about safety and a change in both Conservative and New Labour policy towards control as well as care in the community. This included the introduction of supervision registers to identify and provide information on service users 'who are liable to be at risk of committing serious violence or suicide or serious self neglect' (NHS Executive, 1994). At a macro level, therefore, decisions were being taken to prioritise people with serious mental illness rather than those with common mental health problems.

Users and carer have also been instrumental in effecting change. Organisations such as the National Schizophrenia Fellowship (now Rethink) and the Initiative to Reduce the Impact of Schizophrenia (IRIS) were key to raising awareness of poor services for young people with first episode psychosis, and acted both as pressure groups and think tanks for redesigning services.

At the same time, during the 1990s, evidence began to emerge of the long duration of untreated illness prior to receiving treatment, and the benefits of intervening early in terms of recovery. Studies across the world on first episode psychosis have consistently found an average of one to two years between the onset of psychotic symptoms and the start of treatment (McGlashan, 1999) with long DUP linked to male gender, poor pre-morbid functioning, poor psychosocial support (Larsen et

al, 1998) and an insidious presentation with predominantly negative symptoms (Larsen et al, 1996; Drake et al, 2000). Long DUP can also be caused by stigma and fear (Lincoln and McGorry, 1995), a lack of knowledge about mental illness and mental health services in the general community, methods of health care delivery and the educational system (Lincoln et al, 1998). Such delays would be unacceptable in physical illness, where two week waits for suspected cancer referrals and two hour 'pain to needle' thrombolysis targets in suspected myocardial infarction are part of standard care in the UK.

The first EIS in the UK started in Birmingham in 1990. Since 1995, the Early Intervention Beacon service has developed into a service exclusively for people experiencing first episode psychosis and the Birmingham model of care has significantly influenced national policy in this area.

In 1998, the Government announced in *Modernising Mental Health Services* that EIS for young people in the early phase of psychosis would form part of the new structure of services for the severely mentally ill:

'Early intervention matters to prevent relapse, reduce the risk of suicide and ensure public safety... professionals in primary care and in specialist services need the proper education and training to recognise early symptoms and risk and to take appropriate action.' (Department of Health, 1998: 35).

The *National Service Framework for Mental Health* stressed the necessity for prompt assessment of young people at the first sign of a psychotic illness in light of *'the growing evidence that early assessment and treatment can reduce levels of morbidity'* (Department of Health, 1999: 44)

The *National Plan for the NHS* further stated that:

'Fifty early intervention teams will be established by 2004 so that ... all young people who experience a first episode of psychosis, such as schizophrenia will receive the early and intensive support they need.' (Department of Health, 2000: 119).

Recent and emerging guidance on treatment of schizophrenia from the National Institute for Clinical Excellence (NICE) has also recommended that:

'Early intervention services are developed so as to provide the correct mix of specialist pharmacological, psychological, social, occupational and educational intervention at the earliest opportunity.' (National Institute for Clinical Excellence, 2002)

A range of *Policy Implementation Guides* (Department of Health, 2001) has further developed the ideas encapsulated in the National Service Framework for Mental Health and National Plan (see figure 1).

Figure 1: The Policy Implementation Guidance on Early Intervention

The Policy Implementation Guidance on Early Intervention suggest that early intervention service should be able to:

- Reduce the stigma associated with psychosis and improve professional and lay awareness of the symptoms of psychosis and the need for early assessment
- Reduce the length of time young people remain undiagnosed and untreated.
- Develop meaningful engagement, provide evidence-based interventions and aid recovery during the early phase of illness
- Facilitate development and provide opportunities for personal fulfilment including social life and employment and training opportunities
- Provide a user-centred service that is a seamless service available for those from 14–35 years of age
- At the end of the treatment period (up to 3 years), ensure that the care is transferred thoughtfully and effectively.

Arguments Against Early Intervention Services

A number of commentators have spoken out against the development of specific EIS. Pelosi (2003) has argued that for every individual who is appropriately treated during a prodromal phase of schizophrenia, there may be others with similar clinical features who will never develop the illness. Some people may therefore be given anti-psychotic medication and specific psychotherapy unnecessarily (Verdoux, 2001).

However, EIS are targeted at people with a first episode psychosis and not at those in prodrome. Although services such as the PACE clinic in Australia and EDIT services in Birmingham UK are directed at trying to engage people with risk factors for psychosis (primary prevention) and people who are exhibiting prodromal symptoms, UK EIS are targeted at people with a definite first episode illness.

Pelosi has also argued that people with first episode psychosis can be treated by comprehensive locality psychiatric services that have good links with family doctors (Pelosi and Birchwood, 2003).

However evidence suggests that generic Community Mental Health Teams (CMHTs) are often unable to respond to first episode psychosis in a specialised and focused manner. Training physicians to a high level and then installing them in isolation within CMHTs will also do little to change mainstream clinical practice. There is also plenty of evidence to suggest that GPs in the UK do not see themselves as primarily involved with people with serious mental illness (Bindman et al, 1997) and that communication between primary and secondary care about people with serious mental illness can be variable (Lang et al, 1997).

Refocusing services on people experiencing a first episode of psychosis may also theoretically be detrimental to services aimed at people with longer-term mental health needs. Pelosi argues that early intervention services may lead to a diversion of resources to specialised teams making it even more difficult to provide decent care to people with severe and enduring mental disorders (Pelosi and Birchwood, 2003). The Government has, however, promised new money to fund the 50 new EIS, so

monies should not be redirected from existing services for people with serious mental illness.

Others have suggested that the time scale for developing new EIS has failed to take into account the lack of expertise in this field (Bradshaw and Everitt, 1999). Commissioners and providers may be rushed into developing and delivering new EIS to achieve 'green light status' and therefore extra funding and newly formed EIS may therefore not have key processes or appropriately skilled practitioners in place.

This may indeed be a legitimate concern. However there are also ongoing formative and summative evaluations of the roll out of EIS across England funded by the Department of Health and the Mental Health Research network that will provide practical guidance on service formation and delivery by 2005/6.

74

Arguments for Early Intervention Services

There are many more arguments for developing EIS rather than continuing with the status quo. Birchwood argues that what we are currently practising is late intervention and indeed late intervention in a low intensity haphazard and coercive way (Pelosi and Birchwood, 2003).

Young people surveyed by a Rethink (www.rethink.org/reachingpeopleearly) found current services stigmatising, therapeutically pessimistic and youth insensitive. Users and carers expressed significant levels of dissatisfaction with current mental health service response to first episode including unhappiness with the lack of streamed acute wards for first episode, a lack of wider age specific psychosocial opportunities in recovery such as access to work training and education and use of sub-optimal medication doses often connected to the use of older style neuroleptics. Users are less likely to stay engaged with services they feel are un-therapeutic, which may account in part for current high service disengagement rates. Services for younger teenagers were particularly criticised, with young people aged between 14 and 18 years of age deemed too young to access adult services and referred to Child and Adolescent Mental Health Services (CAMHS) services with little if any

experience of treating psychosis. The 14-35 year age range of the new EIS will therefore help to address these specific issues and overcome the traditional problems of continuity of care between CAMHS and adult mental health services.

In addition to user and carer concerns, bespoke EIS are required in response to the association between DUP and longer-term outcomes. Although still disputed (Ho and Andreasen, 2001), it is highly likely that an association exists between DUP and outcome in first episode psychosis, particularly functional and symptomatic outcome at 12 months and symptom reduction one treatment begins (Drake et al, 2000; McGlashen, 1999; Larsen et al, 2000; Norman and Malla, 2001; Harrigan et al, 2003). Long-term follow up studies also demonstrate that outcome at two years strongly predicts outcomes 15 years later (Harrison et al, 2001). Long DUP is also associated with increasing behavioural disturbance and family difficulty (often involving multiple failed attempts to access care), life threatening behaviour (Power, 1999) and increased use of the Mental Health Act (Humphreys et al, 1992).

The relationship between DUP and outcome is potentially confounded by other predictors of outcome such as pre-morbid adjustment, family psychiatric history, level of education, mode of onset and gender. However, a recent study of 354 first episodes of psychosis patients followed up 12 months after remission of psychotic symptoms found that DUP remained a significant predictor of outcome after adjusting for the effects of other variables (Harrigan et al, 2003).

A further rationale for intervening intensively and early in first episode is the concept of a 'critical period' in the early phase of psychosis, with major implications for secondary prevention of impairments and disabilities. Many health professionals have been educated within a mental health system that still perceives the management of schizophrenia in Kraepelinian terms as 'the orderly management of decline' (Harding et al, 1992). Indeed, the phrase Kraepelin coined, 'dementia praecox,' reflects the perceived relentless, downward, deteriorating course and uniformly poor outcome of psychotic illness. However Birchwood et al (1996) challenges this

mindset, arguing that deterioration occurs in the pre-psychotic period and early in the course of psychosis, but that this often stabilises after two to five years and may even relent. He suggests that intervention targeted in the early years after onset, particularly the first three years, is likely to have a disproportionate impact relative to later interventions.

Early intervention is also more than simply intervening early to try and reduce duration of untreated psychosis. The content as well as the timing of the treatment is important. Cognitive behavioural therapy and low dose drug regimes are associated with improved longer-term outcomes (McGorry et al, 1996; Lewis et al, 2002). Evidence suggests that patients' needs during the early phases of the illness differ from those of individuals with longer-standing illness (Norman and Townsend, 1999). The former are generally younger, living with their families, attempting to negotiate the normal developmental phases of late adolescence and young adulthood and using alcohol and drugs socially or excessively. They are often still dealing with the initial personal trauma of psychosis, have strong hopes of returning to a normal level of functioning and are more likely to reject a paternalistic approach to medical interventions. Engagement, or the formation of a 'therapeutic alliance' is crucial and indeed is an independent predictor of treatment retention rates and of good symptomatic and functional outcomes in psychosis (Birchwood et al, 2000). Engagement can be fostered by searching for common ground, avoiding premature confrontation of their explanatory model of illness and delivering treatment in as flexible a manner as possible through home visits, short waiting lists and frequent contact with a single worker.

Early intervention services also include a specific focus on the prevention of relapse that involves working with the patient and their family to identify their unique early warning signs of psychotic relapse and to prepare and rehearse a response (Birchwood et al, 1996). Recent evidence suggests that early intervention teams delivering specialised care are superior to standard care for not only maintaining contact with professionals but also for reducing readmissions (Craig et al, 2004).

Conclusion

This review has argued that for many inter-related reasons, EIS focussed on patients with a first episode psychosis is now a high priority in the Government's mental health agenda. EIS really is an idea whose time has come.

The evidence base and experience during the past decade suggest that the development of EIS across England will make a significant difference to the lives of patients and their families. There are legitimate concerns about the pace of change and specifically the already missed National Plan target of having 50 new EIS in place by April 2004. Indeed, the National Service Framework five-year review (Department of Health, 2004), suggested that the 41 teams in existence in 2004 were mostly smaller than envisaged and employed only a total of 174 staff. There are also worries being voiced that small changes to existing secondary care services that do not follow an early intervention model (and therefore demonstrate poor fidelity to the policy implementation guidance in this area) may be sufficient for Primary Care Trusts to 'tick the box' for early intervention (Singh and Fisher, 2005). However the combination of new monies, strong leadership in the field and an increasingly robust underpinning evidence base suggest that we will look back at the first decade of the new millennium as a turning point in the development of good quality socially inclusive services for people with psychosis.

References

- Bindman, J., Johnson, S., Wright, S., Szmulker, G., Bebbington, P., Kuipers, E., Thornicroft, G. (1997) 'Integration between primary and secondary services in the care of the severely mentally ill: patients' and general practitioners' views', *British Journal of Psychiatry*, 171: 169-74.
- Birchwood, M., Fowler, D. and Jackson, C. (2000) *Early intervention in psychosis*. Chichester: John Wiley and Sons.
- Birchwood, M., Todd, P. and Jackson, C. (1998) 'Early intervention in psychosis, the critical period hypothesis', *British Journal of Psychiatry*, 172: Suppl.33: 53-59.

Bradshaw, T. and Everitt, J. (1999) 'The benefits of training in psychosocial intervention', *Nursing Times*, 95: 48-9.

Craig, T., Garrety, P., Power, P. *et al.* (2004) 'Lambeth Early Onset (LEO) Team: Randomised controlled trial of effectiveness of specialised care for early psychosis', *British Medical Journal*; 329: 1067-73.

Department of Health (1998) *Modernising mental health services: safe, secure and supportive*. London: Department of Health.

Department of Health (1999) *The National Service Framework for Mental Health*. London: Department of Health.

Department of Health (2000) *The National Plan for the NHS*. London: Department of Health.

Department of Health (2001) *The Mental Health Policy Implementation Guide*. London: Department of Health.

Department of Health (2004) *The National Service Framework for Mental Health- Five years on*. London: Department of Health.

Drake, R.J., Clifford, J.H., Akthar, S. and Lewis, S.W. (2000) 'Causes and consequences and duration of untreated psychosis and schizophrenia', *British Journal of Psychiatry*; 177: 511-15.

Harding, C.M., Zubin, J. and Strauss, J.S. (1992) 'Chronicity in schizophrenia: revisited', *British Journal of Psychiatry*; 161: 27-37.

Harrigan, S.M., McGorry, P.D. and Kirstev, H. (2003) 'Does treatment delay of first episode psychosis?', *Psychological Medicine*, 33: 9-110.

Harrison, G., Hopper, K., Craig, T., *et al* (2001) 'Recovery from psychotic illness: A 15 and 25 year international follow up study', *British Journal of Psychiatry*; 178: 506-17.

Ho, B.C. and Andreasen, N. (2001) 'Long delays in seeking treatment for schizophrenia', *Lancet*, 357: 898-900.

Humphreys, M., Johnstone, E., Macmillan, J. and Taylor, P. (1992) 'Dangerous behaviour previousing first admissions for schizophrenia', *British Journal of Psychiatry*, 161: 501-05.

Knapp, M. (1997) 'Costs of schizophrenia', *British Journal of Psychiatry*, 171: 509-18.

Lang, F., Johnstone, E.C. and Murray, G.D. (1997) 'Service provision for people with schizophrenia: role of the general practitioner', *British Journal of Psychiatry*, 171: 165-68.

Larsen, T., Moel, V.B., Hansen, L. and Johannessen, J. (2000) 'Pre-morbid functioning versus duration of untreated psychosis in one year outcome and first episode psychosis', *Schizophrenia Research*, 45: 1-9.

Larsen, T.K., Johannessen, J.O. and Opjordsmoen, S. (1998) 'First episode schizophrenia with long duration of untreated psychosis – pathways to care', *British Journal of Psychiatry*; 172: Suppl.33: 45-52.

Larsen, T.K., McGlashen, T.H., Johannessen, J.O. and Vibe-Hanson, L. (1996) 'First episode schizophrenia to pre-morbid patterns by gender'. *Schizophrenia Bulletin*; 22: 241-56.

Lewis, S., Tarrier, N., Haddock, G., *et al.* (2002) 'Randomised controlled trial of cognitive behavioural therapy in early schizophrenia: Acute phase outcomes', *British Journal of Psychiatry*, 181: Suppl.43: S91-S97.

Lincoln, C., Harrigan, S. and McGorry, P.D. (1998) 'Understanding the topography of the early psychosis pathway: An opportunity to reduce delays in treatment', *British Journal of Psychiatry*; 172 Suppl.33: 21-5.

Lincoln, C.B. and McGorry, P.D. (1995) 'Who cares? Pathways to psychiatric care for young people experiencing a first episode of psychosis', *Psychiatric Services*; 46: 1166-71.

McGlashan, T.H. (1999) 'Duration of untreated psychosis in first episode schizophrenia: Marker or determinant of course', *Biological Psychiatry*; 46: 899- 907.

- McGlashen, T. (1999) 'Duration of untreated psychosis in first episode schizophrenia: Marker or determinant of course?', *Biological Psychiatry*, 46: 899-907.
- McGorry, P., Edwards, J., Mihalopoulos, C., Harrigan, S. and Jackson, H. (1996) 'EPPIC: An evolving system of early detection and optimal management', *Schizophrenia Bulletin*, 22: 305-326.
- Meltzer, H., Baljit, G. and Petticrew, M. (1995) *OPS Surveys of psychiatric morbidity in Great Britain: The prevalence of psychiatric morbidity among adults living in institutions*. London: HMSO.
- Meltzer, H., Baljit, G. and Petticrew, M. (1996) *OPS Surveys of psychiatric morbidity in Great Britain: The prevalence of psychiatric morbidity among adults living in institutions*. London: HMSO.
- National Institute for Clinical Excellence (2002) *Guidance on the use of the newer (atypical) antipsychotic drugs for the treatment of schizophrenia*. London:
- NHS Executive (1994) *Introduction of supervision registers for mentally ill people from 1 April 1994*. HSG (84), 5.
- Norman, R. and Malla, A. (2001) 'Duration of untreated psychosis: A critical examination of the concept and its importance', *Psychological Medicine*, 31: 381-400.
- Norman, R.M.G. and Townsend, L.A. (1999) 'Cognitive behavioural therapy for psychosis: A status report', *Canadian Journal of Psychiatry*. 44: 245-52.
- Pelosi, A. and Birchwood, M. (2003) 'Is early intervention of psychosis as waste of valuable resources?', *British Journal of Psychiatry*, 182: 196-98.
- Power, P. (1999) 'Suicide and early psychosis', in P. McGorry and C. Jackson (eds) *The recognition management of early psychosis*, Cambridge: Cambridge University Press.
- Prior, L. (1991) 'Mind, body and behaviour theorizations of madness and the organisation of therapy', *Sociology*, 25: 403-22.
- Rogers, A. and Pilgrim, D. (2001) *Mental Health Policy in Britain*. Basingstoke: Palgrave.
- Scull, A. (1977) *Decarceration: community treatment and the deviant- a radical view*. Engelwood Cliffs-NJ: Prentice-Hall.
- Singh, S. and Fisher, H. (2005) 'Early intervention in psychosis: obstacles and opportunities', *Advances in Psychiatric Treatment*, 11: 71-8.
- The Sainsbury Centre for Mental Health (2003) *The economic and social costs of mental illness*. London: The Sainsbury Centre for Mental Health.
- Verdoux, H. (2001) 'Have the times come for early intervention in psychosis?' *Acta Psychiatry Scand*; 103: 321-22.
- Weller, M.P.I. and Muijen, M. (1993) *Dimensions of community mental health care*. Kent: Saunders.
- Yung, A.R., and McGorry, P.D. (1996) 'The Prodromal Phase of first episode schizophrenia', *Schizophrenia Bulletin*. 22: 353-70.

Notes on Contributor:

Address for correspondence:

Dr Helen Lester
National Primary Care Career Scientist
Department of Primary Care
Clinical Sciences Building
University of Birmingham
Edgbaston
Birmingham
B15 2TT
Tele: 0121 414 2684
Fax: 0121 414 6571
H.E.Lester@bham.ac.uk

