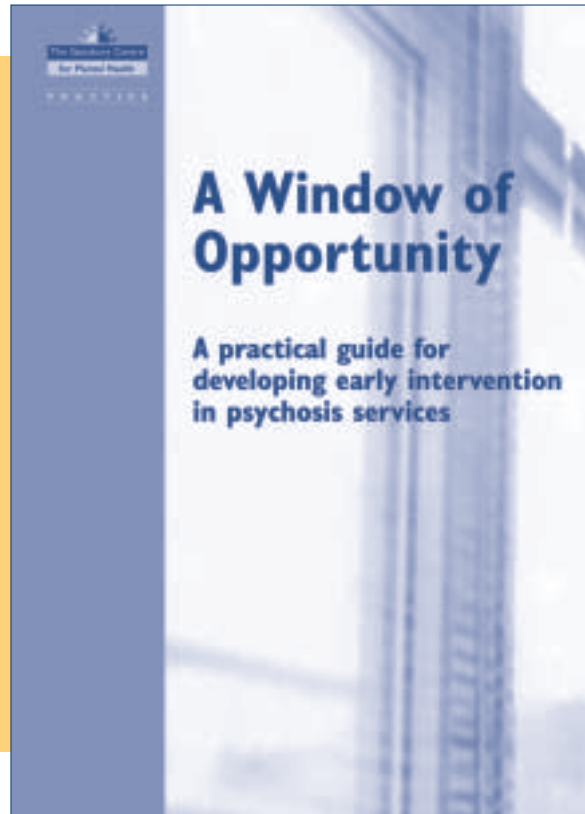




An introduction to a topic of current importance or controversy, giving clear and independent comment and analysis of the issues that lie behind it.



## BRIEFING 23

**T**he Sainsbury Centre for Mental Health (SCMH) is a registered charity, working to improve the quality of life for people with severe mental health problems. It aims to influence national policy and encourage good practice in mental health services, through a co-ordinated programme of research, training and development. SCMH is affiliated to King's College London.

*A Window of Opportunity: A practical guide for developing early intervention in psychosis services* is available @ £15 plus 10% p&p from SCMH Publications 020 7827 8352 or [www.scmh.org.uk](http://www.scmh.org.uk)

# A Window of Opportunity: A practical guide for developing early intervention in psychosis services

## Introduction

Psychosis first tends to emerge during the mid to late teenage years and early twenties, during an important developmental stage for young people. Consequently, mental health services that are offered at this stage of a person's life should not only provide effective and appropriate interventions, but also be sufficiently competent to work sensitively to address the distinctive needs and everyday culture of this client group.

Early intervention in psychosis (EIP) teams are one way of achieving this goal. These teams specialise in working with young people aged between 14 and 35 who are experiencing their first episode of psychosis. They provide a range of services, including anti-psychotic medications and psycho-social interventions (PSIs), tailored to the needs of young people with a view to facilitating recovery. They also take an optimistic view of the person's ability to recover, and eschew conventional preoccupation with symptom management and diagnosis.

To support the development of EIP, the Sainsbury Centre for Mental Health has published a practical guide on the subject. This briefing summarises the guide’s main points.

**The benefits of early intervention**

EIP has, in recent years, become a ‘must-do’ for mental health services. Its inclusion as a key target in the *NHS Plan* (Department of Health, 2000) has impelled many mental health services to develop EIP. But there are also wider justifications for EIP.

There is a growing body of evidence indicating that EIP effectively addresses inequalities in mental health. While untreated psychosis may not result in a potentially irreversible deterioration of brain functioning (Heinimaa & Larsen, 2002), clear evidence exists that intervening early can reduce the long-term harm people may experience (Ho *et al.*, 2003). This harm reduction potential is important. EIP services seek to promote a long-term recovery from psychosis and to provide clients with the chance to live a ‘normal’ life.

**The duration of untreated psychosis and the ‘critical period’**

Central to EIP are the notions of the duration of untreated psychosis (DUP) and the so-called ‘critical period’.

A prerequisite for early and effective treatment is early detection. Offering treatment during the ‘critical period’ of the first three years of a first-episode of psychosis can decrease the likelihood of relapse and social disability, limit adverse psychological problems, and reduce longer-term health care costs (Birchwood *et al.*, 1998, McGorry & Jackson, 1999).

The DUP is the time lag between the first onset of psychotic symptoms and the point at which treatment is provided.

Current Government guidance requires the

DUP be reduced to a service median of less than three months, with an individual maximum of less than six months (Department of Health, 2003). Recent studies, however, show that people can have been ill for up to two years and have made numerous attempts to get help, often becoming acutely ill before being offered a service (Birchwood *et al.*, 2001).

**Working with young people**

EIP services seek to address not only the symptoms of psychosis but, most importantly, how it is experienced by the individual. The disruption caused by psychosis can result in a myriad of social problems that can impair a young person’s confidence, functioning, and, ultimately, their ability to perform the daily roles (e.g. son/daughter, student, employee) they are expected to play. These problems can include educational and vocational disadvantage, impaired financial autonomy, and difficulties establishing and maintaining relationships.

In this way, an individual is slowly reduced from being a complex, multi-dimensional being to a one-dimensional ‘psychiatric patient’. EIP services acknowledge that clients are more than just a diagnosis; they are complex human beings with distinctive needs. EIP services are sensitive to the developmental needs of young people and the different ways in which they seek help. They seek to enable clients themselves to resume their interrupted lives, so they can once again play a meaningful part in society.

**A comprehensive EIP service**

It is essential for any EIP service to deliver faithfully the fundamental components of the approach as defined by the evidence if the intended outcomes are to be achieved. These are shown in the table below.

Core Feature	Service Design Notes
1 Early detection and assessment	<ul style="list-style-type: none"> <li>EIP requires a strategy for detecting psychosis at the earliest possible stage, thereby minimising the DUP.</li> <li>Assessment needs to be comprehensive, involving all professional groups, client, family and friends.</li> <li>Working with diagnostic uncertainty must be possible during the assessment phase.</li> </ul>
2 Pharmacological treatment	<ul style="list-style-type: none"> <li>Management of symptoms should include low dose atypical antipsychotic medication, prescribed in accordance with National Institute for Clinical Excellence guidelines.</li> <li>There should be routine monitoring for side effects and prompt action taken to alleviate the unwanted effects of treatment.</li> <li>Strategies for treatment resistance are required.</li> </ul>

**Table 1: The core features of EIP (continued)**

Core Feature	Service Design Notes
3 Care co-ordination	<ul style="list-style-type: none"> <li>• Key workers must be allocated rapidly and, where necessary, adopt assertive engagement approaches.</li> <li>• Care plans need to be focused on recovery with an emphasis on empowering the client.</li> <li>• Planning must reflect the preferences and priorities of individual clients.</li> <li>• All relevant parties (including carers and significant others) should be involved in care planning.</li> <li>• Sustained involvement should continue for three years.</li> <li>• Caseloads for individual key workers should not exceed 15.</li> </ul>
4 Co-morbidity	<ul style="list-style-type: none"> <li>• There needs to be specific and ongoing assessment and planning for:               <ul style="list-style-type: none"> <li>– anxiety disorders</li> <li>– depression</li> <li>– suicidality</li> <li>– alcohol / substance use and misuse</li> <li>– post-traumatic features.</li> </ul> </li> <li>• Carer morbidity must also be recognised and assessed for.</li> </ul>
5 Basics	<ul style="list-style-type: none"> <li>• Proper attention must be given to:               <ul style="list-style-type: none"> <li>– housing</li> <li>– income / finance</li> <li>– physical healthcare</li> <li>– practical support.</li> </ul> </li> </ul>
6 Psychosocial interventions	<ul style="list-style-type: none"> <li>• Young people’s personal and social developmental needs must be recognised and addressed.</li> <li>• Psycho-education should be provided to clients, families and carers.</li> <li>• Families should receive support and training around such issues as loss and adjustment, relapse prevention, expressed emotion, etc.</li> <li>• Strategies for preventing relapse are required.</li> <li>• Cognitive behavioural therapy (CBT) should be available.</li> </ul>
7 Education and occupation	<ul style="list-style-type: none"> <li>• All clients should undertake vocational assessment.</li> <li>• Clients need to be supported into employment, education or other valued occupations within normal environments.</li> <li>• The achievement of normal social roles should be afforded the highest priority.</li> </ul>
8 Acute care	<ul style="list-style-type: none"> <li>• Wherever possible, acute and crisis care should be provided at home.</li> <li>• Where needs indicate a period of care away from home, this should be provided in suitable, safe, age-appropriate environments, which are not unnecessarily restrictive.</li> <li>• The use of the Mental Health Act should be avoided where possible.</li> </ul>
9 Style	<ul style="list-style-type: none"> <li>• Embracing and promoting optimism about recovery is an essential cultural principle for the service.</li> <li>• The service must be sensitive to individual needs relating to culture, gender, age, etc.</li> <li>• The service must be designed to be accessible, acceptable and engaging, being particularly sensitive to the needs of young people.</li> </ul>
10 Partnerships	<ul style="list-style-type: none"> <li>• The service needs to be designed and delivered using a partnership approach involving:               <ul style="list-style-type: none"> <li>– primary care</li> <li>– adult mental health services</li> <li>– child and adolescent psychiatry</li> <li>– social services</li> <li>– non-statutory services</li> <li>– education</li> <li>– clients and carers</li> <li>– youth organisations</li> <li>– drug and alcohol services</li> <li>– criminal justice services.</li> </ul> </li> </ul>

While these core features must be common to all EIP services, how they are configured will vary widely. Most existing services in England have one predominant pathway by which people gain access to EIP. Some work predominantly with primary care services. Sheffield’s EIP team, for example, has worked hard to educate primary care staff in the early detection of psychosis and receives most of

its referrals directly from General Practitioners (GPs). Others, such as the ETHOS service in south-west London, receive most of their referrals from specialist mental health services. A smaller number of services have made significant connections with youth services. The Insight team in Plymouth, for example, is based within a youth enquiry service and enables young people to refer

themselves to it. Whether a service is based in an urban, rural or mixed area will also have a fundamental influence on how it is configured.

## Building an EIP service

Creating an EIP service is a demanding, time-consuming process. Some of the vital steps are listed below.

### Project design and management

Project design will need to address issues such as structure, reporting mechanisms, membership, roles and leadership. A project management strategy needs to be agreed and may involve the establishment of a multi-agency strategy group or project management team. While membership of the project management team needs to be decided locally, it will be important to ensure broad representation from appropriate professional groups and agencies and that the membership (most importantly, perhaps, the chair) are of sufficient seniority (i.e. management board level) with explicit responsibility for delivering on EIP targets.

The appointment of a project lead is recommended in policy guidance. Given the nature of the task and the timescales involved, this is advisable. With responsibility for the design and implementation of a detailed project plan, this individual will require enthusiasm, energy, imagination and appropriate mental health knowledge and experience. They will also need to be credible across a broad range of agencies, with the ability to engage and inspire a diverse body of stakeholders.

### Stakeholder involvement

The meaningful involvement of all stakeholders is a considerable challenge and project leads should not underestimate the time required to achieve this. There will be some merit in establishing interest groups and networks to act as ‘think-tanks’ and advisory groups. However, evidence shows that such forums can be unattractive to clients and families and may risk limiting active involvement to familiar parties only (often adult mental health and social services). Consideration should be given to the need for more targeted approaches, the use of media (such as newsletters and questionnaires) and the running of educational events to achieve the broadest possible involvement. Realistically, project leads should allocate sufficient time to engage clients and their families, and GPs (who can prove to be elusive stakeholders), individually.

## Working in partnership

A major component of EIP is the attempt to engage people effectively and early in the development of psychosis. Equally important is the way that EIP specialists and teams interact with existing mental health and other services. Such connections and partnerships are important for all aspects of mental health care, but they are doubly so for EIP, where the aim is to prevent future harm through prompt actions to resolve psychosis and to divert people from involvement with secondary care services, such as acute inpatient care. These various links and interfaces and the key tasks they pose that need to be addressed, can be grouped into four main areas (see Box 1 for examples).

### Needs assessment

Ideally, service design would always follow a thorough assessment of local need. The Government recommends an audit of all 14-35 year olds presenting to mental health services with psychosis for the first time as a basis for service planning (Department of Health, 2001). Conducting an audit would also enable an examination of local pathways to care and the obstacles facing young people and their families. Such data can prove powerful as an aid to service design and in negotiations with commissioners.

Understanding the level of morbidity within a local population is a vital building block in the design of local services. Policy guidance suggests an average incidence rate of 15 people per 100,000 population per year. Averages, of course, can be misleading; inner city populations, university towns and areas that attract transient populations of young adults can expect significantly higher rates.

### Workforce development

Establishing the workforce to deliver EIP is a major service design consideration. The approach is based on a relatively large, highly skilled workforce, working with small numbers of clients. Required specialist skills include early detection, relapse prevention, family work, PSIs, psycho-education, assertive engagement, CBT for psychosis, concordance techniques, vocational assessment and more. Furthermore, recruiting staff with values, knowledge, experience and attitudes that are pertinent to young people and the EIP approach will be crucial.

The workforce required for EIP can already be considered scarce. All professional groups in mental health services are experiencing recruitment difficulties, with high calibre medical and nursing staff proving increasingly difficult to attract and retain. The

**Box 1: Sample connections for EIP services**

Links to existing mental health services within the same organisation:

- Identifying and agreeing with existing services the boundaries of each team and its functions.
- Establishing mechanisms to resolve clinical disagreements or disputes, while the person is receiving care, so they are not lost in the system.

Links to other health and social care providers:

- Building links with primary care practitioners to ensure rapid identification and referral of possible cases.
- Developing shared training with Child and Adolescent Mental Health Services (CAMHS) to extend their expertise on developmental and family issues to the care of people with psychosis.

Links to other public services and the voluntary sector:

- Ensuring that the police and criminal justice system, and any existing court diversion schemes, are aware of the service and are able to refer to it.
- Working with schools and school nurses to develop appropriate responses to possible cases.
- Linking with university counselling and welfare services to ensure rapid assessment and treatment.

Links to the general public:

- Develop a local community education programme that can challenge the prejudices surrounding psychoses and destigmatise severe mental illness.
- Develop promotional material and work with local media to publicise the service and encourage people to seek assistance.

creation of new specialist community mental health services over recent years has resulted in a ‘brain drain’ of highly skilled staff to these areas at the expense of mainstream services, such as community mental health teams and acute wards. Those charged with developing EIP services have a responsibility to recognise these problems, and the workforce requirements of EIP services need to be incorporated into broader local workforce planning activity.

**Financing early intervention in psychosis**

The apparent costliness of EIP services is understood to be the main cause of reluctance

amongst commissioners and providers to develop services in England. For this reason, it is important that these costs are understood in the context of the health economics evidence for best practice interventions in psychosis.

The cost of introducing EIP services may appear prohibitive, but health economists would argue that these apparently more expensive approaches promise to save as much as it currently costs to meet the long-term needs of people with high levels of disability.

An important consideration, nevertheless, will be how to fund the initial implementation of these approaches. In the early stages new services will need to exist alongside services for previous generations of clients with continuing care needs. The concept of investing-to-save through ‘pump-priming’ and bridging funds is familiar to those involved with the development of mental health services and should be given serious consideration.

Once local incidence rates are understood, it is possible for planners to describe the likely minimum cost of an EIP service at the outset. The examples given below (see Table 2) are based on populations of 200,000 and one million respectively, with average incidence rates (i.e. 15 per 100,000). It works on a figure for running costs of £5,000 per service user per year.

This scenario assumes that a prospective model for service implementation has been chosen. Since clients are expected to remain with services for three years, the cost at year 3 represents the recurrent annual cost of the service. Where services are offered retrospectively (i.e. to all clients within the three-year ‘critical period’ of a first-episode psychosis), the year 3 figure will apply from the outset. Using this formula to provide an illustration of projected service cost will enable planners to give commissioners an early indication of likely costs.

**Training and development**

Working in EIP means being equipped with the skills to work with a diverse group of people, from young teenagers to adults in their thirties. It is questionable whether the skills to implement a comprehensive EIP

**Table 2: Calculating the cost of EIP services**

Predicted no. of new cases per annum	X £5,000 / head	Minimum cost year 1	Minimum cost year 2	Minimum cost year 3
30	=	£150,000	£300,000	£450,000
150	=	£750,000	£1.5m	£2.25m

service exist in current mental health services. A recent survey of existing adult and CAMHS teams (Singh *et al.*, 2003) found that staff had insufficient skills to deliver specialist interventions for young people referred at first episode.

Consequently, it is unrealistic to expect staff allocated to, or selected for, the new EIP services to arrive ‘fit for purpose’. Acknowledging this fact clearly presents a considerable challenge to in-service training and to in-house team development processes.

### The essential capabilities for EIP

The challenge is, however, more formidable than this. As there is no ‘one size fits all’ approach to EIP service development, local priorities will dictate what service response is appropriate and feasible and thus what kind of workforce is needed. An effective training programme cannot be planned in isolation from such considerations. Furthermore, the kind of training provided needs to be responsive to the precise role of the team, and the care sector in which it is to be located. In addition to the capabilities required of all mental health workers (The Sainsbury Centre for Mental Health, 2001), EIP practitioners need a number of specific capabilities, examples of which are outlined in Box 2. The full list is available in *A Window of Opportunity: A practical guide for developing early intervention in psychosis services*.

### Training in EIP skills

Training programmes in EIP are under development at a number of places across England, including the Initiative to Reduce the Impact of Schizophrenia (IRIS) ([www.iris-initiative.org.uk](http://www.iris-initiative.org.uk)), the University of Sheffield ([www.mentalhealthsheffield.com](http://www.mentalhealthsheffield.com)), and the University of York ([www.york.ac.uk/healthsciences](http://www.york.ac.uk/healthsciences)). Many of the principles of EIP are addressed within existing courses on PSIs for people with serious mental health problems.

The Sainsbury Centre for Mental Health has run a pilot training programme with contents similar to those outlined in Table 3, developed after consultation with colleagues from the Early Psychosis Prevention and Intervention Centre in Melbourne, Australia, IRIS in Birmingham, and the Lambeth Early Onset Service in London.

## Conclusion

Early intervention is a radical new way of dealing with psychosis. It offers the prospect that more people will avoid serious mental illness through early and effective care and treatment, and that

### Box 2: Sample capabilities for EIP workers

- **The ability to identify the target group for EIP:** a clear understanding of who the service is for, as well as the philosophy, principles and aims of EIP.
- **The ability to recognise the factors that precipitate acute mental illness, relapses and crises:** including a recognition of the impact of the trauma of psychosis on a young person’s life during a critical stage in their personal, social and educational development.
- **The ability to work within a team framework:** to share information and to work effectively within the multidisciplinary team; a willingness to share traditional roles within the team to meet the needs of individual clients.
- **The ability to engage young people experiencing psychosis:** requiring that practitioners take time to engage with clients and carers according to their needs, rather than the needs of the service, or individual team members.
- **The ability to engage with, and work alongside, family members throughout the ‘critical period’:** providing clear information about the illness and support for family members, particularly during the early stage of the illness and at times of crisis.
- **The ability to help young people gain access, or return, to education, training and employment:** to help young people restore their self-esteem, gain access to education, training and employment agencies, and also provide ongoing support to help young people maintain their progress in achieving their goals.

those who do develop psychosis will be more likely to recover and resume a normal life. These are radical claims for any service, and EIP services will need careful evaluation and research to see if the promising worldwide developments in this field can be sustained and repeated.

Implementing EIP will not be easy. Grafting on another specialist team, without careful consideration of how the service will affect other teams and services, is likely to lead to confusion for clients and practitioners alike. The whole system of care will be affected by the introduction of EIP services, as all new cases of psychosis or suspected psychosis will have to be managed by EIP services by 2006. This means that referral pathways will need to be arranged, existing teams may need to transfer cases, and team members may move to new teams. Additionally, there are substantial training implications as all EIP service members will need to be conversant with the skills necessary to work with people where diagnosis is uncertain, but help is needed.

**Table 3: Training requirements for EIP**

Thematic Area	Specific contents
The concept of EIP and treatment models	<ul style="list-style-type: none"> <li>• What is EIP?</li> <li>• The prodrome and early detection.</li> <li>• First-episode psychosis.</li> <li>• Psychosis in young people: clinical profile of the target group.</li> <li>• The UK policy context.</li> <li>• Frameworks for evidence-based delivery, including treatment models.</li> <li>• Approaches to treatment of psychosis in young people.</li> </ul>
Developmental theory of adolescence and young adulthood and early onset psychosis	<ul style="list-style-type: none"> <li>• Developmental theories of adolescence and the concept of vulnerability.</li> <li>• Adapting psychological treatment approaches to take account of developmental needs in early onset psychosis.</li> </ul>
Youth culture and early psychosis	<ul style="list-style-type: none"> <li>• Impact of psychosis on a young person – biopsychosocial perspectives.</li> <li>• Consequences of social exclusion.</li> <li>• Risk and risk-taking behaviours in the context of early psychosis.</li> <li>• Harm minimisation.</li> </ul>
Promoting and maintaining social inclusion	<ul style="list-style-type: none"> <li>• The needs of young people: social networks, housing, work, leisure, and education.</li> <li>• Supporting young people to pursue their goals in education, training and employment, in the context of recovery.</li> <li>• Working for social inclusion.</li> <li>• Age and culturally sensitive services: the characteristics of a service that meet the needs of young people.</li> </ul>
Developing integrated services for young people with psychosis and local service implementation	<ul style="list-style-type: none"> <li>• Models of EIP services.</li> <li>• Identifying existing service components.</li> <li>• Team working and the 'team approach'.</li> <li>• Local opportunities for developing EIP services.</li> </ul>
Developing and maintaining collaborative therapeutic relationships – Engagement	<ul style="list-style-type: none"> <li>• What do young people and their families need during the initial stage of contact with services?</li> <li>• The process of engaging the young person.</li> <li>• Respecting the rights of the individual – human rights, confidentiality, trust.</li> <li>• Positive approaches to engagement.</li> </ul>
Developing and maintaining collaborative therapeutic relationships – Assessment	<ul style="list-style-type: none"> <li>• Mental health assessment – assessment during the prodromal phase and in first-episode, early signs, functional assessment, and co-morbidity.</li> <li>• Psycho-education.</li> <li>• Working collaboratively to promote adherence.</li> <li>• Assessing and monitoring the side-effects of medication.</li> </ul>
Relapse prevention	<ul style="list-style-type: none"> <li>• Early signs awareness and monitoring.</li> <li>• Identifying a relapse signature.</li> <li>• Developing relapse prevention strategies.</li> <li>• Implementing strategies into clinical practice.</li> </ul>
Working within the context of the family and social networks	<ul style="list-style-type: none"> <li>• The experience of living with a young person who is developing a psychosis.</li> <li>• Working with the family at a time of acute crisis.</li> <li>• Carer participation.</li> <li>• Models of working with families in clinical practice.</li> </ul>
Action planning and audit	<ul style="list-style-type: none"> <li>• Action planning for the local development of EIP services.</li> <li>• Evaluation and audit of EIP services.</li> </ul>

The EIP service will have a wider range of stakeholders to deal with, including education, housing, criminal justice, and youth services. Good links are essential if the potential benefits of EIP are to be realised. The prospect that EIP will enable young people to return to school or college and resume normal lives must drive these links. A change of culture is required, as mental health services move away from a passive reception of 'cases', towards a more active role in seeking people showing the first signs of difficulty and giving them the opportunity to regain their lives.

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- Questions or comments on this briefing should be directed to Richard Powell at SCMh ([r.powell@scmh.org.uk](mailto:r.powell@scmh.org.uk))

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**The Sainsbury Centre**  
for Mental Health

*Working for Excellence in Mental Health Services*

134–138 Borough High Street, London SE1 1LB  
T 020 7827 8300 F 020 7403 9482  
[www.scmh.org.uk](http://www.scmh.org.uk)