Early intervention in psychosis: service models worldwide and the Irish experience

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Abstract

This paper examines the concept of early intervention in psychosis at primary and secondary prevention levels. Examples of early intervention service models from different countries are presented and we discuss current evidence for efficacy. We highlight the Irish experience of early intervention to date, and discuss future implementation of early intervention services in Ireland.

Key words: Early intervention; Psychosis; Service models.

Introduction

Over the past 20 years there has been a growing interest in the field of early intervention in psychosis. This concept appeals to clinicians, researchers and policymakers alike. There are 200 early intervention services in various countries worldwide including Australia, Singapore, New Zealand, Canada, USA, and Scandinavia. In the UK, the Department of Health announced the establishment of 50 early intervention teams by 2004 as part of the National Health Service Plan;[1] early intervention is now part of government policy and has been included in the mental health implementation guide.[2] In this article we review some of the concepts of early intervention and discuss the implementation of early intervention services in the Irish mental health service.

Early intervention strategies

In public health terms, early intervention strategies can be broadly divided into primary and secondary prevention.

Primary prevention

Primary prevention constitutes preventing disease occurrence. There are two components salient to the success of primary prevention strategies: firstly, identification of the population at risk of developing psychosis and secondly, providing treatment to those identified as being at risk. This is an ambitious goal and there is ongoing research to improve the predictive capacity of screening tools and to assess the efficacy of interventions in the prodromal phase of psychosis. This is defined as the 'period between the most valid estimates of the onset of change in the person and the onset of psychosis'.[3] A Cochrane review of primary prevention studies has concluded that 'specialised treatment services for people with prodromal symptoms are only justified on an experimental basis'.[4] There is a large European multi-centre study addressing both aspects of primary intervention underway,[5] however at this time primary prevention remains a research agenda.

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Secondary prevention

Secondary prevention services focus on reducing the duration of untreated psychosis (DUP) by early detection and providing phase-specific optimal interventions.[6] DUP is defined as the period between the emergence of psychotic symptoms and initiation of adequate treatment, and on average is estimated to range from one to two years.[7] While the notion that untreated psychosis is 'biologically toxic' has little empirical evidence,[8] there is less doubt about the 'psychosocial toxicity' of untreated psychosis and the distress it causes to the individual, family and society at large.[9]

Delay in treatment for psychotic symptoms interferes with psychological and social development of individuals and increases risk for substance misuse and violence.[6] Longer DUP is also associated with greater severity of negative symptoms and increased suicidality.[7,10] Furthermore, several studies, including a meta-analysis and a systematic review, have reported an association between prolonged DUP and poorer outcome.[7,11-15] This supports the hypothesis that the early phase of psychosis comprises a 'critical period'.[16]

Types of early intervention (EI) service model

As primary prevention remains a research topic at present we concentrate on secondary prevention models. There are a number of differing service models and approaches to the management of early psychosis. The first consideration is the setting; EI services can be based within the child and adolescent mental health services, general adult mental health services, primary care or within youth services. Formats range from specialist EI services exclusively focusing on the early stages of psychosis to the other extreme of service model, generic based services, where early and first episode patients are managed within existing resources. There may be individuals or committees with a special interest in this group. Specialist EI services take many formats including a 'stand alone' EI service, a 'hub and spoke' model, a 'piggy-back' supplementary EI model or a tertiary consultation EI service or clinic. Generic based services embed EI workers within an established service or provide mental health workers with EI training and clinical guidelines.

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There are advantages to specialist services including a 'user friendly' approach, separation from patients with chronic illness, the staff develop expertise in early intervention and there are improved detection and retention rates.[6,17] However, specialist services have also been criticised for being resource intensive and can lead to fragmentation of service delivery and loss of continuity of care.[18]

Stand-alone services consist of a team dedicated to early intervention and treating solely first episode psychosis. In the 'hub and spoke' model early intervention workers are sited within community mental health teams.[17-19] A 'hub and spoke' model is easier to establish and requires fewer resources than a stand-alone model but it can also lead to fragmentation of services and does not incorporate early detection due to the lack of public education campaigns.[17,18]

Providing early intervention within a generic service is less expensive and may lead to complementarities with existing resources, however this model has been criticised for not being youth friendly, does nothing to reduce the stigma that establishing a specialist service in the community or within youth services can, and does not provide an essential function of early detection – educating the public and primary care in early recognition to reduce the DUP.[18]

Research comparing specialised services with standard care have shown the effectiveness of specialist services,[20] however no direct comparison has yet been made between specialised services, the 'hub and spoke' models and enhanced standard care. Therefore, it is not possible to draw any firm conclusions as to which type of service models best delivers early intervention and finance often dictates the choice of service established.

Early intervention services worldwide

There are a significant number of early intervention programs, services and other interventions around the world. In countries such as Australia and the UK, departments of health have identified early intervention as a key service area for development. Examples of long established services in a number of countries are described below for illustration purposes. Each service model reflects the context of the local mental health culture.

Australia: EPPIC (Early Psychosis Prevention and Intervention Centre) is a research and treatment centre in Australia. The pioneering work of McGorry and colleagues at EPPIC set out the principles and strategies that have been adopted by several early intervention services. Established in 1992, EPPIC is a community-based specialist stand alone service in Melbourne, Australia, with a catchment area population of 880,000. EPPIC provides phase-oriented services to individuals with first episode psychosis between the age of 15 and 29 years for an 18 month period. The components of this model include a multidisciplinary mobile assessment team that operates 24 hours a day, 7 days a week, outpatient case management and a 16-bed inpatient unit. The service provided entails comprehensive assessment, intensive case management, low dose antipsychotics and psychosocial interventions, including family work with a strong focus on promoting recovery.[6,21,22]

Scandinavia: The TIPS (early Treatment and Intervention in Psychosis) study in Norway and Denmark was established in 1997. This quasi-experimental research-intervention based early detection programme covers four areas in Scandinavia and focuses on reducing the duration of untreated psychosis through intensive community, sustained education programmes. There are two specialist EI teams covering two healthcare sectors in Norway with a total population of 370,000 inhabitants which are compared with two control sectors offering treatment as usual, one in Norway and the other in Denmark, having a total population of 295,000. The four sectors have equivalent treatment protocols for individuals presenting with first-episode psychosis. The EI teams follow patients for two years. TIPS achieved a significant reduction of DUP to a median of five weeks in the early detection sectors compared to 16 weeks in the control sectors through educational campaigns combined with early intervention teams.[23]

Canada: Canada has extensive early intervention coverage across most of the provinces including PEPP in London, Ontario. The Prevention and Early Intervention for Psychosis Programme (PEPP), was established in 1996 and is a stand alone outpatient based EI service that serves a catchment area of 390,000 people. The programme includes early community case detection and phase-specific interventions. Early detection strategies include improving access by adopting an open referral policy, effective communication with referral sources and a community-wide case-detection programme. Phase-specific treatment interventions use a modified assertive case management model with intensive medical and psychosocial input provided by a case manager. Patients are managed within the programme for two to three years. Second-generation antipsychotics are used exclusively and a wide range of psychosocial interventions such as family, group and individual interventions are offered.[24]

United Kingdom: In the UK early intervention is considered an integral part of comprehensive community mental health services, though the type of service varies considerably among the regions and sectors. The Lambeth Early Intervention Service (LEO) is a stand alone service in London. The LEO team was set up in 2000 and is run by the London and Maudesley Foundation Trust. It is a specialised community service offering phase-specific interventions, inpatient care and assertive outreach to young people from 16-35.[25] The OASIS (Outreach and Support in South London) service works in tandem with LEO and has a research team evaluating the effectiveness of early intervention for young people at high risk of developing psychosis. A randomised controlled trial comparing outcomes for participants treated by LEO with care from the community mental health team showed that outcomes were better at 18 months for those receiving care from the specialist early intervention service. [25,26]

Is early intervention effective?

The evidence base regarding the effectiveness of specialist early intervention services has grown over the last 15 years. Results from studies using a quasi-experimental design with historical and/or prospective controls show a modest superiority of specialised early intervention services over standard psychiatric service in the short-term. Introduction of early intervention services resulted in fewer admission rates, high adherence to medication and improved functional outcomes.[20,21,23,27-30]

Results from randomised controlled trials (RCT) are also

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encouraging. The OPUS trial is a large RCT (n = 547) in Denmark. This study found an intensive early intervention programme to be associated with better clinical outcome and greater user satisfaction in comparison with standard treatment at two year follow-up.[31] A randomised controlled trial in the UK comparing LEO (n = 144) with care as usual showed that people referred to LEO had a reduced number of inpatient admissions, were more likely to have returned to work or study than others receiving treatment as usual from community mental health teams; were more likely to have maintained or rebuilt good relationships with families and friends and were more likely to be taking their medication regularly after 18 months.[25] However, statistical significance was lost after controlling for potential co-founders such as ethnicity, sex and previous psychotic episode, the difference was no longer significant, with dropout rates and total number of admissions remained significant.[25]

Research is now emerging as to whether improvements in clinical and psychosocial measures are maintained in the medium and longer term. A systematic review of longitudinal outcome studies of first-episode psychosis in 2006 identified five studies out of 37 that exceeded five years of follow-up duration and concluded that outcome of first episode psychosis may be more favourable than previously reported, and that treatment and methodological variables in outcome studies are important contributors to outcome.[32]

A recent report from the OPUS trial suggested that short-term improvement in clinical outcomes was not sustained at five-year follow-up and queried whether early intervention services should manage patients beyond a two year period.[33] A report from EPPIC comparing EI patients with controls showed improved outcomes at approximately eight years, with less positive symptoms and a higher proportion in paid employment.[34] These reports suggest that further research is needed into how long specialist EI services should manage patients to optimise outcomes in the medium and long-term.

Cost-effectiveness of early intervention

Psychosis is an expensive illness for patients, their families and society. One third of the overall cost is attributable to financial direct costs and two-thirds to burden of disease. Early intervention services require investment by health departments and mental health services and while early intervention is effective in improving outcomes, it is equally important that such services represent value for money. Studies conducted by EPPIC in Australia, LEO in the UK, the OPUS trial in Denmark and the Parachute project in Sweden have shown reduced costs in the initial phases.[25,26,28,33] This is due primarily to reduced inpatient costs.

A recent study by Access Economics[35] was commissioned by the Orygen Research Centre in Australia in 2008, comparing early intervention treatment (using cost data from the EPPIC, OASIS, LEO services and the OPUS trial) with treatment as usual. The study showed a net present value of savings of $212.5 million for all FEP incidences per annum in Australia over a five year critical period.

Evidence has shown that early intervention reduces costs in the short-term, and is now emerging that economic benefits of early intervention persist over longer periods. EPPIC patients cost less at eight years than historical controls, and more were in paid employment reducing the burden of disease in addition to the direct costs, though more research in this area is required.[34]

The Irish experience to date

Three prospective studies have examined first-episode psychosis in the Irish population: The Cavan-Monaghan First Episode Psychosis study started in 1995. This prospective study of 'all' incident cases with first episode psychosis in a defined geographical area of 105,000 has yielded important biological and epidemiological data over the past 13 years.[36,37] This study is based within Cavan-Monaghan Mental Health Service, a community-based service model comprising two community mental health teams, including home-based treatment teams, a specialist service for the elderly and a community rehabilitation team. Central to the delivery of health services in this model is the use of home-based treatment as an alternative to hospital admission.[38]

The South Dublin First Episode Psychosis study took place between 1995 and 1998, with follow-up assessments ongoing. All cases (171) resident in the South Dublin catchment area of 165,000 who presented with first episode psychosis were included. Broad inclusion criteria included all first lifetime presentations (12 years or older, without an upper age limit) provided that they were not prescribed antipsychotic medication for more than 30 days prior to their referral to the service.[39] The four year and eight year data from this study have been published recently and the principal finding was that increasing duration of untreated psychosis was independently associated with reduced likelihood of remission, poorer functional outcome and increasing psychopathology at four years.[14,15,39]

The third study is being undertaken by DELTA/DETECT in South Dublin. This prospective study is taking place within the first Early Intervention service for psychosis set up in Ireland and examines all cases of first episode psychosis presenting between the ages of 17 and 65 in the catchment area.

Early intervention services in Ireland

DELTA: (Detection, Education and Local Team assessment) commenced operations in 2005, covering St John of God Hospital and the Cluain Mhuire Catchment Area (172,000).

DETECT: International guidelines suggest that the catchment area population of an early intervention service should be of the order of 350,000. In 2007 DETECT (Dublin East Treatment and Early Care Team) was established, replacing DELTA and covering a population of 375,000 serviced by three catchment areas; Cluain Mhuire service, Elm Mount Mental Health services and Newcastle Mental Health Services. The Health Service Executive co-funded the project from 2005 and are the sole funders of DETECT since January 2009.

The HSE directed that DETECT, as a pilot service, develop an early intervention model for Ireland's mental health system, provide an evidence base for roll-out of early intervention services nationally and contribute to international early intervention service research. Unlike many of the initial early intervention services, DETECT is not a stand alone service but rather is integrated with the local community mental health teams (CMHTs), works intimately with them and is in reality an arm of existing mental health services.

DETECT provides rapid, early assessment, often in the

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patient's own home, and offers phase-specific interventions, including cognitive behavioural therapy for psychosis, psychosocial rehabilitation programmes and family education. In addition, DETECT has established very close links with primary care and provides education on early psychosis and at-risk mental states for general practitioners in training and continuing medical education for established general practitioners. A survey conducted by DETECT showed over 80% of GPs found the service useful or very useful in determining suitability for referral and in formulating treatment plans after assessment.[40] Similar levels of satisfaction were found in surveys of CMHTs who work with DETECT.

The future of early intervention services in Ireland

Early intervention in psychosis is an important concept that has been endorsed by the College of Psychiatry of Ireland, by the Irish Government and most recently by a resolution of the European Parliament in February 2009. In the UK, the Department of Health has mandated that early intervention services be established across the country. The document, *A Vision for Change*, the report of the Irish expert group on mental health policy published in 2006, endorsed the concept of early intervention, awaited the results from the HSE pilot project and recommended establishment of a second pilot project in a further Irish population to determine the how early intervention services might best be incorporated within the Irish mental health services.[41] The South East Dublin and Wicklow mental health services are predominantly, although not exclusively, urban. So it is somewhat easier to deliver phase specific interventions than in less densely populated areas.

Strategies to identify those at risk of psychosis, to reduce the duration of untreated psychosis and improve outcome in those with a shorter duration of psychosis are well documented internationally and phase specific interventions have been shown to be effective. The task now is to incorporate the standard of early intervention into a country with vastly differing resources within each catchment area.

The needs of a rural area like Cavan-Monaghan, which has an average of 25 new cases per year, are bound to be different to the needs of a large city. Therefore, planning in Ireland should focus on analysis of how the early intervention model would fit into different areas of need and concentrate on service planning development.

A further challenge arises from the current global economic downturn where opportunity cost, or the challenge of correctly using resources where they will make a difference and not detract from other areas of need, is a mammoth task. As the Irish mental health service is undergoing significant structural changes in moving towards full implementation of a community-based model, we believe this is a good time to incorporate early intervention concepts within this model.

Conclusion

Early intervention in psychosis is a welcome development which has brought a public health perspective to mainstream psychiatry. While it is safe to say that primary prevention is still in a research phase and will be so for a considerable time, there is evidence that outcomes are improved at least in the short-term in those whose duration of untreated psychosis is reduced. There is a clear and immediate need to reduce unnecessary delays that many people with overt psychosis experience in getting effective treatment in Ireland. The Irish pilot model of early intervention services is designed to reduce duration of untreated psychosis, is integrated within the community mental health team and offers additional phase specific psychological and occupational therapies as well as providing carer education programmes.

The questions to be asked in the Irish context are whether this Irish model can reduce delays; improve outcome and whether it is cost-effective. If so, based on each early intervention model servicing a 350,000 population, Ireland would need nine more such centres. The focus of this debate in Ireland now should be 'how' rather than 'why' to intervene early.

Declaration of Interest: None.

References

1. Department of Health. The NHS Plan: a plan for investment, a plan for reform. Department of Health. London, 2000. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4002960 (accessed Feb 2009).
2. Department of Health. The Mental Health Policy Implementation Guide. Department of Health. London, 2001. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009350 (accessed Jul 2009).
3. Yung AR, McGorry PD. The prodromal phase of first-episode psychosis: past and current conceptualizations. Schiz Bull 1996; 22(2): 353-70.
4. Marshall M, Rathbone J. Early intervention for psychosis. Cochrane Database Syst Rev. 2006; (4): CD004718.
5. Klosterkötter J, Ruhrmann S, Schultze-Lutter F et al. The European Prediction of Psychosis Study (EPOS): integrating early recognition and intervention in Europe. World Psychiatry 2005; 4(3): 161-7.
6. Edwards J, McGorry PD. Implementing Early Intervention in Psychosis: A Guide to Establishing Early Psychosis Services. London; Dunitz Ltd, 2002.
7. Perkins DO, Gu H, Boteva K, Lieberman JA. Relationship between duration of untreated psychosis and outcome in first-episode schizophrenia: a critical review and meta-analysis. Am J Psychiatry 2005; 162(10): 1785-804.
8. Wyatt RJ. Neuroleptics and the natural course of schizophrenia. Schiz Bull 1991; 17(2): 325-51.
9. McGorry PD, Warner R. Consensus on early intervention in schizophrenia Schiz Bull 2002; 28(3): 543-4.
10. Clarke M, Whitty P, Browne S et al. Suicidality in first episode psychosis. Schiz Res 2006; 86(1-3): 221-5.
11. Norman RM, Malla AK. Duration of untreated psychosis: a critical examination of the concept and its importance. Psychol Med 2001; 31(3): 381-400.
12. Marshall M, Lewis S, Lockwood A, Drake R, Jones P, Croudace T. Association between duration of untreated psychosis and outcome in cohorts of first-episode patients: a systematic review. Arch Gen Psychiatry 2005; 62(9): 975-83.
13. Norman RM, Lewis SW, Marshall M. Duration of untreated psychosis and its relationship to clinical outcome. Br J Psychiatry Suppl. 2005; 48: s19-23.
14. Whitty P, Clarke M, McTigue O et al. Diagnostic stability four years after a first episode of psychosis. Psychiatr Serv 2005; 56(9):1084-8.
15 Crumlish N, Whitty P, Clarke M et al. Beyond the critical period: longitudinal study of 8-year outcome in first-episode non-affective psychosis. Br J Psychiatry 2009; 194(1): 18-24.
16. Birchwood M, Todd P, Jackson C. Early intervention in psychosis. The critical period hypothesis. Br J Psychiatr Suppl. 1998; 172(33): 53-59
17. Singh SP, Fisher HL. Early intervention in psychosis: obstacles and opportunities. Adv Psychiat Treat 2005; 11: 71-8.
18. Singh PS, Fisher HL. Early intervention services. Psychiatry 2004; 3: 17-21.
19. Pinfold V, Smith J, Shiers D. Audit of early intervention in psychosis service development in England in 2005. Psychiat Bull 2007; 31: 7-10.
20. Yung AR, Organ BA, Harris MG. Management of early psychosis in a generic adult mental health service. Aust NZ J Psychiatry 2003; 37: 429-436.
21. McGorry PD, Edwards J, Mihalopoulos C, Harrigan SM, Jackson HJ. EPPIC: an evolving system of early detection and optimal management. Schiz Bull 1996; 22(2): 305-26.
22. Amminger GP, Harris MG, Conus P et al. Treated incidence of first-episode psychosis in the catchment area of EPPIC between 1997 and 2000. Acta Psychiat Scand 2006; 114: 337-345.
23. Melle I, Larsen TK, Haahr U et al. Reducing the duration of untreated first-episode psychosis: effects on clinical presentation. Arch Gen Psychiatry 2004; 61(2): 143-50.
24. Malla A, Norman R, McLean T, Scholten D, Townsend L. A Canadian programme for early intervention in non-affective psychotic disorders. Aust NZ J Psychiatry 2003; 37(4): 407-13.
25. Craig TK, Garety P, Power P et al. The Lambeth Early Onset (LEO) Team: randomised controlled trial of the effectiveness of specialised care for early psychosis. BMJ 2004; 329(7474): 1067.
26. Garety PA, Craid TKJ, Dunn G et al. Specialised care for early psychosis: symptoms, social functioning and patient satisfaction. Br J Psych 2006; 188(1): 37-45.
27. Agius M, Shah S, Ramkisson R, Murphy S, Zaman R. Three year outcomes of an early intervention for psychosis service as compared with treatment as usual for first psychotic episodes in a standard community mental health team-fiinal results. Psychiatr Danub 2007; 19(3): 130-8.
28. Cullberg J, Mattsson M, Levander S, Holmqvist R, Tomsmark L, Elingfors C, Wieselgren IM. Treatment costs and clinical outcome for first episode schizophrenia patients: a 3-year follow-up of the Swedish 'Parachute Project' and two comparison groups. Acta Psychiat Scand 2006; 114(4): 274-281.
29. Goldberg K, Norman R, Hoch JS et al. Impact of a specialized early intervention service for psychotic disorders on patient characteristics, service use, and hospital

costs in a defined catchment area. Can J Psychiatry 2006; 51(14): 895-903.
30. Malla A, Norman R, Bechard-Evans L, Schmitz N, Manchanda R, Cassidy C. Factors influencing relapse during a 2-year follow-up of first-episode psychosis in a specialized early intervention service. Psychol Med 2008; 38(11): 1585-93.
31. Petersen L, Jeppesen P, Thorup A et al. A randomised multicentre trial of integrated versus standard treatment for patients with a first episode psychotic illness. BMJ 2005; 331(7517): 602
32. Menezes N, Arenovich T, Zipursky R. A Systemtatic review of longitudinal outcome studies of first episode psychosis. Psychol Med 2006; 36(10): 1349-62.
33. Bertelsen M, Jeppesen P, Petersen L et al. Five-year follow-up of a randomized multicenter trial of intensive early intervention vs standard treatment for patients with a first episode of psychotic illness: the OPUS trial. Arch Gen Psychiatry 2008; 65(7): 762-71.
34. Mihalopoulos C, Harris M, Henry L, Harrigan S. McGorry P. Is Early Intervention in Psychosis Cost-Effective over the Long Term? Schizophr Bull 2009 Jun 9. [Epub ahead of print] DOI: 10.1093/schbul/sbp054
35. Access Economics Pty Limited. Cost effectiveness of early intervention for psychosis. Report for Orygen Research Centre. Melbourne, Australia, 2008.
36. Scully PJ, Quinn JF, Morgan MGet al. First-episode schizophrenia, bipolar disorder and other psychoses in a rural Irish catchment area: incidence and gender in the Cavan-Monaghan study at 5 years. Br J Psychiatry Suppl. 2002; 43: s3-9.
37. Baldwin P, Browne D, Scully PJ et al. Epidemiology of first-episode psychosis: illustrating the challenges across diagnostic boundaries through the Cavan-Monaghan study at 8 years. Schizophr Bull 2005; 31(3): 624-38.
38. McCauley M, Rooney S, Clarke K, Carey T, Owens J. Home-based treatment in Monaghan: the first two years. Ir J Psych Med 2003; 20(1): 11-14.
39. Clarke M, Whitty P, Browne S et al. Untreated illness and outcome of psychosis. Br J Psychiatry 2006; 189: 235-40.
40. Renwick L, Gavin B, McGlade N et al. Early intervention for psychosis service: Views from primary care. Early Intervention in Psychiatry 2008; 2(4): 285-290.
41. A Vision for Change: Report of the Expert Group on Mental Health Policy. Department of Health and Children. Dublin: Stationery Office, 2006.

https://doi.org/10.1017/S0790966700001555 Published online by Cambridge University Press