special articles

Psychiatric Bulletin (2001), **25**, 146–148

DAVID WHITWELL

Service innovations: early intervention in psychosis as a core task for general psychiatry

Early intervention in psychosis is a strategy for which there is increasing theoretical and pragmatic justification. Many studies have been published describing the benefits of early intervention as carried out by specialised and innovative projects. The present paper describes how a generic community mental health team (CMHT), covering a population of 50 000, introduced strategies for early intervention with no extra funding. The team worked together to change old attitudes and practices. A style of intervention was developed to engage with and keep in contact with people with recent onset psychosis. This appears to be achievable – and this model may be an alternative to the setting up of specialised teams.

The early intervention movement

International interest in this area has grown rapidly in the past 10 years, with progress being presented in a supplement to the *British Journal of Psychiatry* (1998, **172**, Suppl. 33). Much of the rationale for early intervention comes from changing views of schizophrenia. The old Kraepelinian idea of gradual and inevitable decline has been challenged. It has been observed that on many measures the illness reaches its peak of severity after 2–5 years, after which the level of disability remains the same or may decrease – the 'plateau effect' (McGlashen, 1988). Long-term outcome studies (Mason *et al*, 1996; Warner, 1994) have confirmed the heterogeneity of outcome in schizophrenia.

Many people who develop psychotic illness go untreated for long periods – 1–2 years on average. This untreated period may set in train processes – biological, psychological and social – that add greatly to the subsequent chronicity of the illness. Psychosis may be 'toxic' to the brain. Also, social and psychological damage done may be irreversible. The 'critical period' hypothesis (Birchwood *et al*, 1998) suggests that given these new insights into the illness there may be a window of opportunity for intervening early.

Early intervention is used to describe two different things. In this paper it refers to a strategy for treating early psychotic illness as quickly and effectively as possible. It involves shortening the duration of untreated psychosis and tackling the problems of non-engagement with services. It is thus a secondary prevention strategy. A second, more ambitious, early intervention strategy involves trying to intervene with people before the psychosis develops. This is an exciting prospect but is not beyond the research stage – and is not discussed here.

How to put early intervention into practice

One model is to develop a special early intervention team. That is the way that most of the innovative projects around the world have been set up. It has enabled people to focus on the special problems of early intervention and test out responses. However, there are disadvantages to this option. These include funding problems and the risk that increased complexity of services can create artificial boundaries and may threaten continuity of care.

An alternative model is to incorporate early intervention into the working of the generic CMHT, which is the commonest service configuration in the UK (Thornicroft *et al*, 1999). One advantage of this is that improvements in care introduced as part of early intervention will influence the whole service and not just a specialised part of it.

A user-friendly style

Innovative approaches and projects are developing in all fields of psychiatry and early intervention work combines a number of these. Taken together they constitute a novel and refreshing approach to psychiatry.

It begins with a positive optimistic stance. If the outcomes of psychotic illness are very variable there is no reason in any individual case why a good result should not be achieved. Recent results show more favourable outcomes than studies carried out a decade or so ago (Singh *et al*, 2000). Focusing on narrow diagnostic categories and excluding borderline cases is no longer defensible. In the past there were real concerns that becoming involved with psychiatry could do more harm than good – so that an effort was made to keep people out. This is quite different from the idea that it is best to

https://doi.org/10.1192/pb.25.4.146 Published online by Cambridge University Press

special articles

start treating people who have developed psychotic symptoms as soon as possible.

There are now great efforts made to enhance engagement with help – particularly with disaffected young people. This requires a move from the old-fashioned paternalistic 'take it or leave it' procedure to a partnership approach (Coulter, 1999). Using information and making decisions becomes more of a joint venture. Users involvement in their own care – and also in the planning of services – is an essential part of this new paradigm.

Early intervention project within an established CMHT

The Marine Hill Team serves a population of 50 000 in the area of North Somerset, immediately to the south of Bristol. It has low/average morbidity with pockets of deprivation. The early intervention project was started in 1997. The team consisted of one part-time consultant, one part-time clinical assistant, one psychologist, one full-time and one part-time occupational therapists, two G grade and two E grade nurses, one part-time art therapist, two social workers, two support workers and one secretary.

Developing the project within the team

Once the rationale had been accepted the team worked together to develop the model.

First, existing practices were reviewed. This involved becoming aware of why early intervention was not happening in the existing service, audit of cases and studies of obstacles that had occurred in pathways to care.

Second, attitudes were challenged. It became apparent that many have trained at a time when psychosis was neglected as a topic. Odd experiences would be explained away or 'normalised'. They were not focused on or seen as a problem in themself. The life problems and conflicts that people had were seen as the real focus for help. It took much work to highlight and change this attitude.

Third, a shared concept of psychosis was developed. Schizophrenia means different things to different people. Discussion brought to light the way remnants of obsolete theories cling to this term. By contrast, psychosis can be used without so may unintended implications to describe certain symptoms. Information leaflets were produced – an exercise that helped to develop a clear and shared view of what psychosis is.

Fourth, skills training took place. Knowledge of phenomenology was needed to be reviewed and put into practice in interview situations. The subject of psychosis is difficult for many people and skill is needed to be able to discuss it freely. The first level of psychological help for people suffering from psychosis is to be able to talk to someone about it. Skill in this basic 'counselling about psychosis' is one of the most essential requirements for early intervention work – if not for all psychiatry.

Work with local stakeholders

The managers of the service supported the project. However, there was no extra funding available. This meant that the early intervention project had to be developed as a way of doing existing work differently, and with slightly altered priorities. The team was responsible for reviewing all referrals from the area. The project ensured that anyone who presented with psychotic symptoms, or what might be psychotic symptoms, was treated as a priority. The project began in a deliberately low-key way because of fear that the team would be overwhelmed with cases. However, as time passed and confidence increased there were more efforts to tell general practitioners in the area about the project. The next stage will involve other agencies such as schools, colleges, the police and probation.

The comparatively low inception rate for psychotic illness, compared with that for depression or neurotic disorders, means that general psychiatric teams that take on this task will only need to make a relatively small adjustment to their priorities to be able to accommodate early psychosis.

One problem is that the division between child and adult psychiatry occurs at a time when people are particularly likely to present with psychotic illness. There is a need for good communications between the different services, and clear decisions and responsibility in individual cases.

Developing a style of intervention

It is a flexible, yet assertive style from the start. A keyworker is assigned when the referral is received and the initial aims is to make contact and ensure some engagement with the service.

Keyworkers are backed up by other workers – to make extra support possible and to cover periods of leave. Continuity is very important. There is a register of all early intervention cases and they are reviewed by the full teams at least monthly.

Simple counselling about psychosis is a starting point to a psychological approach. A problem-solving approach is used with day-to-day issues and anxiety management techniques where needed. More specific cognitive–behavioural therapy focused on psychotic symptoms can be arranged.

In-patient treatment remains necessary for many patients at some stage. The team is in a good position to arrange this as it has a close link with the ward (at Southmead Hospital) that serves the area. Keyworkers can remain involved. Admission can be seen as one part of the treatment and not a disastrous set-back.

The aim is a partnership model in which decision-making is shared. This is very relevant to medication. Openness with information and full involvement in decision-making are seen as ways to improve the acceptance of antipsychotic medication. Oral medication, low dose regimes and depots are all used. Atypical antipsychotic drugs are used to increase the acceptability of treatment. Attempts are made to involve the families

https://doi.org/10.1192/pb.25.4.146 Published online by Cambridge University Press

special articles

of those referred, as a routine. Where appropriate, on-going regular family work is undertaken – looking at information, coping skills and problem-solving.

The team has had to adjust the activities to match the needs of this mainly young group of people. Young persons' activity groups, young women's groups and football groups have all been successful. New ideas emerge as the composition of the group changes. Practical help can be provided by support workers – either intensively for a short period or as part of a longer term plan. Advice and help from a welfare rights worker is needed by many. This covers issues relating to benefits and other money problems. There are good links to the employment service.

Conclusions

Early results are very encouraging. It appears to be quite possible for a generic CMHT to develop a focus on early intervention in psychosis as one of its main priorities. The adaptation of services to achieve this borrows from a number of initiatives, and taken together they constitute a new (user-friendly) style for delivering psychiatric care. Changes in attitude are more important in the setting-up of services than any change in organisation. The focus of early intervention is a powerful catalyst towards changing the approach of a team. The process of this change is a very positive one – capturing the interest and enthusiasm of the workers and increasing the cohesiveness of the team.

The justification for this approach does not depend on the outcome of some treatment trial still under way. It is an attempt to overcome shortcomings in services that leave many people without care or treatment. This work attempts to improve the ability of the team to carry out one of its core functions, arguing against this being a specialised task that should be allocated to a special team.

Acknowledgements

This is based on work undertaken at Marine Hill CMHT, Marine Hill, Clevedon, North Somerset BS21 7PW. Developing the approach was a team effort involving: Adrian Morton, David Maynard, Lissie Porter, Jill Leppard, Celia Keeping, Jill Bailey, Caroline Day, Martin Bowditch, Jean Walton, Beverly Hemmens and Sean Kelly.

References

BIRCHWOOD, J. M., TODD, P. & JACKSON, C. (1998) Early intervention in psychosis: the critical-period hypothesis. *International Clinical Psychopharmacology*, **13**(Suppl. 1), 31–40.

COULTER, A. (1999) Paternalism or Partnership? *British Medical Journal*, **319**, 719–720.

McGLASHEN, T. (1988) A selective review of North American long term follow-up studies of schizophrenia. *Schizophrenia Bulletin*, **14**, 515–542.

MASON, P., HARRISON, G., GLAZEBROOK, C., *et al* (1996) Characteristics of outcome in schizophrenia at 13 years. *British Journal of Psychiatry*, **167**, 596–603.

SINGH, S. P., CROUDACE, T., AMIN, S., *et al* (2000) Three-year outcome of first-episode psychoses in an established community psychiatric service. *British Journal of Psychiatry*, **176**, 210–216.

THORNICROFT, G., BECKER, T., HOLLOWAY, S., *et al* (1999) Community mental health teams: evidence or belief? *British Journal of Psychiatry*, **175**, 508–513.

WARNER, R. (1994) *Recovery from Schizophrenia: Psychiatric and Political Economy*. London. Routledge.

David Whitwell Consultant Psychiatrist, Southmead Hospital, Bristol BS10 5NB

https://doi.org/10.1192/pb.25.4.146 Published online by Cambridge University Press